



PATIENT

Pirulo Castillo

SPECIES

Canine

BREED

Chihuahua

SEX

MN

AGE

11yr

WEIGHT

8.4lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Gabriel Ferrer

HOSPITAL NAME

Pulse Pet Ultrasound

REFERRING VET

Dr. Alma Alicea

INVOICE

24979

DATE

06/01/2026

PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound due to suspicion of Pancreatitis. Px has Hx of anorexia, bloody diarrhea and vomiting since 5/24. Taken to ER clinic in Alexandria, VA 5/26. Treated as outpatient, no improvement noted. Then hospitalized by rDVM since 5/28. Px labs so far include CBC/Chem/cPL done in US. Here have done cbc, chem, chest/abd rads. Intial labs in USA 5/26 - HCT 68%, plt 49K (agglutination noted), wbc 7.5K. Chem wnl. cPL 658. Recheck CBC/chem 5/29 - CBC wnl. Chem wnl. Chest rads/abd. rads - unremarkable. DDx pancreatitis. Referred by rDVM since he continues to have moderate to severe abd. pain and intermittent episodes of vomiting in spite of treatments. Vomits at times are liquid, w/ slight diluted dark color as if blood, and other times are bile colored. Currently eating bland chicken intermittently. Current Mx: Famotidine, Cerenia, Metronidazole, Unasyn, Ondansetron, Regaln, Buprenorphine IV, Gabapentin orally. Abnormal PE/Chem/CBC/UA Results: Radiographs attached below for your reference.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone and cystourethral junction exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The residual prostate appeared normal and free of pathology. Mild dilated prostatic urethra with normal post-prostatic urethra structure and tone to a depth of 2 cm.

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 of pelvic dilation was present. The left kidney measured 3.6 cm in length. The right kidney measured 4.0 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The bilateral adrenal glands were mildly enlarged in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 2.0 cm length. The right adrenal gland measured 2.1 cm length and 0.75 cm width in the caudal pole. A non-capsule deforming non-homogenous variably hyperechoic non-mineralized cranial right adrenal nodule was present measuring 1.2 by 0.95 cm.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder



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The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. A mid-liver discrete to indistinctly marginated mildly hyperechoic intraparenchymal nodule was present measuring 1.8 cm in diameter. The gallbladder was non-distended in size with thin walls and mild to moderate congealed non-organized debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mild thickened wall. Intact wall layering was maintained and distinct. The stomach contained a mild amount of anechoic fluid. The stomach wall measured 0.58 cm in width.

The small intestine was non-thickened, exhibiting intact wall layering with mild altered wall layer ratio owing to propensity for mildly thickened intestinal muscularis layer. The duodenum wall measured 0.45 cm width. The jejunum wall measured 0.44 cm width. No pathology at the level of the ileocolic junction.

Normal visible colon wall layers were present with semi formed to possible soft feces in lumen.

Pancreas

The pancreas was normal in size and contour with mild heterogeneous to remodeled parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. Indistinct pancreatic capsule compared to adjacent isoechoic omentum.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

Primary

- Gastroenterocolopathy exhibiting mild, non-obstructive gastric stasis and semi-formed to soft fecal matter in colon
- Non-homogenous remodeled pancreas
- Discrete liver nodule- suspect benign nodular criteria, i.e. hyperplasia or lipogranuloma
- Non-organized gallbladder debris (non-mucocele)
- Age-related renal changes
- Bilateral mild adrenomegaly with cranial right adrenal nodule- hyperplasia, functional vs non-functional adenoma, emerging right adrenal tumor possible

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastrointestinal tract exhibited primarily mild mural changes, which although non-specific suggest inflammatory criteria, i.e. IBD or other with contributing factors such as dietary intolerance, infectious disease, enterotoxin, mild to chronic pancreatitis, less likely occult hepatic neoplasia as potentials. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. A fresh fecal analysis is recommended to rule out parasitic ova/giardia.

Empirically, a limited antigen or hydrolyzed diet trial with potential long term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Proviale or Visbiome), cobalamin



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supplementation pending assessment of cobalamin level +/- antibiotic trial with consideration for adverse effects on normal GI flora with long term antibiotic use and as needed gastrointestinal support with assessment of clinical response may prove beneficial. Endoscopic gastrointestinal biopsies could be considered if available.

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Monitoring of systemic BP for evidence of hypertension, which may allude to emerging right pheochromocytoma is recommended. Concurrent adrenal workup with LDDST is warranted if clinical signs consistent with Cushing syndrome are non-reported or arise. Sonographic monitoring of the right adrenal nodule, discrete liver nodule, and gastrointestinal tract is indicated pending further clinical assessment.

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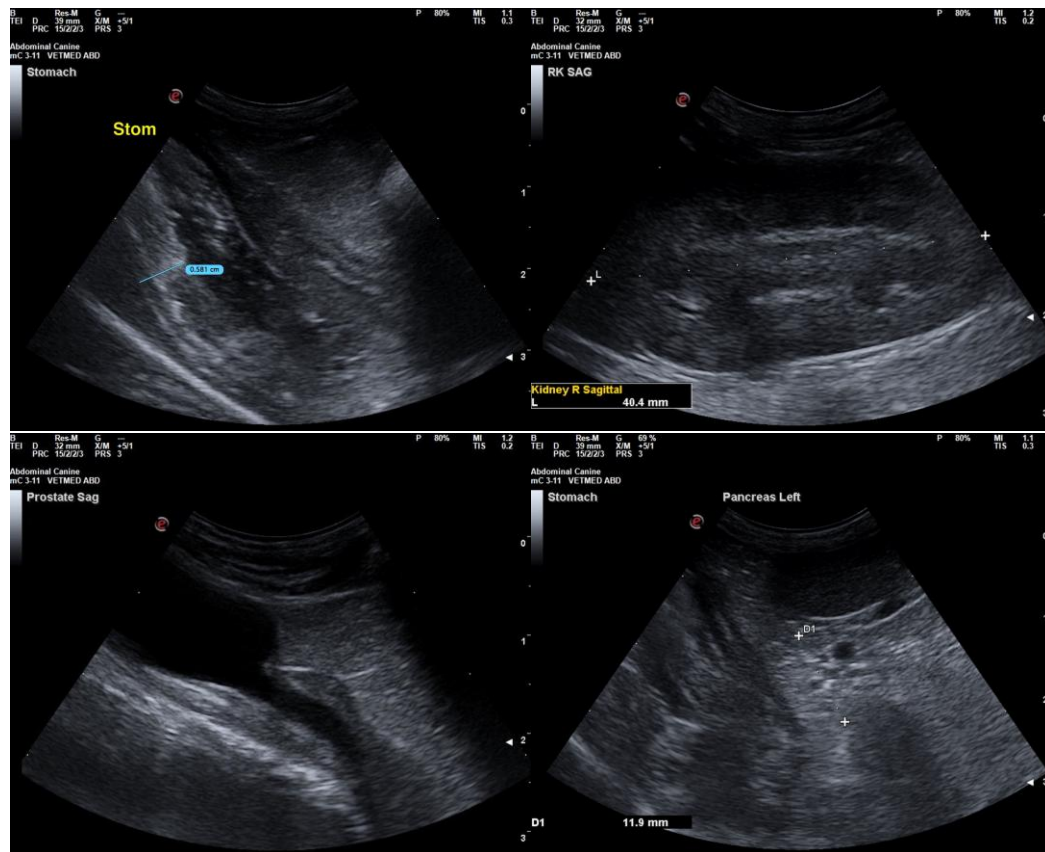
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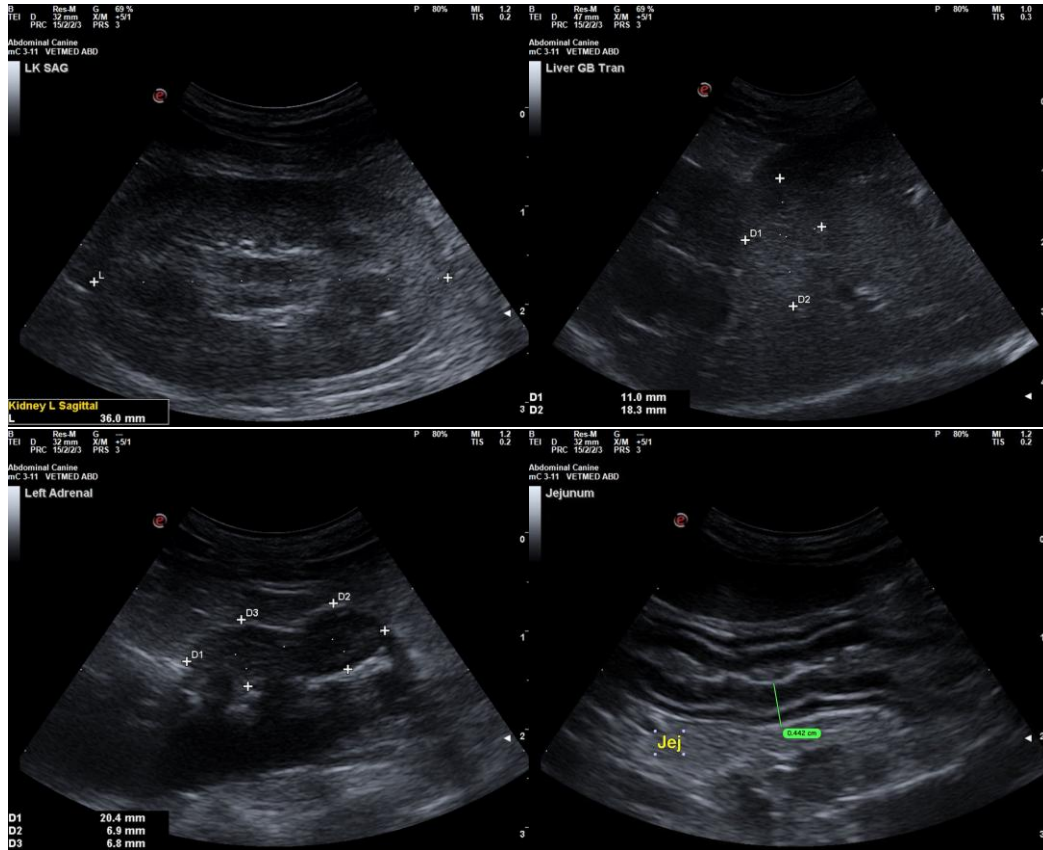
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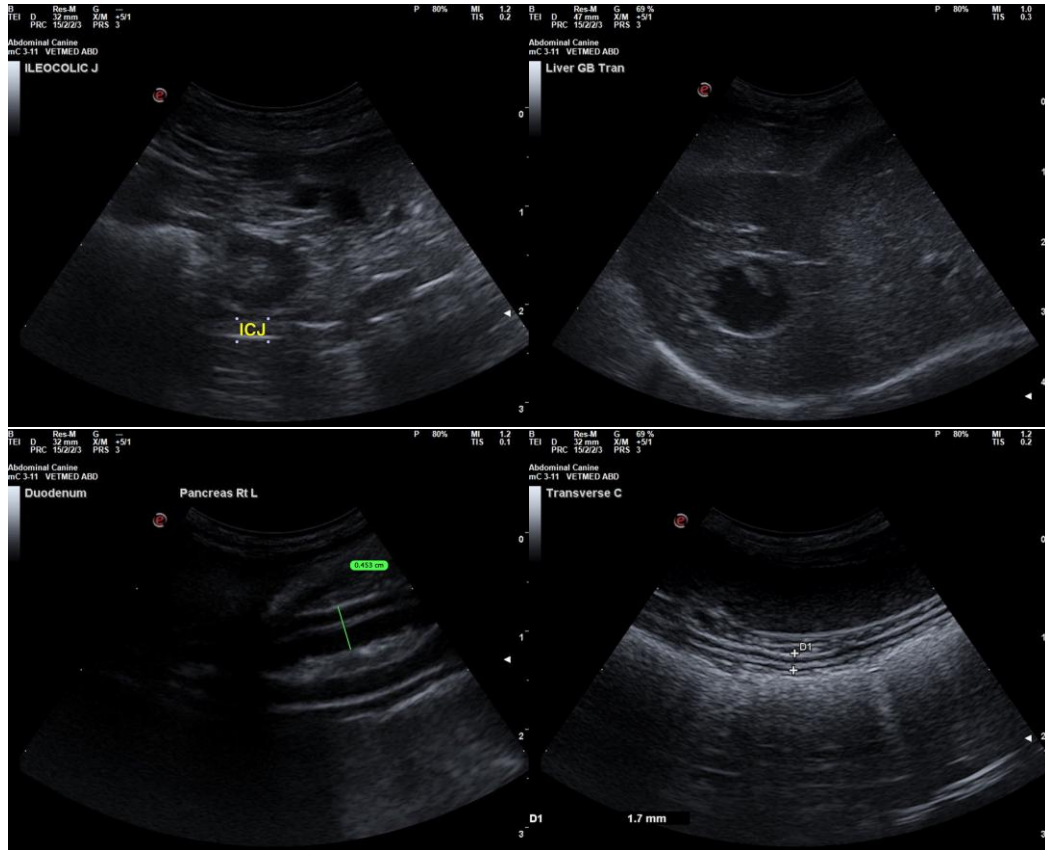
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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