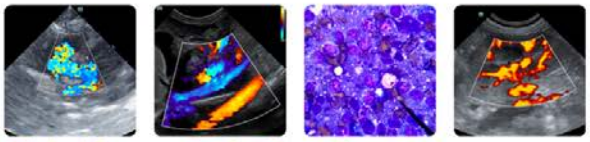


PATIENT

Sophie Aponte

SPECIES

Canine

BREED

Mixed

SEX

Spayed Femlae

AGE

9 Years 4 Months

WEIGHT

51 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. Jose Gonzalez

INVOICE

71957

DATE

11/19/25

PRESENTING CLINICAL SIGNS

Patient presented as a referral for an abdominal ultrasound to evaluate PU/PD for about 1 week. Diagnostics were performed and showed that pt has hyperglycemia and glycosuria and a UTI caused by E.coli. Pt was prescribed glycobalance and enrofloxacin. By O the urinating problem and drinking has improve with the medication prescribed.

Abnormal PE/Chem/CBC/UA Results: Bloodwork and u/a attached as supporting document.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (6.66 cm) with mild pyelectasia at 0.19 cm. Overall echogenicity is normal with adequate 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (7.12 cm). Overall echogenicity is normal with adequate 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 normal in size measuring 0.53 cm at the cranial pole and 0.62 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

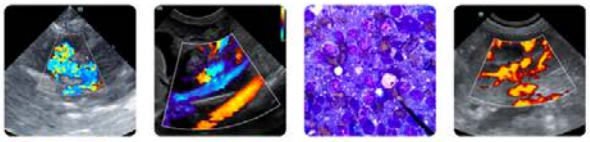
The right adrenal gland is normal in size measuring 0.65 cm at the cranial pole and 0.64 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (1.17 cm in width at the level of the hilus) and shape. The blood flow through the hilus and splenic parenchyma appears normal. There is a hypoechoic nodule visualized within the parenchyma measuring 0.64 cm x 0.94 cm.

Liver

The liver is large with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.



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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of debris that is formed into a hyperechoic "sludge ball". The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.43 cm. Jejunum wall measures 0.39 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The right limb of the pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. 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. A prominent mesenteric lymph node is visualized measuring 0.52 cm in diameter. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Hypoechoic nodule in the spleen – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Large, hyperechoic liver – Findings are most consistent with a vacuolar hepatopathy/diabetic hepatopathy.
- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hyperglycemia and glucosuria reported are most consistent with diabetes mellitus. Recommend confirming these values and starting insulin management. Ideally the urine should be cultured and checked for ketones.

There is mild pyelectasia in the left kidney. This is likely secondary to PU/PD, but if the UTI is confirmed, this could represent early pyelonephritis.

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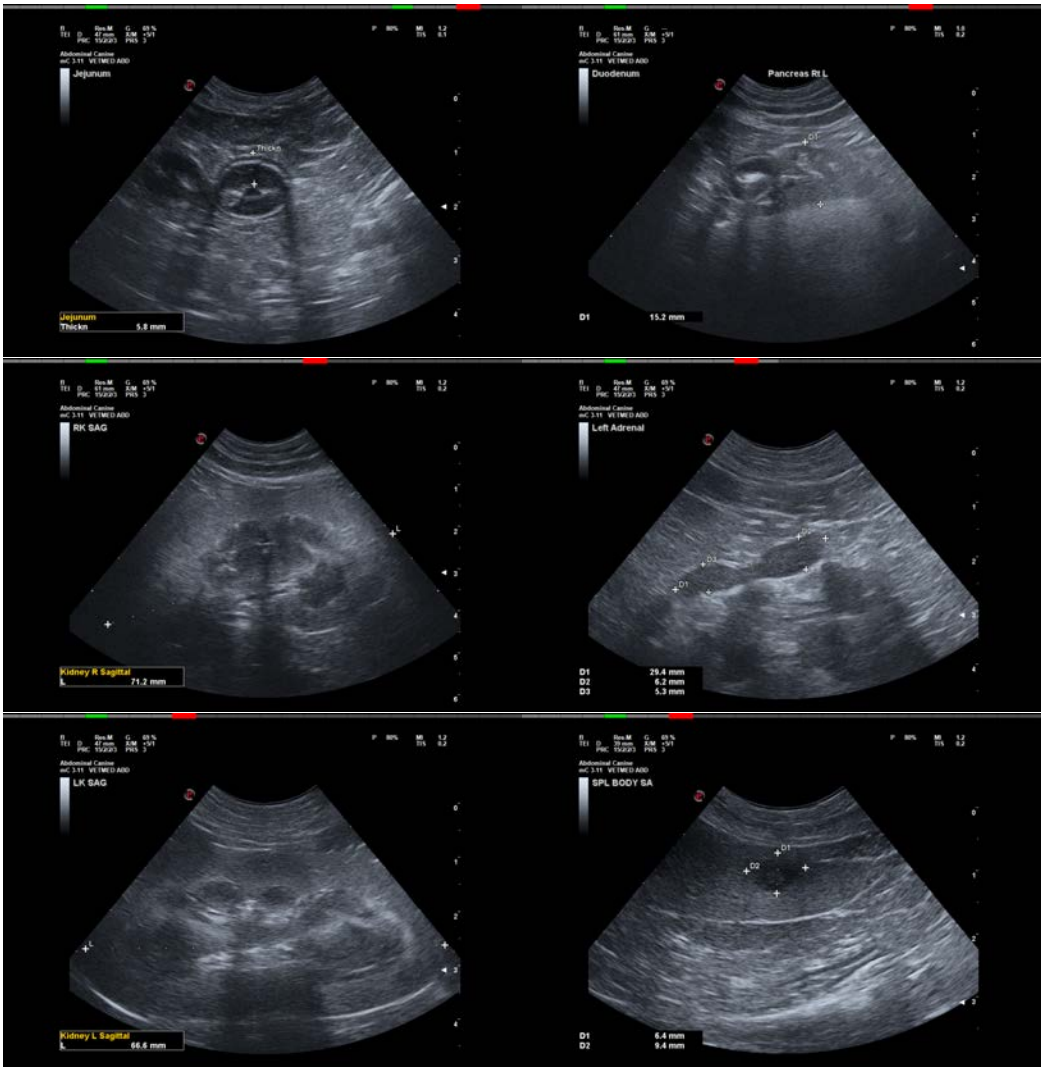
There is a small nodule in the spleen. Options moving forward would include ideally a fine needle aspirate or continued monitoring with ultrasound, as an early neoplastic lesion cannot be ruled out.

The pancreas is prominent and mottled, most consistent with pancreatic remodeling and possible chronic pancreatitis. Correlate with PLI level and consider empirical treatment for pancreatitis if clinically appropriate.

The changes in the liver are most consistent with a diabetic hepatopathy. If there is concern for a more significant hepatopathy, then consider a fine needle aspirate and a liver function test.



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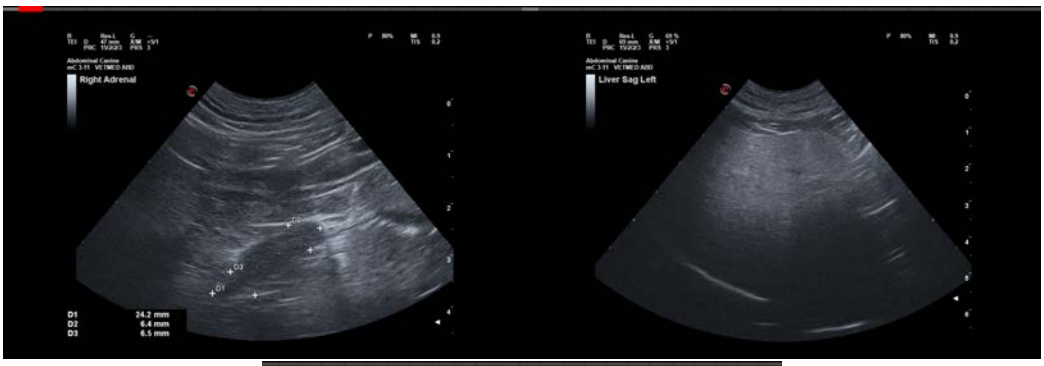

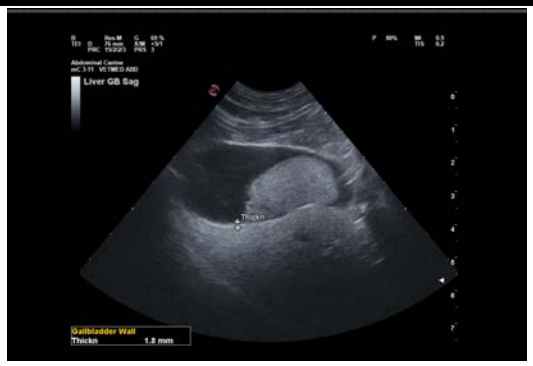

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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