



## PATIENT

Princess Gonzalez

## SPECIES

Canine

## BREED

West Highland Terrier

## SEX

Spayed Female

## AGE

14 Years

## WEIGHT

9.4 lbs

## INTERPRETED BY

Kathleen Sennello DVM,  
MS, Diplomate ACVIM  
(Small Animal Internal  
Medicine)

## IMAGING PERFORMED BY

Gabriel Ferrer, DVM

## HOSPITAL NAME

Pulse: Pet Ultrasound

## REFERRING VET

Dr. Carlos Soto

## INVOICE

72277

## DATE

1/15/26

## PRESENTING CLINICAL SIGNS

Presented for an abdominal ultrasound to evaluate hx of pancreatitis, gastritis and colitis. Pt has been having chronic vomiting and regurgitation. since Oct 2025. PT also has hx of PP and PU/PD. Pt has been eating home cooked diet. DDX: Gastritis, vs pancreatitis

Abnormal PE/Chem/CBC/UA Results: Bloodwork attached from Oct 2025

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is mildly to moderately distended with anechoic urine. The majority of the bladder wall appears normal with a smooth mucosal surface. In some views of the bladder there is an irregularity to the ventral wall, possibly consistent with folding of the bladder wall or less likely a mass lesion measuring 0.95 cm x 0.98 cm. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi.

The left kidney has a normal shape and size (3.81 cm) with mild pyelectasia at 0.18 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.17 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### Adrenal Glands

The left adrenal gland is large and abnormal in appearance, measuring 0.60 cm at the cranial pole and 1.0 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is abnormal in appearance in that there is a hyperechoic nodule at the caudal pole measuring 1.0 cm x 1.11 cm in diameter. No evidence of vascular invasion visualized.

The right adrenal gland is normal in size measuring 0.49 cm at the cranial pole and 0.42 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

### Spleen

The spleen is subjectively normal in size and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. Rare discrete focal hyperechoic, perivascular parenchymal abnormalities are present. The appearance of these lesions is most consistent with benign splenic myelolipomas. The blood flow through the hilus and splenic parenchyma appears normal.

### Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the



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vasculature and biliary tract appear normal. There are numerous poorly defined hypoechoic nodules in the parenchyma. An example on the left side measures 0.80 cm x 0.75 cm.

The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

### ***Gastrointestinal***

The stomach contains moderate fluid. The gastric wall appears of normal thickness in some regions, measuring at 0.30 cm with intact wall layering. In other areas it becomes significantly thickened and somewhat irregular, mostly with intact wall layering, but it is somewhat reduced in some areas and measures up to 1.38 cm. Intraluminally, there are soft tissue structures most suggestive of prominent rugal folds, but polypoid mass lesions or other mass lesions can't be ruled out.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.53 cm. Jejunum wall measures 0.44 cm. There is mild mucosal speckling visualized associated with some areas of the small intestine. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with non-formed fecal material. The descending colon wall appears somewhat prominent, measuring at 0.25 cm with intact wall layering.

### ***Pancreas***

The pancreas is visible/mildly mottled in the left limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

### ***Free Abdomen***

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

### **PRIMARY FINDINGS**

- Mildly distended urinary bladder with an irregular mass effect in the ventral wall. A folded bladder is suspected (not fully distended). Recommend correlating with a urinalysis and reevaluation with a distended urinary bladder.
- Hyperechoic nodule at the caudal pole of the left adrenal gland- At this time this has the appearance most consistent with a benign lesion (adenoma, focal hyperplasia, etc.). An early neoplastic lesion cannot be ruled out.
- Large, heterogeneous liver with ill-defined hypoechoic nodules – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The nodules observed trend toward a more benign process but underlying neoplasia cannot be ruled out.



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- Large gallbladder with a large amount of non-organized intraluminal echogenic debris – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.
- Severe gastric wall thickening with slightly reduced detail of wall layering and questionable intraluminal soft tissue structures – Findings are suggestive of gastric hypertrophy, although an early neoplastic lesion cannot be ruled out.
- Mildly thickened small intestine with mild mucosal speckling – Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.

## SECONDARY FINDINGS

- Age related changes visualized associated with both kidneys.
- Benign myelolipomas visualized in the spleen.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is mildly to moderately fluid distended with some areas exhibiting severe wall thickening. Wall layering is largely intact but has reduced distinction in some regions. Additionally, there are soft tissue structures visualized within the lumen, which are likely prominent rugal folds, but polypoid mass lesions or true mass lesions cannot be ruled out. These changes could be considered with severe hypertrophic gastropathy or a true mass effect (leiomyoma, leiomyosarcoma, carcinoma, round cell neoplasia, etc.). Consider upper GI endoscopy both to evaluate the esophagus and the stomach and to obtain biopsies. If hypertrophy is present, you could consider treatment for helicobacter gastritis. If the changes are persistent, surgical evaluation may be warranted.

There is a hyperechoic nodule at the caudal pole of the left adrenal. This generally has a somewhat benign appearance at this time. If signs of Cushing's are present, you could consider adrenal function testing (ideally wait for when there are fewer concurrent medical issues occurring). Additionally recommend a blood pressure evaluation. If hypertension is present, consider measuring catecholamine levels, looking for possible pheochromocytoma. Recommend close continued monitoring of the caudal pole with ultrasound (recheck in 6-8 weeks), looking for any evidence of rapid growth.

The liver is large and heterogeneous with some ill-defined nodules. Generally, this has the appearance of regenerative nodules and a vacuolar hepatopathy, although more significant hepatopathy could be present. Options for further evaluation could include a liver function test and a fine needle aspirate.

There is a large amount of non-organized debris visualized in the gallbladder. Consider starting chronic Ursodiol therapy and continued monitoring of the gallbladder.

The small intestine appears subjectively mildly thickened and there is some mild mucosal speckling. A concurrent enteropathy could be present. For potential empirical therapy, consider:

- Recommend a hydrolyzed protein prescription diet.
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.



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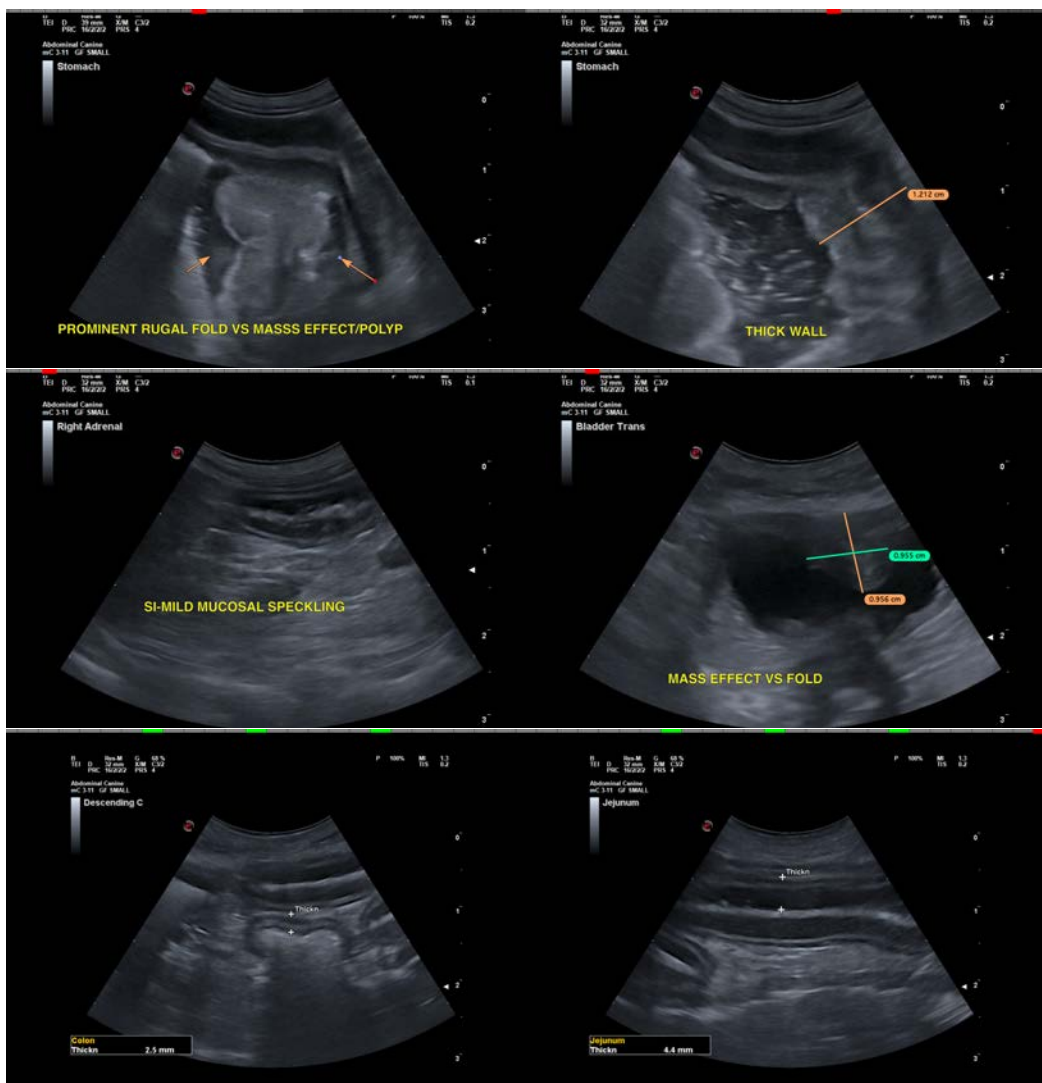
1/15/26

- Recommend chronic probiotic therapy.

If the diarrhea is persistent despite taking these measures, then biopsies of the GI tract may be warranted.

On some views of the bladder there is the impression of a “mass effect”. The bladder is not fully distended, so this could represent folded bladder wall or similar. Recommend evaluation of a urinalysis and reevaluation of the urinary bladder when it is fully distended.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).





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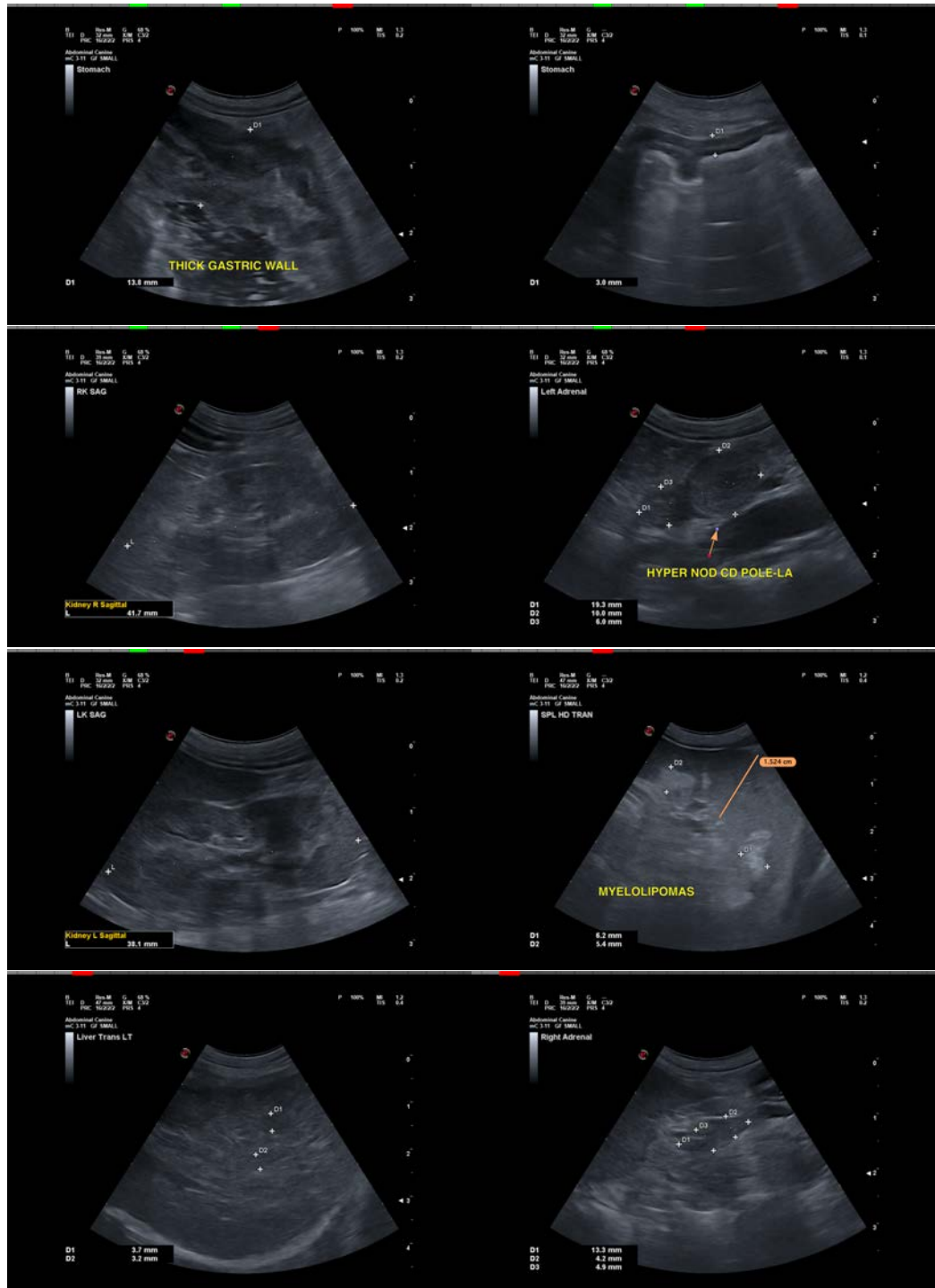
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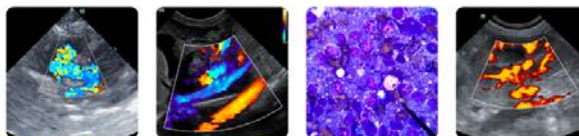
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

[info@sonopath.com](mailto:info@sonopath.com)