



PATIENT

Milo Flores

SPECIES

Canine

BREED

Mixed

SEX

MN

AGE

14 years

WEIGHT

18 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Gabriel Ferrer

HOSPITAL NAME

Pulse Pet Ultrasound
Services

REFERRING VET

Dr. Fonseca

INVOICE

11513

DATE

3/19/2026

PRESENTING CLINICAL SIGNS

- Px presented as a referral due to having episodes of vomiting, anorexia, and diarrhea.
- Px visited rDVM on Tuesday and that same night Px was discharged.
- Px was then hospitalized on Wednesday due to Px now having bloody diarrhea.
- Px is currently hospitalized.
- Px was diagnosed with Diabetes mellitus and Cushing's Disease a few years ago and both conditions are currently under control.
- Px is utd on Vx and preventatives.

Abnormal PE/Chem/CBC/UA Results: Radiographs and 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, masses or cystic calculi.

The prostate is normal in size (1.12 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 (5.58 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. Mild pyelectasia noted measuring 0.3 cm. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.39 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 large in size measuring 0.86 cm at the cranial pole and 0.92 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 measuring 0.9 cm at the cranial pole and 0.83 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 (1.4 cm in width at the level of the hilus) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There's a subtle hypoechoic nodule visualized in the



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parenchyma measuring 0.94 cm and a hyperechoic nodule measuring 0.41 cm, most consistent with benign myelolipoma.

Liver

The liver is large in size, and rounded. The parenchyma is 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 moderately distended. The wall of the gall bladder appears slightly thickened and hyperechoic at 0.28 cm with what appears to be a regular adhered debris. There is a moderate amount of non-organized echogenic debris. The common bile duct is visualized at the level of the duodenal papillae measuring 0.45 cm.

Gastrointestinal

The stomach contains mild/moderate fluid. It measures at a normal thickness of 0.33 cm 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 (0.5 cm), jejunum (0.56 cm) 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. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with non-formed/liquid fecal material and gas shadowing distally. Descending colon wall is somewhat prominent measuring at 0.3 cm with intact wall layering.

Pancreas

The pancreas is prominent and mottled in both limbs. 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 mesenteric lymph nodes. A large hypoechoic lymph node is visualized measuring 0.86 cm x 2.36 cm. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenomegaly. Findings are most consistent with the current diagnosis of hyperadrenocorticism.
- 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.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.



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- Large 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.
- Moderate gallbladder debris with a thickened gallbladder and dilated bile duct. Findings could be consistent with mild cholecystitis/choleangiohepatitis.
- Mild/moderate fluid distension of the stomach. Given the recent vomiting reported this could represent gastric ileus.
- Mild small intestinal thickening. The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).
- Fluid distended distal colon with mild wall thickening and intact wall layering. Findings are most consistent with colitis.
- Prominent mesenteric lymph nodes. Findings are most consistent with a reactive lymph node although early neoplastic lymph node cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

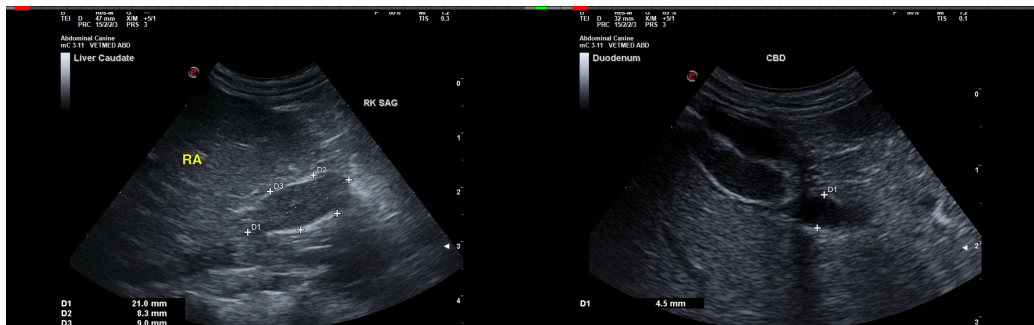
Findings are most consistent with acute gastroenterocolitis. No focal lesions are visualized associated with the GI tract. Although a small focal lesion or similar cannot be definitively ruled out. A small unseen focal lesion cannot be definitively ruled out. The pancreas is visible in both limbs but not overtly inflamed. Correlate with a PLI level. If there's significant elevation, mild concurrent chronic pancreatitis could also be an issue.

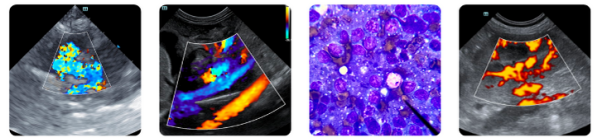
There's a small hypoechoic nodule in the spleen. Options moving forward would include continued monitoring with ultrasound or a fine needle aspirate.

The liver changes are most consistent with a diabetic/vacuolar hepatopathy. The gallbladder has changes most consistent with a mildly thickened wall and some adherent debris. Given these preexisting health conditions, choleangiohepatitis or cholecystitis could be a concern. Options would include close continued monitoring or empirical treatment for cholecystitis with ursodiol and a course of antibiotics.

Small intestine is mildly thickened. If chronic gastrointestinal symptoms develop, further workup for a primary enteropathy may be warranted.

If symptoms are persistent despite treatment, consider repeat evaluation in the future looking for the progression of today's lesions or the development of new lesions.





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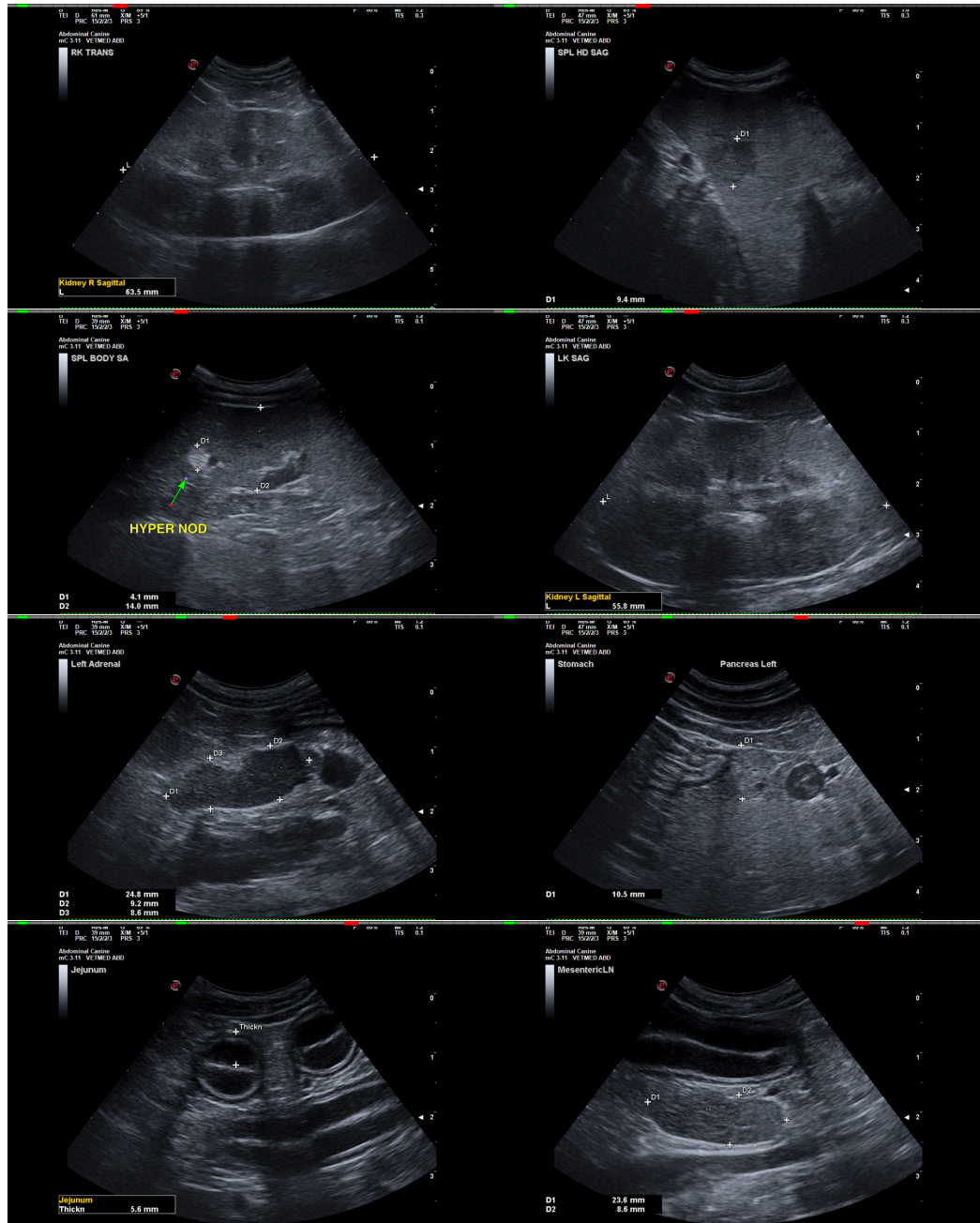
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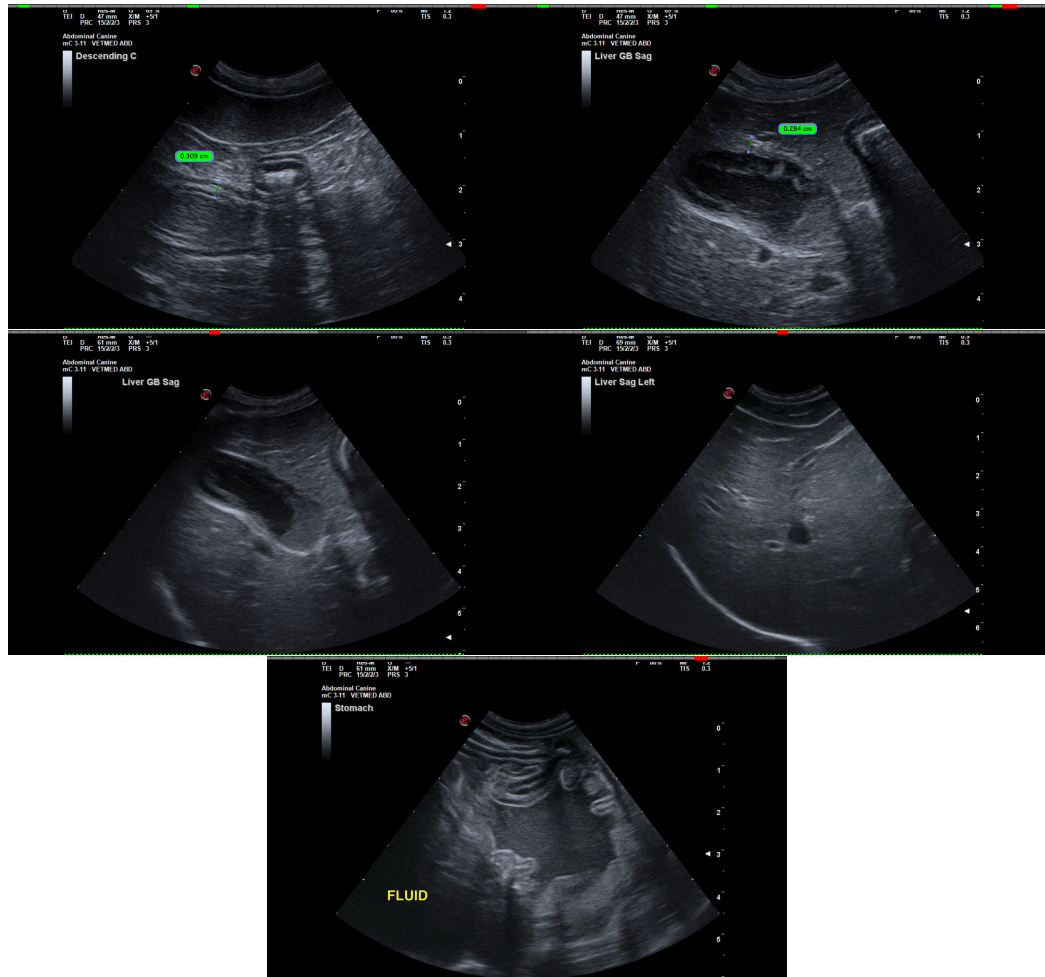
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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