



## PATIENT

Leo Cabral

## SPECIES

Canine

## BREED

American Pit Bull  
Terrier

## SEX

MN

## AGE

11

## WEIGHT

62lb

## INTERPRETED BY

R. McKenzie Daniel,  
DVM, DABVP  
(Canine and Feline)

## IMAGING PERFORMED BY

Sorbo

## HOSPITAL NAME

JM Pet Resort &  
Veterinary Clinic

## REFERRING VET

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## INVOICE 24022

DATE  
02/27/2026

## PRESENTING CLINICAL SIGNS

- Multiple cutaneous masses (including lipoma)
- Pruritus (paw licking)
- Overweight history
- Recurrent pyoderma / pododermatitis
- Dental disease
- Major active problems
- Mast cell tumor (incompletely excised; multiple sites historically)
- Hepatic disease with progressive enzyme elevation
- Hypertriglyceridemia (previously documented)
- Heart murmur
- Skin mass (chronic SQ lesions)
- Tapeworm infection (suspected historically)
- Recent clinical concerns
- Cervical and thoracolumbar pain with neurologic features (stiff gait, reluctance to turn head, limb lifting while eating)
- Splenomegaly/thickened spleen on palpation
- Post-surgical wound infection with seroma (drug-resistant Staphylococcus)
- Delayed wound healing
- Possible mast cell tumor recurrence at surgical site
- History of lipoma (right ventral thorax)
- Abnormal PE/Chem/CBC/UA Results: Physical exam findings BAR, normal hydration and perfusion Stiff gait, spinal pain on palpation, increased patellar reflexes Thickened spleen on abdominal palpation Fluctuant thoracic mass consistent with lipoma Healing surgical sites with prior seroma No peripheral lymphadenopathy Normal cardiopulmonary auscultation on recent exams CBC Mild neutrophilia (78%) Otherwise unremarkable CBC Platelets adequate Chemistry Marked hepatopathy ALT 1635 (severely elevated) ALP 589 ↑ GGT 47 ↑ AST mildly ↑ Total bilirubin mildly ↑ Other abnormalities Hypercholesterolemia (416) Normal: -Renal values (BUN/creatinine) -Electrolytes -SDMA -Pancreatic lipase Urinalysis Dark yellow urine 1+ protein 3+ ketones Trace blood RBC 4-10/hpf High USG (1.042) No bacteria

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder presented uniformly thickened urinary bladder wall isoechoic to the adjacent normal urinary bladder wall. The luminal margin of the thickened urinary bladder wall was mildly asymmetrical in contour. Mineralization or echogenic foci within the thickened areas of urinary bladder wall was not present. The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence



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of pelvic dilation was present. The left kidney measured 5.9 cm in length. The right kidney measured 7.1 cm in length.

The area of the aortic trifurcation was free of pathology.

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**Adrenal Glands**

The left adrenal gland was borderline enlarged in size with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.79 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.64 cm width at the caudal pole.

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**Spleen**

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. An asymmetrically marginated, non-homogenous hyperechoic caudal nodule was present without associated capsule distortion, measuring 2.5 cm in diameter. A separate mildly expansive isoechoic non-homogenous medial splenic nodule was present measuring 2.7 cm in diameter. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

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**Liver/Gallbladder**

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and mild non-organized debris. The cystic and common bile ducts were normal.

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**Gastrointestinal**

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

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**Pancreas**

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

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**Free Abdomen**

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

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**ULTRASONOGRAPHIC FINDINGS**

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## Primary

- Chronic hepatopathy
- Mild gallbladder debris
- Variably echogenic splenic nodule
- Age-related renal / adrenal changes with borderline left adrenomegaly
- Mild cystitis pattern

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the liver was nonspecific but most consistent with benign hepatopathy. Considerations for the liver may include benign vacuolar hepatopathy, inflammatory/infectious/immune mediated disease, hyperplasia, hematopoiesis, toxic hepatopathy (i.e., copper) or other with neoplasia thought less likely. No evidence of post-hepatic obstruction. Ultrasound guided FNA of the liver using a 25-gauge needle and assuming normal coagulation parameters would be warranted for screening cytology. Hepatosupportive medications such as Denamarin or Vitamin E as well as Ursodiol due to its antioxidant and immunomodulatory effects within the liver would be warranted, although these medications may not result in decreased hepatic enzyme levels. Leptospirosis titers / PCR may be considered if clinically indicated. Core or surgical biopsy is likely required for definitive diagnosis. Adrenal workup or screening could be considered if clinical signs consistent with Cushing's syndrome are non-reported or arise.

Potential etiologies for the splenic nodules may include benign processes such as nodular hyperplasia, extramedullary hematopoiesis, hematoma, infection, infarction, or neoplasia. Ultrasound guided FNA of the nodule using 25-gauge needle and assuming normal coagulation parameters may be considered. Otherwise, sonographic monitoring of the splenic nodules for any changes in size or appearance with initial recheck in 3-4 weeks would be a more conservative approach. Assuming no pathology on three view chest radiographs, diagnostic and prophylactic splenectomy with concurrent hepatic biopsies, assuming normal clotting status may be considered.

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.



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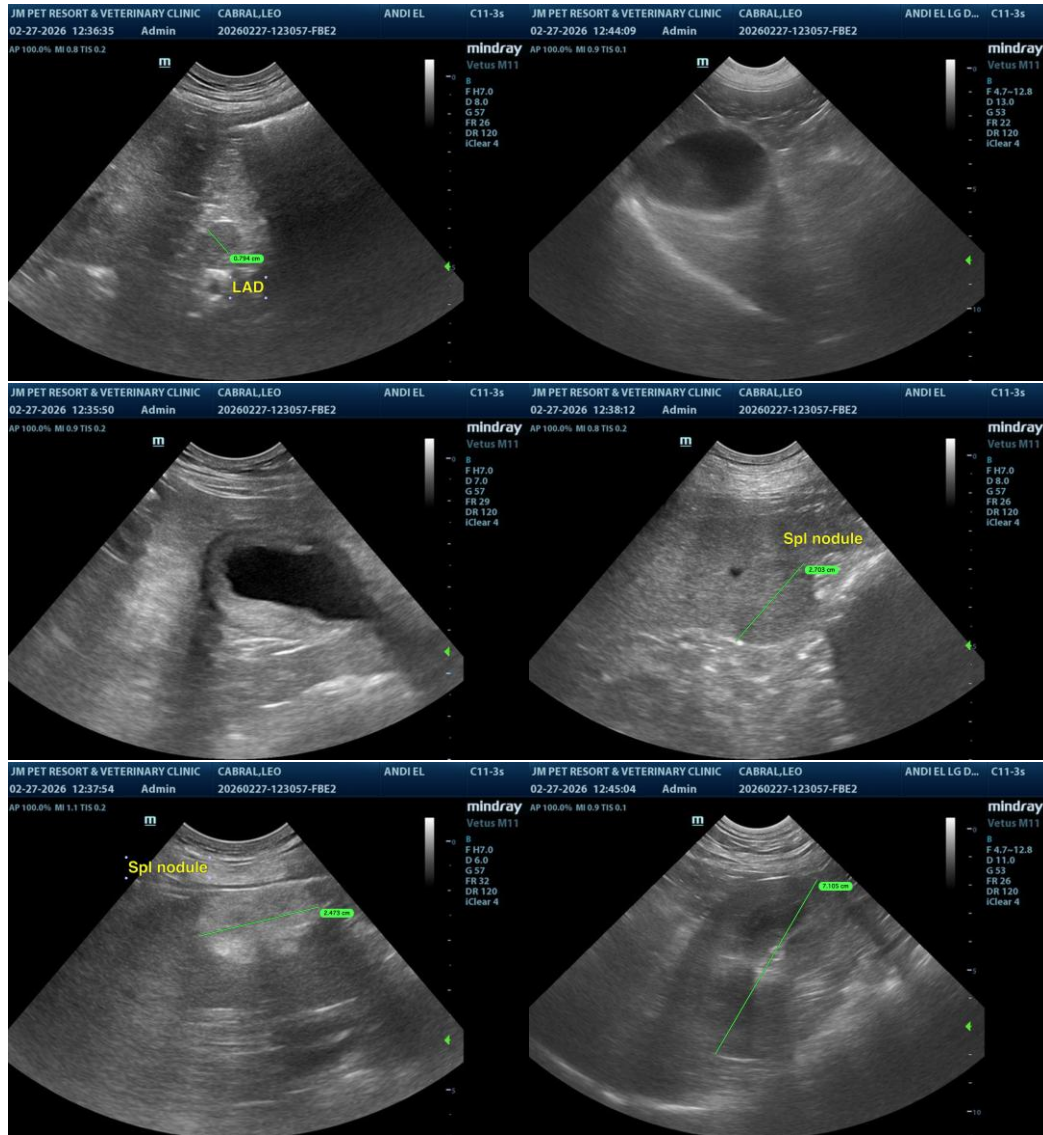
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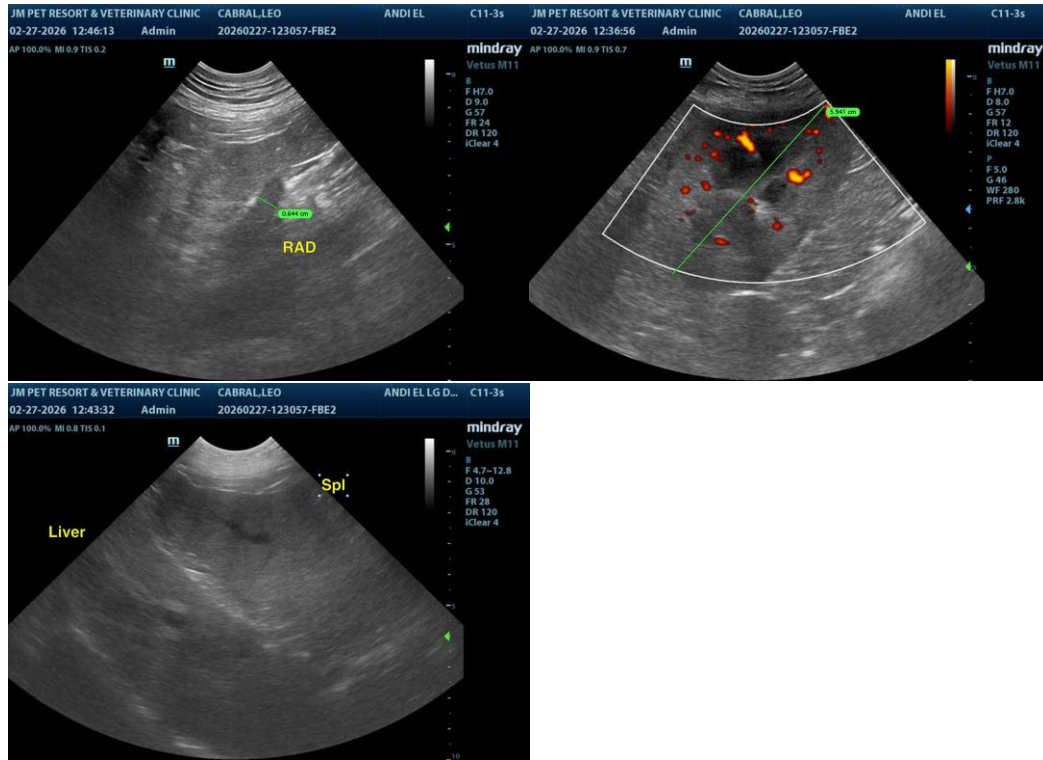
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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