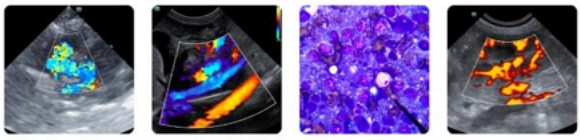


DATE

4/27/26

PATIENT

Honey Allen

SPECIES

Canine

BREED

Terrier mix

SEX

Female, spayed

AGE

11/25/26

WEIGHT

16 lbs.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

HOSPITAL NAME

Jacksonville VH

REFERRING VET

Dr. Burk

INVOICE

13680

PRESENTING CLINICAL SIGNS

Patient History: Presented for 6 month wellness exam and bloodwork- dental tartar, low grade heart murmur, mild shoulder pain. Decreased albumin, mild increase in alp compared to previous results: 4/7/26 albumin 2.9, alp 166. 2/10/25 albumin 3.4, alp 142

Current Medications: Proin for usmi.
Labwork Results: Labwork not attached, reported as: 4/7/26- alp 166, alb 2.9, glob 3.1, trigly 317. t4 1.9. ft4 39. urine sg 1.021 protein trace. upc 0.2.
Bile Acids Pre 2.6 < 13 umol/L. Bile Acids Post 26.0 (HIGH) < 25 umol/L
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The wall in the region of the apex is mildly to moderately thickened (up to 0.41 cm) with an irregular mucosal surface. The wall tapers to a normal thickness as it extends toward the cystourethral junction. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (3.74 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Trace pyelectasia is present (0.16 cm in the longitudinal plane). A few non-obstructive nephroliths are visualized. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.27 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A few non-obstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.76 cm at cranial pole) (0.64 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (0.86 cm at cranial pole) (0.60 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.43 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.09 x 1.01 cm isoechoic to slightly heterogeneous nodule is observed at the medial aspect approximately mid-body. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. The parenchyma is hypoechoic relative to the spleen. A 0.82 x 0.43 cm cyst is observed on the left side. The remaining parenchyma is homogeneous. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic to mineralized partially dependent sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

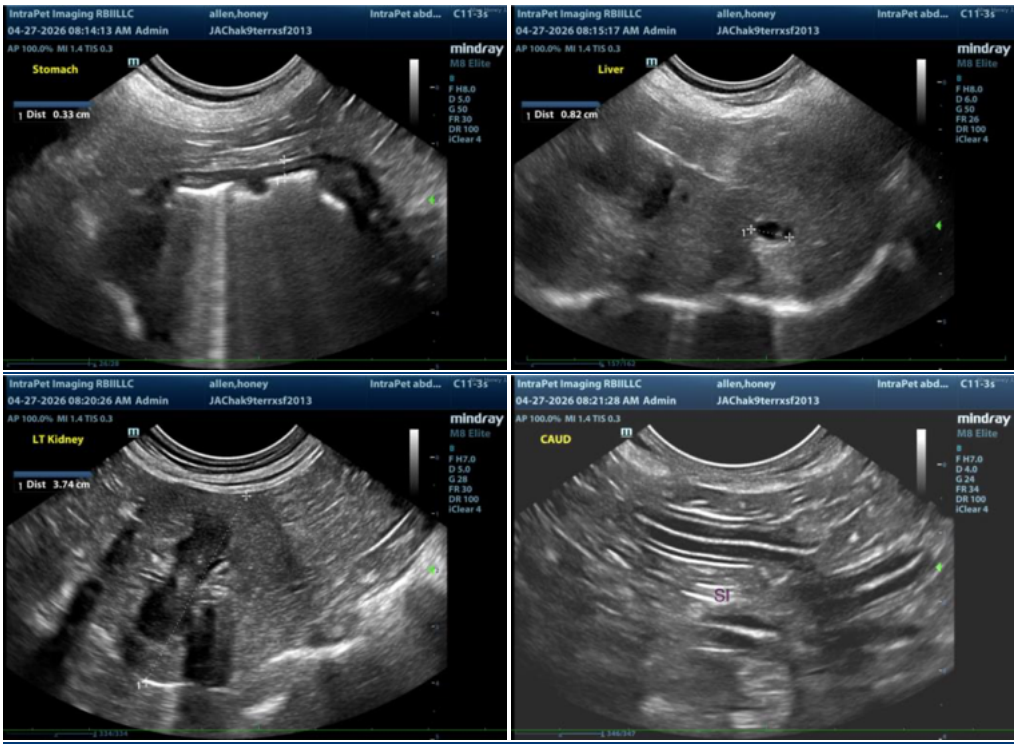
- Excessive gallbladder sludge/sand. Considerations include cholestasis, fasting or an emerging mucocele.
- Left hepatic cyst, likely a benign incidental finding with a lower possibility of an emerging vascular tumor or other pathology.
- The splenic nodule near the hilus could be consistent with an emerging tumor (i.e., sarcoma, round cell tumor). Alternatively, a benign process (i.e., focus of lymphoid hyperplasia) is possible.

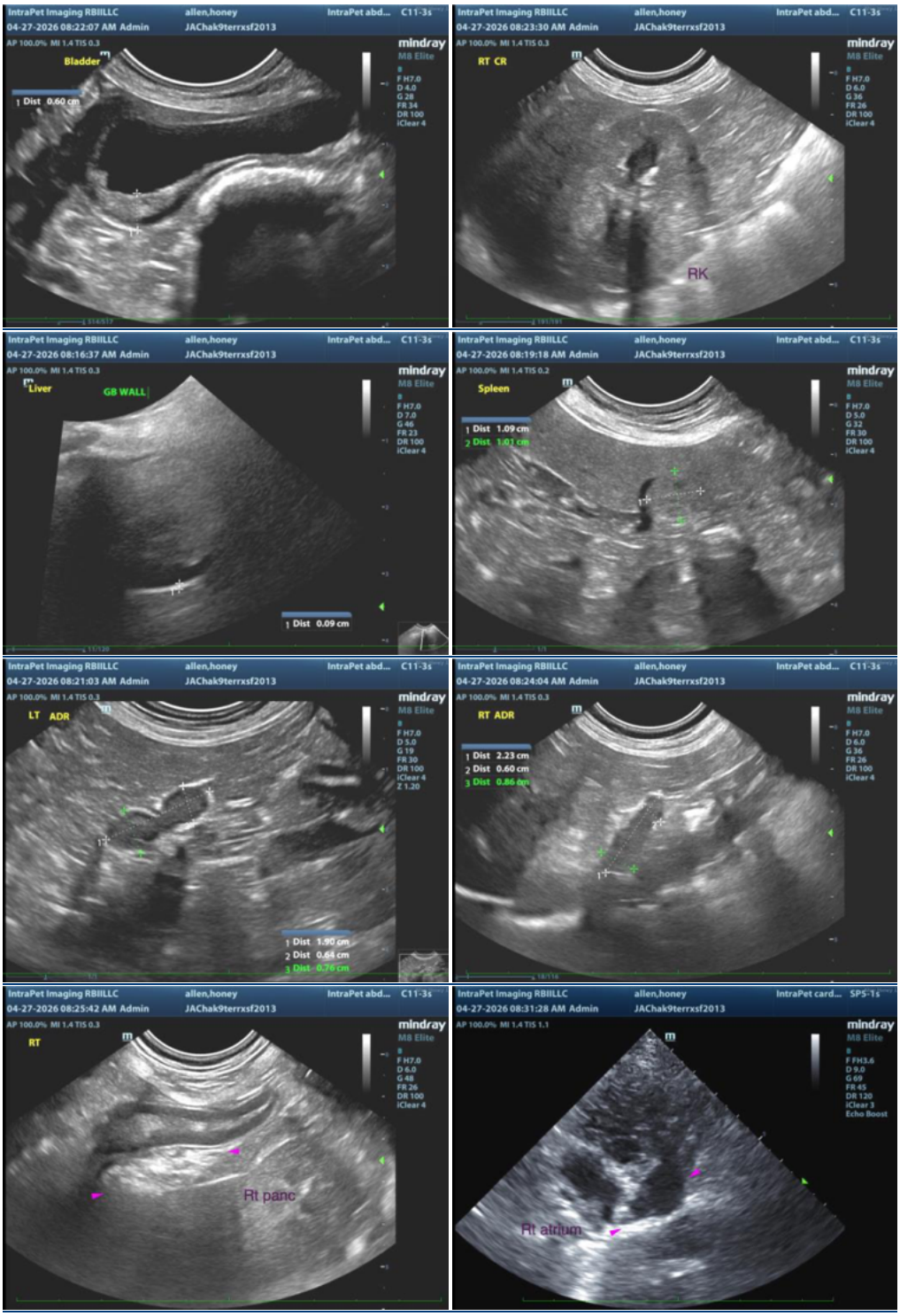
Secondary Findings:

- Bilateral nonspecific, age-related renal changes with non-obstructive nephrolithiasis and trace left pyelectasia.
- Mild bilateral adrenomegaly
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The urinary bladder wall changes could be consistent with cystitis. Correlation with the patient's clinical history and urinalysis findings is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the splenic nodule, consider the following:
  1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
  2. Fine needle aspiration (assuming normal clotting status). A 25-gauge needle should be used.
- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.
- Regarding the hypoalbuminemia, consider the following:
  1. Fecal evaluation for ova and Giardia
  2. GI panel including serum cobalamin, folate, TLI, PLI and resting cortisol level
  3. +/- endoscopic or surgical GI biopsies if indicated
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.

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mindray
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Bladder
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M8 Elite
Liver
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2 Dist 1.01 cm
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M8 Elite
LT ADR
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3 Dist 0.76 cm
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M8 Elite
RT ADR
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2 Dist 0.60 cm
3 Dist 0.86 cm
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allen,honey
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Rt atrium

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine) info@SonoPath.com