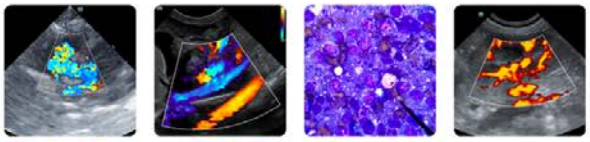


PATIENT

Chiquito Rivera

SPECIES

Canine

BREED

Shih Tzu

SEX

Neutered Male

AGE

12 Years

WEIGHT

17 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. Juan Torres

INVOICE

72652

DATE

12/17/25

PRESENTING CLINICAL SIGNS

Pt presented as a referral for an abdominal ultrasound to evaluate hx of vomiting and anorexia. Pt presented to rDVM in March for difficult evacuation, was passing small amount of feces with a gelatinous appearance. The only abnormality noted on PE was abdominal discomfort and tension, mostly on cranial abdomen. Presented again to rDVM on 12/9/25 with a complaint of anorexia, where O mentioned pt visited Emergency Clinic on 11/28/25 because of severe vomiting and dehydration.

Abnormal PE/Chem/CBC/UA Results: Bloodwork panel and radiographs are attached as supporting documents.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears mildly thickened and irregular, measuring 0.34 cm. In the trigone region there are several small shadowing stones visualized at the cystourethral junction/proximal urethra. Examples measure 0.34 cm and 0.45 cm.

The prostate is normal in size (0.91 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (4.04 cm) with pyelectasia at 0.22 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.61 cm) with pyelectasia at 0.41 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

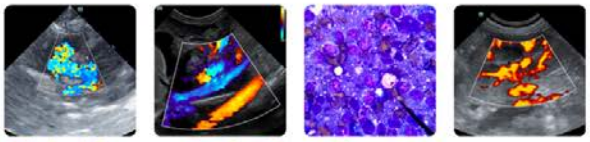
Adrenal Glands

The left adrenal gland is normal in size measuring 0.52 cm at the cranial pole and 0.30 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 0.40 cm at the cranial pole and 0.48 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 normal in size but slightly irregular in shape. It measures 0.88 cm in width at the level of the hilus. The blood flow through the hilus and splenic parenchyma appears normal. There is a slightly hypoechoic “bulge” visualized at the level of the hilus measuring 0.40 cm x 0.57 cm. An association with the vasculature cannot be ruled out. Recommend power doppler evaluation in this region.



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Liver

The liver is subjectively normal in size 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.

The gall bladder lumen is moderately distended with debris. Some of the debris appears adhered to the gallbladder wall. Wall thickening in this region cannot be ruled out. 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 0.42 cm. Jejunum wall measures 0.36 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. The descending colon wall appears mildly thickened and prominent, measuring at 0.25 cm with intact wall 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. There is no evidence of a significant diffuse lymphadenopathy. There is a cluster of lymph nodes at the mesenteric root. An example measures 0.77 cm x 1.21 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mildly thickened/irregular urinary bladder wall with small stones visualized at the cystourethral junction – Recommend urinalysis, culture and radiographs.
- Decreased corticomedullary distinction and pyelectasia noted associated with both kidneys – Pyelectasia of the kidney(s)could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Hypoechoic “bulge” at the hilus of the spleen – Findings are most consistent with a hypoechoic nodule. 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.

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- Hyperechoic liver - The diffuse hepatic changes are non-specific and can be seen with vacuolar hepatopathy, reactive change, nodular hyperplasia or, less likely, inflammatory/immune-mediated disease, infiltrative neoplasia, or other hepatopathy.
- Pancreatic changes most consistent with chronic pancreatic remodeling. Mild chronic pancreatitis is possible.
- Moderate gallbladder debris with some irregularity at the gallbladder wall – Findings are most consistent with adhered debris or focal wall thickening.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

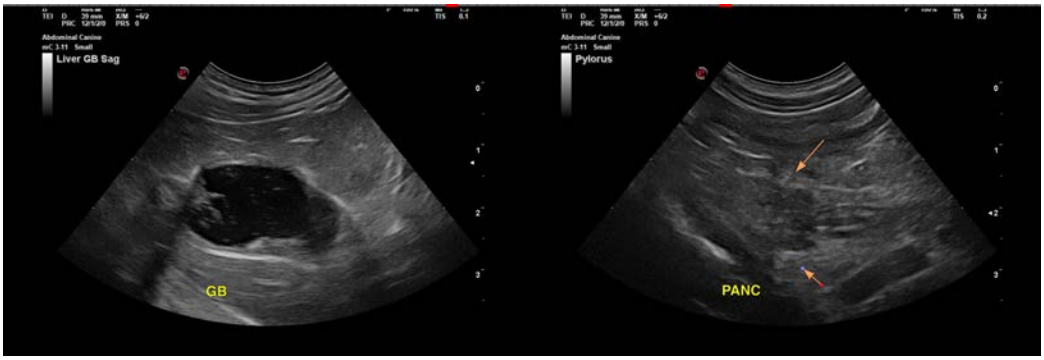
An obvious cause for the vomiting and anorexia reported is not visualized. The pancreas is mildly mottled, most consistent with pancreatic remodeling. Mild chronic pancreatitis is possible. Correlate with a PLI level.

Both kidneys have changes consistent with chronic renal disease and bilateral pyelectasia. Additionally, there are small stones visualized in the urinary bladder and a mildly thickened wall. Recommend a urinalysis, culture, and blood pressure evaluation, looking for possible pyelonephritis, renal disease, etc.

There is a small hypoechoic irregularity visualized at the splenic hilus. I suspect this is a small hypoechoic nodule. Recommend power doppler evaluation in this region to confirm there is no vascular involvement. A fine needle aspirate is likely not possible due to the proximity to the great vessels. Recommend continued monitoring with ultrasound.

The liver is hyperechoic. This is likely most consistent with a vacuolar hepatopathy, although neoplastic infiltration or other hepatopathies are possible. If no other cause for symptoms is identified, consider a liver function test and a fine needle aspirate of the liver (provided coagulation parameters are normal). Additionally consider further evaluation of the hypercalcemia with an ionized calcium +/- PTH and PTHrP level.

There is a moderate amount of debris in the gallbladder and some focal thickening or adhered debris. Consider Ursodiol therapy and continued monitoring of the gallbladder for progression of this thickened area of gallbladder wall.



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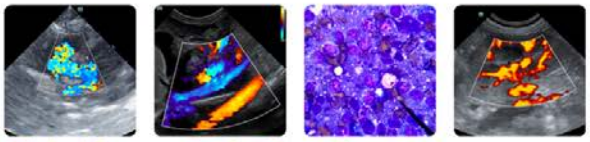

Clinical Sonography & Telecytology
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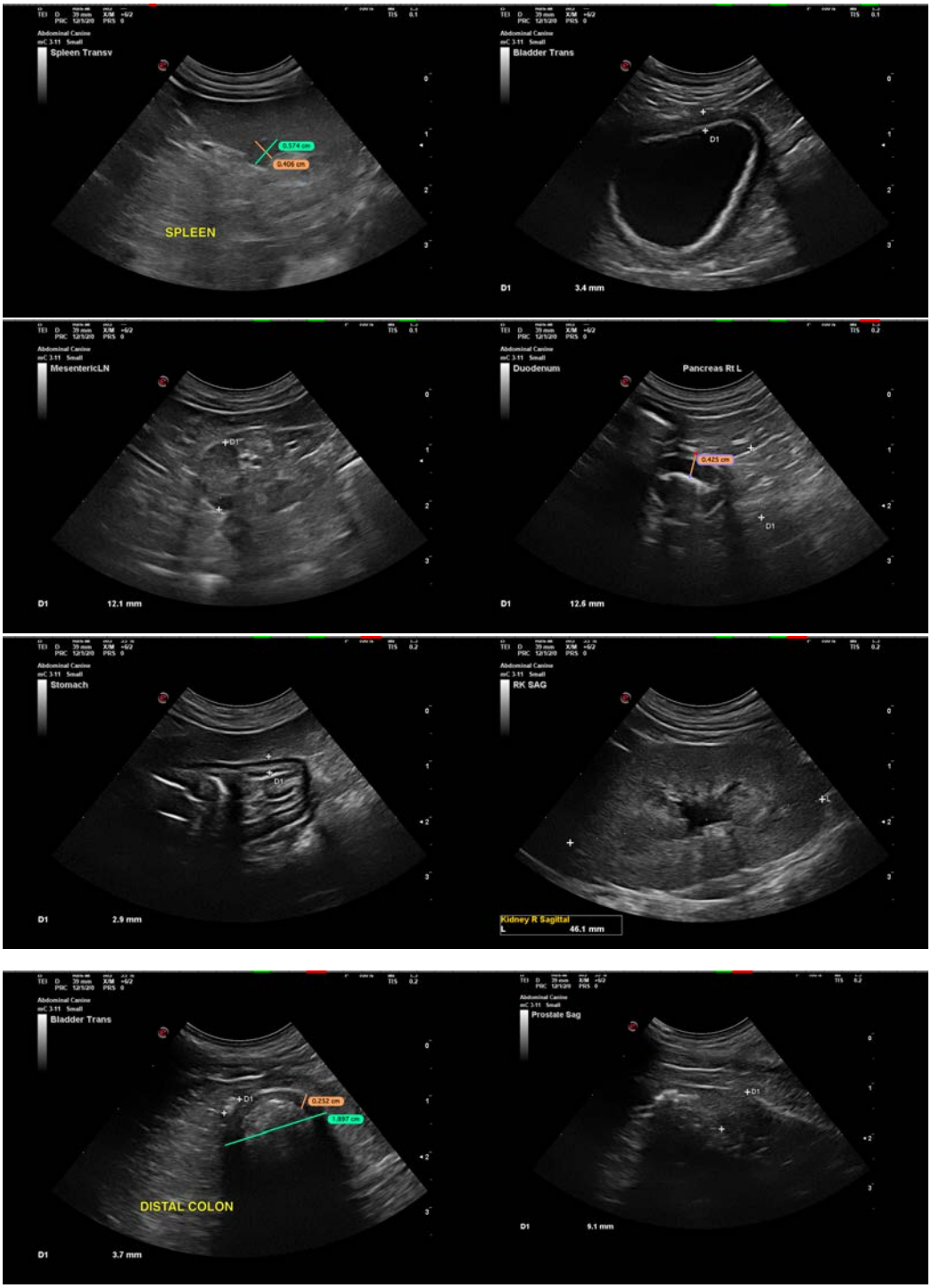

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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