



PATIENT

Pako Wright

SPECIES

Canine

BREED

Chihuahua Mix

SEX

MN

AGE

16 years

WEIGHT

4.90

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Best Friends Animal
Clinic

REFERRING VET

Dr. Phoebe Weaver

INVOICE

10982

DATE

12/18/2025

PRESENTING CLINICAL SIGNS

P is losing a ton of weight but eating great.

Abnormal PE/Chem/CBC/UA Results: Labwork performed in September unremarkable Performed brief abd u/s - abnormal structure seen near liver/GB. Concern for neoplasia given degree of weight loss.

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 visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (3.43 cm). The cortex is of increased echogenicity with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is significant pyelectasia measuring 0.27 cm and there is numerous small cortical cysts noted. There are occasional pinpoint non-obstructive nephroliths noted. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.08 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 a large cortical cyst in the caudal pole measuring 1.6 cm in diameter and significant pyelectasia measuring 0.68 cm. There are also small non-obstructive nephroliths visualized. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

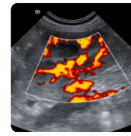
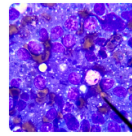
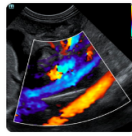
The left adrenal gland is large in size measuring 0.65 cm at the cranial pole and 1.08 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is large in size, and abnormal in appearance measuring 0.97 cm at the cranial pole and 1.85 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 abnormal in appearance in that there's a mixed echogenicity mass effect in the caudal pole measuring 1.86 cm x 1.71 cm. No evidence of vascular invasion is visualized.

Spleen

The spleen is subjectively normal in size (1.4 cm in width at the hilus) 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



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The liver is normal in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

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 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 (0.3 cm), jejunum (0.24 cm) and ileum have a uniform diameter with minimal to moderate fluid/gas distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Visualized peristalsis appears appropriate. The small intestine appears uniformly, mildly distended with fluid and gas. Correlate with the feeding history.

The descending colon appears somewhat distended with non-formed fecal material. Colon wall is normal at 0.21 cm.

Pancreas

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

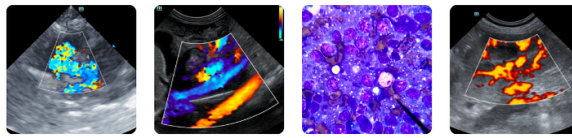
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

Other

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys with bilateral significant pyelectasia, cortical cysts, and non-obstructive nephroliths. Pyelectasia of the kidney(s) could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Mildly heterogenous liver. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy.



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- Large, distended gallbladder with a large amount of hyperechoic non-organized intraluminal material. 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.
- Bilateral adrenomegaly with a mixed echogenicity mass in the caudal pole of the right adrenal. Findings could be consistent with bilateral hyperplasia and a focal lesion. Differentials include adenoma, carcinoma, pheochromocytoma, other.
- Mildly diffusely thickened small intestine with mild fluid and gas distended. Findings could be consistent with a non-fasted patient or mild generalized ileus. Mild thickening could be consistent with mild inflammation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys have significant changes consistent with chronic renal disease. There's significant pyelectasia present. No definitive evidence of an obstruction is visualized but visualization in this region is challenging. Recommend a blood pressure, urinalysis, and culture looking for possible pyelonephritis, etc. Recommend continued monitoring of the kidneys.

There's a large amount of dis-organized debris in the gallbladder with no evidence of significant inflammation. Correlate with current liver values and recommend chronic treatment with ursodiol and continued monitoring for progression to a more significant lesion.

Both adrenals are large and the right adrenal has a mixed echogenicity mass effect in the caudal pole. This could be consistent with bilateral hyperplasia and a concurrent mass effect. If symptoms consistent with Cushing's are present, consider adrenal function testing. Additionally, if hypertension is present, recommend catecholamine levels looking for a possible pheochromocytoma.

If surgical removal would be considered, recommend a contrast CT scan to further evaluate for metastatic lesions, vascular invasion, etc. prior to considering surgery.

Subjectively, the small intestine appears mildly thickened and there is a mild to moderate amount of fluid and gas. This could be consistent with a non-fasted patient, or a degree of ileus. Recommend quantitating caloric intake. If the patient is truly losing weight despite adequate calories, there could be some malabsorption present and you could consider a GI Panel to Texas A&M for a qualitative PLI/TLI, cobalamin, and folate looking for exocrine pancreatic insufficiency, evidence of underlying small intestinal disease, etc.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

Imaging performed by



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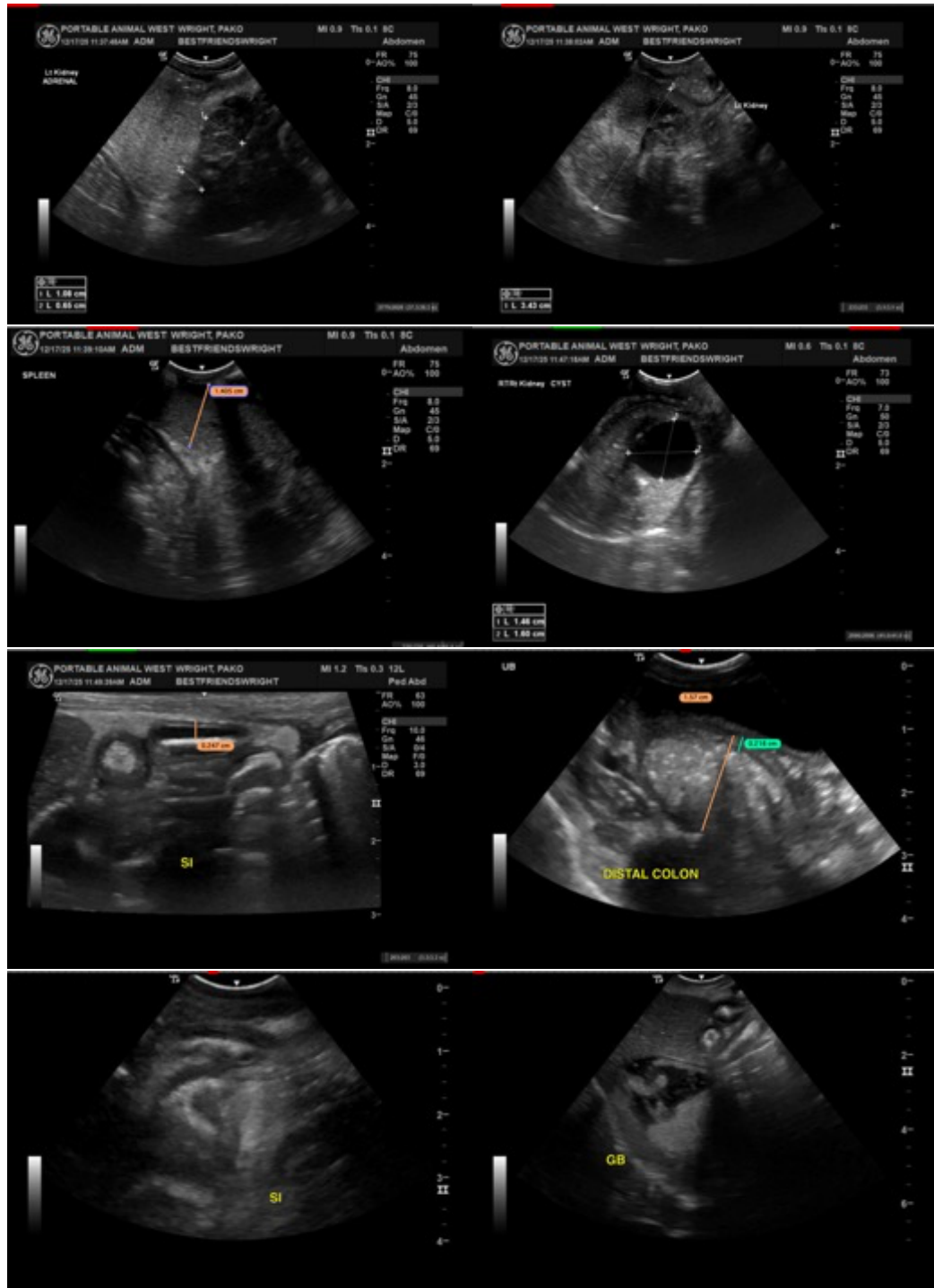
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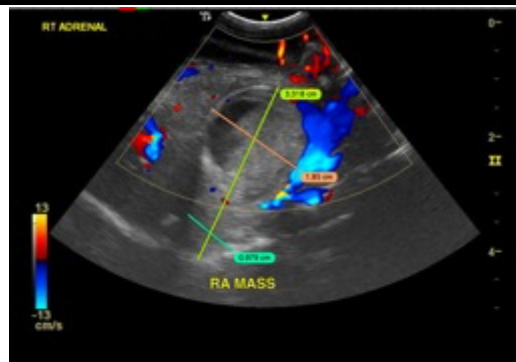
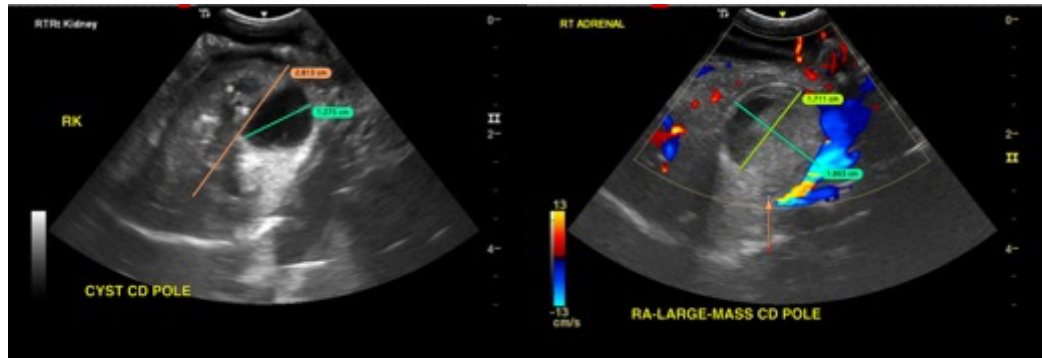
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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