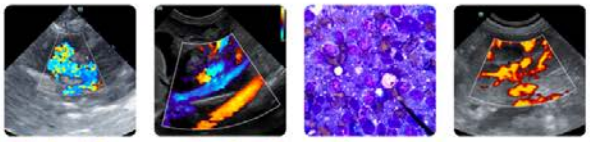

PATIENT

Soldado Rosado

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

15 Years

WEIGHT

24.6 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. Mario Roman

INVOICE

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PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound due to lethargy and vomiting with blood. Px was hospitalized until yesterday 3/11/26. Px is currently on the following Mx: Cerenia, Famotidine, Metronidazole, IV fluids. Radiographs were performed and a radiopaque linear object was observed in the stomach.

Abnormal PE/Chem/CBC/UA Results: rDVM records attached below for your reference

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, or masses. There are numerous dependent small calculi visualized in the urinary bladder. Some of these small stones extend into the region of the cystourethral junction and pre-prostatic urethra (typically measure 1-2 mm).

The prostate is borderline large in size (1.63 cm) with pinpoint mineralizations, possibly consistent with small stones/mineralized debris in the prostatic urethra.

The left kidney has a normal shape and size (5.92 cm) with occasional small non-obstructive nephroliths. Overall echogenicity is slightly hyperechoic with mildly reduced 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.58 cm) with occasional non-obstructive nephroliths. 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.60 cm at the cranial pole and 0.63 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.

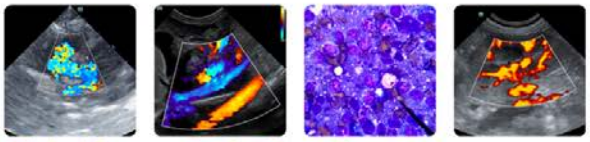
The right adrenal gland is normal in size measuring 0.48 cm at the cranial pole and 0.45 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is large and irregular in appearance. The blood flow through the hilus and splenic parenchyma appears normal. There is a large, solid, mixed echogenicity, hypoechoic mass effect arising from the spleen measuring 5.68 cm x 7.61 cm.

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 is a hyperechoic nodule visualized within the parenchyma measuring 1.26 cm x 0.71 cm.

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 non-organized echogenic debris. Some of the debris appears mineralized, possibly consistent with small cholelithsThe cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. The gastric wall measures as borderline thick at 0.53 cm with a prominent muscularis layer. There are numerous (at least two) thin linear hyperechoic structures visualized within the stomach, measuring 2.05 cm and 0.74 cm in length. Scanning through the stomach, two more linear structures are visualized, so this represent multiple structures, or a linear folded structure such as a wire or similar.

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 0.52 cm. Jejunum wall measures 0.34 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized. The ascending colon wall appears prominent, hypoechoic and somewhat thickened, measuring at 0.55 cm proximally, with subjectively reduced detail of wall layering. Distally, this appears more normal. The descending colon wall appears normal with intact wall layering. Sections of colon are visualized with formed fecal material and gas shadowing distally.

Pancreas

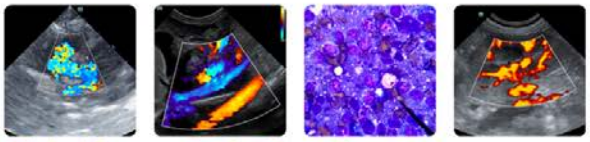
The pancreas is visible/mildly mottled in the right limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent lymph nodes. A left iliac lymph node is visualized measuring 0.69 cm. Additionally, there is a mesenteric lymph node visualized near the ileocecal junction measuring 0.60 cm x 1.7 cm. The omentum is of normal echogenicity.

PRIMARY FINDINGS

- Too numerous to count, small, dependent cystoliths with some stones visualized within the pre-prostatic urethra.
- Borderline large prostate with pinpoint mineralizations – Findings could be consistent with a patient neutered later in life. If the patient was neutered prior to puberty, consider a fine needle aspirate, looking for possible prostatic neoplasia. The mineralization is suggestive of small stones/mineralizations in the prostatic urethra, although mineralization of the parenchyma cannot be ruled out.



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- Large, solid hypoechoic/mixed echogenicity splenic mass – A focal solid mixed echogenicity mass is visualized associate with the spleen. This mass distorts the splenic capsule. Differentials include : benign lesions (lymphoid hyperplasia, hemangioma etc..) or cancerous lesions (hemangiosarcoma, lymphoma, histiocytic sarcoma etc..)

- Large, heterogeneous liver with a hyperechoic nodule – 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 appearance of the hyperechoic nodule is most consistent with a benign lesion. Recommend continued monitoring. An early neoplastic lesion cannot be ruled out.

- Moderate gallbladder debris with some mineralized debris/small choleliths – 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.

- Subjectively mildly thickened stomach with a prominent muscularis layer and hyperechoic intraluminal linear structures – Findings are consistent with mild gastritis and gastric foreign material.

- Thickened proximal ascending colon with reduced detail of wall layering – Findings are most consistent with severe inflammatory or early neoplastic change.

- Large, hypoechoic lymph node near the ileocecal junction – Findings could be consistent with a reactive or early metastatic lymph node.

SECONDARY FINDINGS

- Age related changes visualized associated with both kidneys.

- Changes consistent with mild pancreatic remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a lot going on with this individual. Based on the hematemesis reported, the gastric foreign material may be the most origin issue. Ideally, upper GI endoscopy would be considered to further evaluate and to determine if this can be removed endoscopically or if surgery is necessary.

I'm concerned about the appearance of the proximal ascending colon. This could represent severe inflammatory change or early neoplastic change. Depending whether this would change the ultimate plan, consider a fine needle aspirate of the thickened ascending colon and/or the local enlarged lymph node.

There is a large, solid mass effect in the spleen. This could represent a benign or neoplastic lesion. Ideally a splenectomy would be performed depending on the clinical status of this individual.

There are numerous stones visualized in the urinary bladder. Some of these appear to be in the prostatic and pre-prostatic urethral. Correlate with the patient's clinical symptoms. If there is hematuria, straining, etc.? A cystotomy could be considered with retropulsion of the stones into the urinary bladder depending on patient status.

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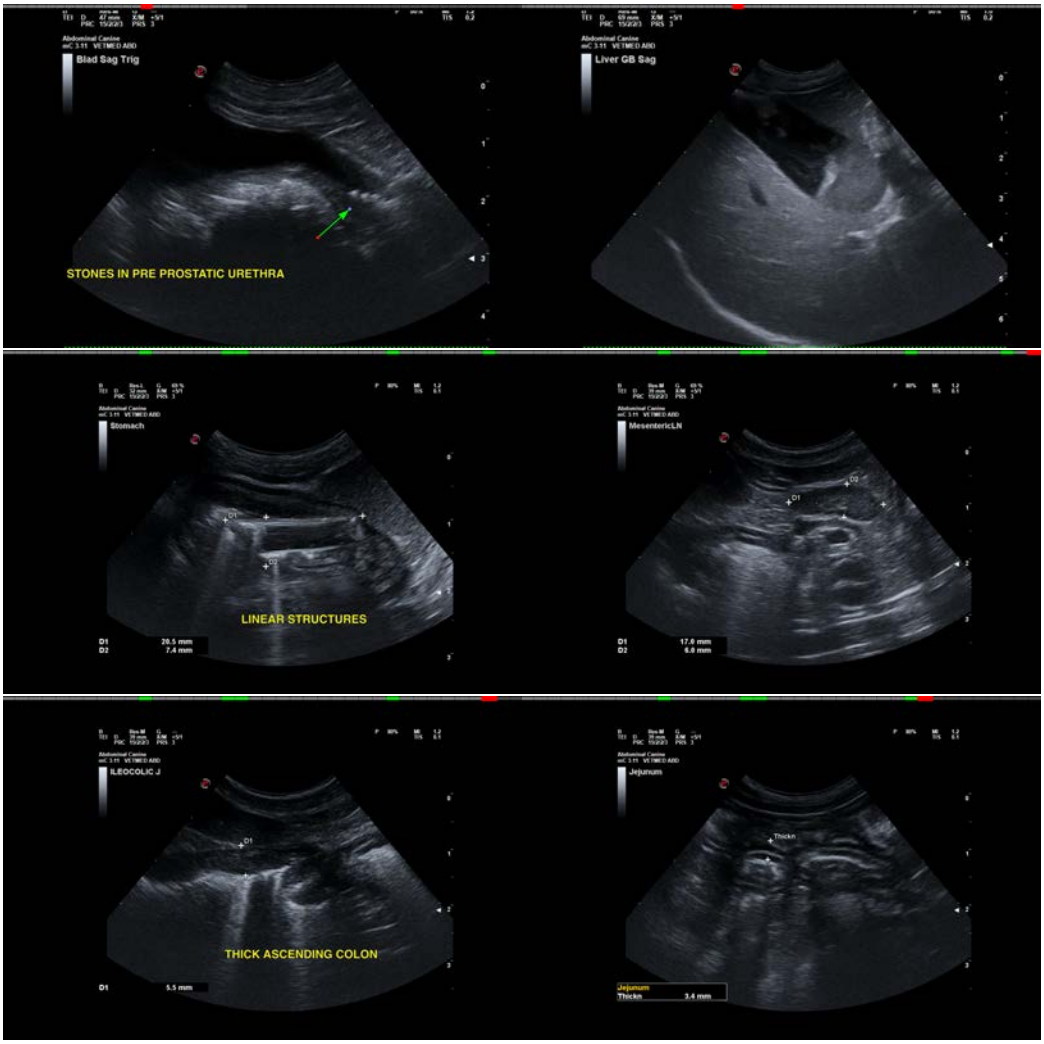
The diagnostic and treatment plan for this patient would be based on clinical assessment and consultation with the surgeon. If it is possible to start with upper GI endoscopy and fine needle aspirate of the ascending colon, this could be considered, and a surgical plan could be determined with this additional information. Otherwise, issues will need to be prioritized, as I suspect dealing with all of these issues at once may be problematic.

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



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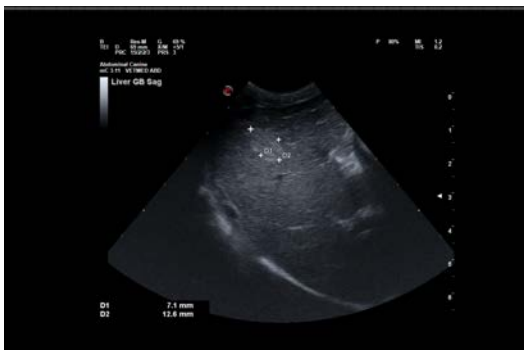

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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