



PATIENT

Chubbalina Fazio

SPECIES

Canine

BREED

Bulldog

SEX

Spayed Female

AGE

12 Years 2 Months

WEIGHT

26.4 kg

INTERPRETED BY

Tam Mengine, DVM,
DABVP (canine/feline
practice)

IMAGING PERFORMED BY

Renee Trionfetti VMD

HOSPITAL NAME

Cypress Veterinary
Clinic

REFERRING VET

Dr. Laura Johnson
VMD

INVOICE

12150

DATE

11/07/25

PRESENTING CLINICAL SIGNS

AUS to further evaluate mild non-regenerative, normocytic, normochronic anemia on BW. Is also having urinary accidents, mostly described at night. Would wake O up at night which is unlike pt. Previous vet started on medication for suspected UTI. BW preformed and noted anemia. Previous vet then started on a prednisone taper. Hx: Hypothyroid Meds: prednisone 20 mg taper: currently on 1.5 tabs BID; Clavamox 375 mg 1 tab PO BID; Benadryl 2 tabs BID; Thyrozine 0.4mg SID; apoquel 16 mg 1/2 BID (paused right now because of pred taper); desmopressin acetate 0.01% 1 drop each eye BID; tacrolimus drops SID

Abnormal PE/Chem/CBC/UA Results: CBC: Hct 34.4% L, RBC 4.96 L, Hgb 11.6 L, normocytic, normochromic, non-regenerative. Plt 577 - Chem: Alb 3.4-n, ALP 231 H, ALT 31-n, Normal Cr, BUN, SDMA, Chol 241-n - T4: 2.6-n - UA: USG > 1.052 H, pH 6.5, WBC 12/hpf, RBC 3/hpf, no bacteria

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. A small amount of echogenic luminal sediment is present, which is freely movable. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 3.0 cm.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). The left kidney measured 6.0 cm in length. The right kidney measured 5.6 cm in length.

Adrenal Glands

The right adrenal gland is mildly diffusely enlarged and of normal echogenicity. They have normal phrenic vasculature and are found in the normal location. The left adrenal gland height is 3.8 mm at the cranial pole and 6.0 mm at the caudal pole. The right adrenal gland height is 1.4 cm at the cranial pole and 1.0 cm at the caudal pole.

Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

The liver is diffusely hyperechoic and subjectively enlarged, with sharp borders and a homogenous echotexture. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis. There is a 1.7 cm x 9.2 mm hypoechoic nodule noted within the left cranial aspect of the liver which does not expand the hepatic capsule.

The gallbladder is distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal



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The stomach is moderately distended with gas. The gastric wall is 3.6 mm with normal deviations due to rugal folds and exhibits appropriate wall layering. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.

The visible portions of the colon (1.5 mm) are of normal thickness with intact wall layering. The ileocecal junction is not seen.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Mildly enlarged right adrenal gland most typical of benign hyperplasia.
- Diffusely hyperechoic liver consistent with a nonspecific hepatopathy. In this patient, this may be secondary to the recent Prednisone use.
- Small hypoechoic liver nodule most typical of a benign regenerative nodule with malignancy deemed less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no apparent cause for the patient's mild anemia nor the urinary accidents on today's ultrasound. If the urinary accidents persist despite treatment with antibiotics, then urine culture should be considered to completely rule out the possibility of underlying cystitis. If this is negative, then referral for a cystoscopy should be considered to rule out the possibility of pathology within the urethra.

Given that the patient is hypothyroid, this is one possible explanation for a mild nonregenerative anemia. Although the patient's thyroid is normal on supplementation, some patients may require additional supplementation to bring their total T4 level into the higher end of normal range. Another possible explanation might be anemia of chronic inflammation although no specific source of inflammation has been identified. Given the small magnitude of the anemia, serial monitoring with CBC, potentially a CBC with pathologist review, could be considered over the next few weeks to determine whether this is a progressive condition.

The appearance of the right adrenal is most typical of benign hyperplasia, although the possibility of an emerging adrenal mass or hypoadrenocorticism cannot be excluded. The patient's well concentrated urine and lack of symptoms of Cushing's disease make hypoadrenocorticism highly unlikely.

The appearance of the liver nodule is most typical of a benign lesion. Biopsy would be needed to completely exclude the possibility of emerging malignancy. If desired, serial sonographic monitoring of



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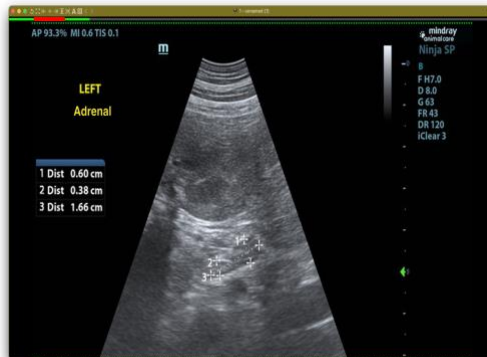
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both the adrenal and the liver could be performed at 4-8 week intervals to determine whether these lesions are changing which may help guide the decision as to whether biopsy would be indicated.



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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