PATIENT

Cooper Hogan

SPECIES

Canine

BREED

Spaniel mix

SEX

Male, neutered

AGE

11 Yrs.

WEIGHT

50.9 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Waterway

REFERRING VET

Dr. Roland

INVOICE

13561

DATE

5/20/26

PRESENTING CLINICAL SIGNS

Pt presented on 5/15 for an episode of where owner found him lying on the floor in a puddle of drool. When she got him up he was unsteady on his feet. Had a similar episode per owner a few weeks ago. During that episode he appeared glazed over and then he vomited and vomited again 30 min later. Previous history of bilious vomiting. Bloodwork shows a thrombocytosis and an eosinophilia. 4DX negative. Urine specific gravity 1.041 + proteinuria, inactive sediment. T4 normal, ALP 317, PSL 282.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.57 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (6.53 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.77 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.59 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.

The right adrenal gland is normal in size (0.67 cm at cranial pole) (0.59 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 subjectively normal in size with a normal capsular contour. There is appropriate echogenicity and echotexture. 1-2 hyperechoic nodules are observed within the parenchyma, the largest measuring 0.71 cm in its longest dimension. Splenic vasculature is normal.

Liver

The liver is prominent in size with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

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The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate to large amount of aggregated, echogenic 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 ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible/prominent in size with slightly irregular peripheral contours. The parenchyma is hyperechoic relative to surrounding omental fat and mottled/heterogeneous in appearance with several small ill-defined hypoechoic nodules. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic effusion.

Lymph nodes

1-2 prominent mesenteric lymph nodes are visualized, one of the nodes measuring 1.81 x 0.38 cm.

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:

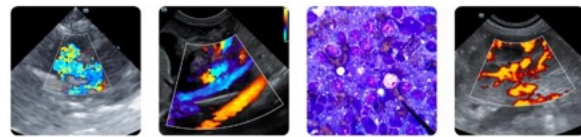
- Excessive gallbladder sludge. This finding could be consistent with cholestasis, fasting or an emerging mucocele.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.

Secondary Findings:

- Mild bilateral nonspecific, age-related renal changes
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The hyperechoic splenic nodules are most consistent with myelolipomas with a lower possibility of more insidious splenic pathology.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the patient's clinical history, a neurologic examination is recommended. Also consider the following:
  1. Baseline blood pressure measurement



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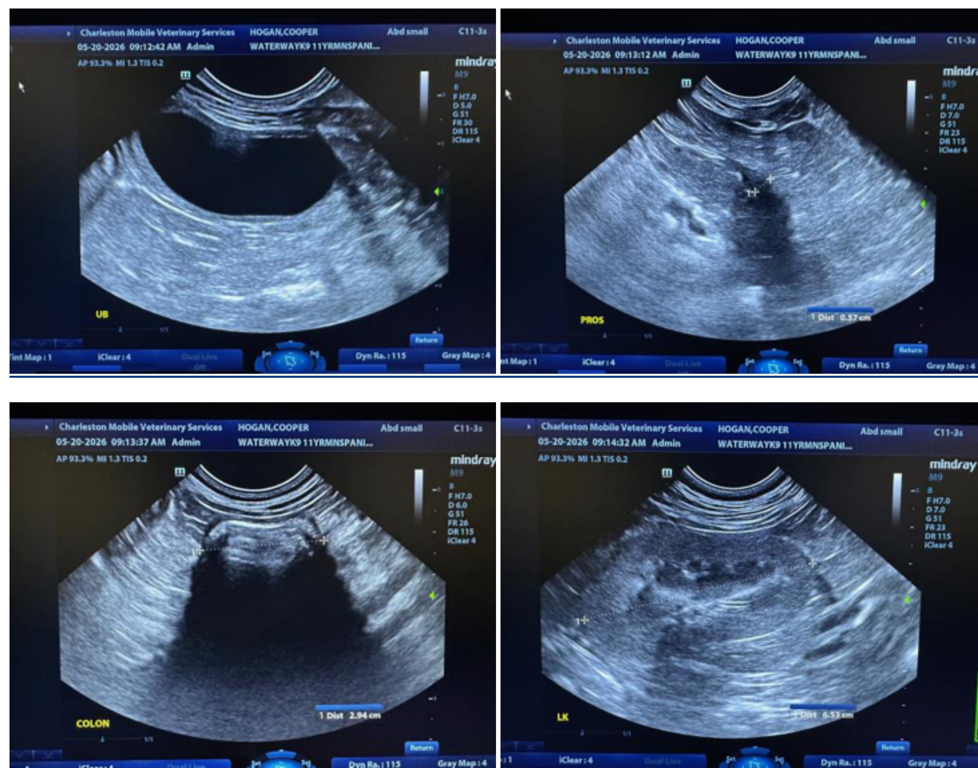
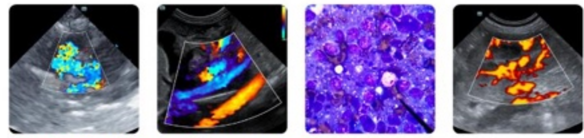
2. Pre and post-prandial serum bile acids to assess hepatic function
3. Three-view thoracic radiographs to assess cardiopulmonary status
4. +/- neurology and/or cardiology consultation to further evaluate seizure vs syncopal episodes.

- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.
- 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.





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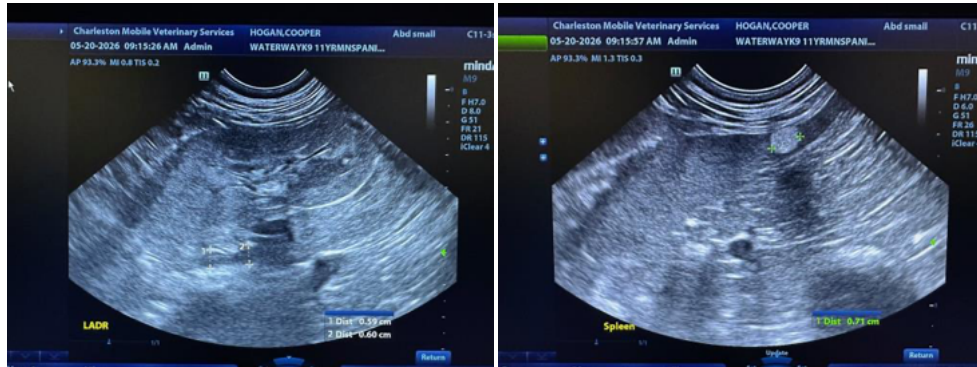

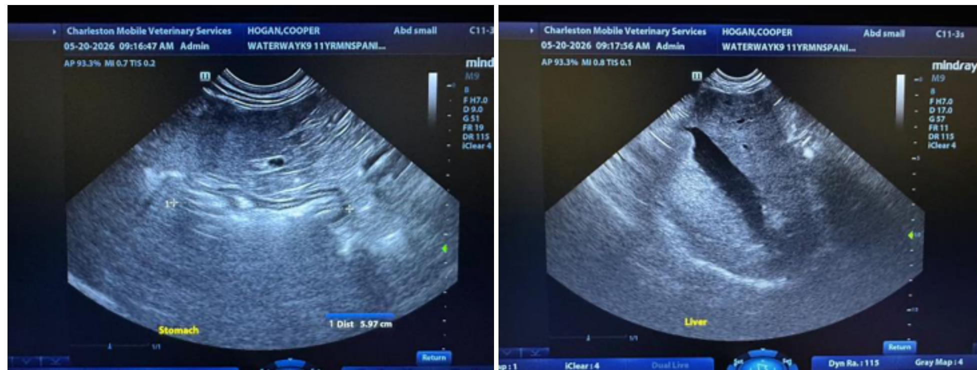

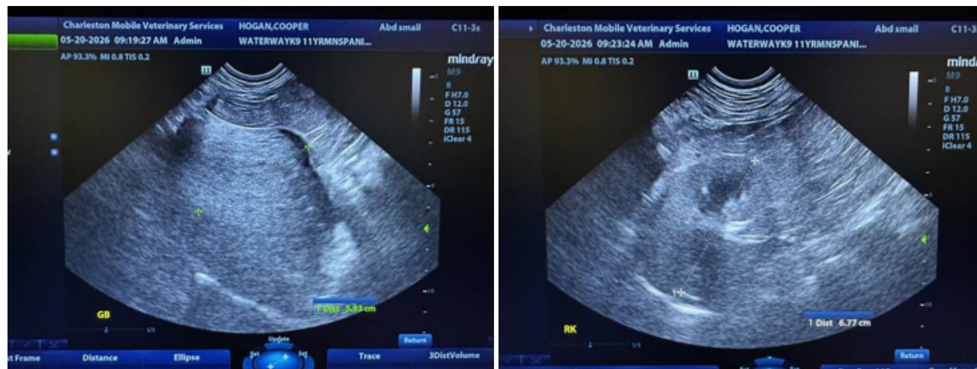

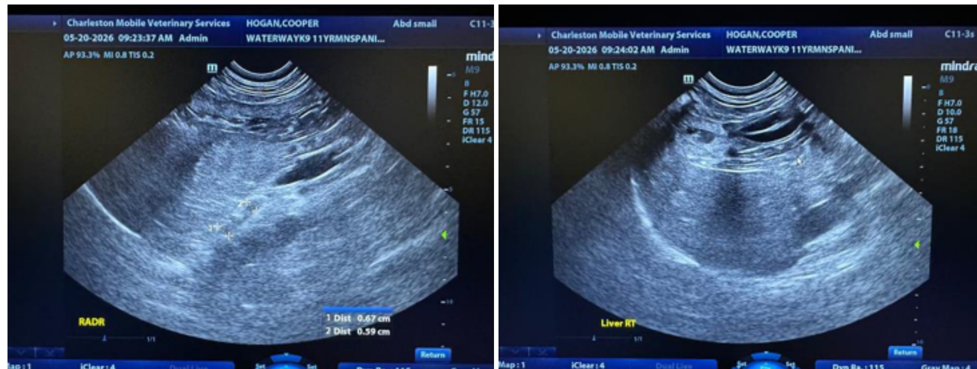

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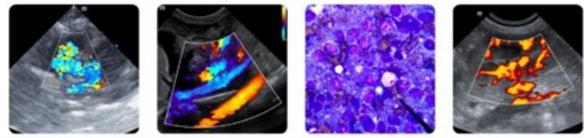

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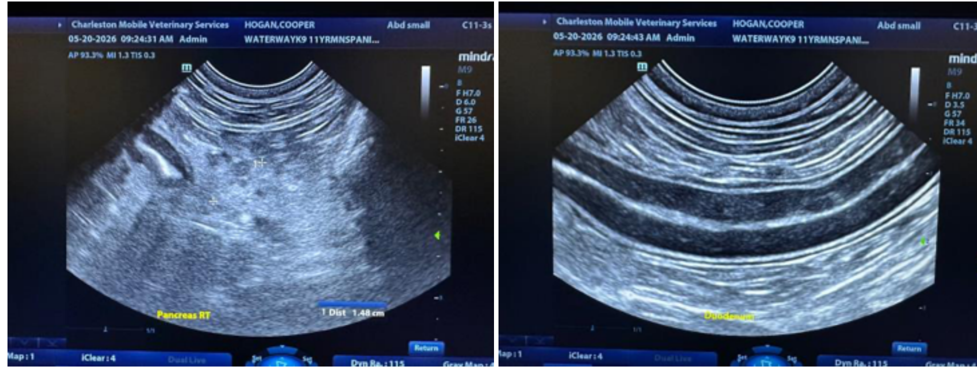

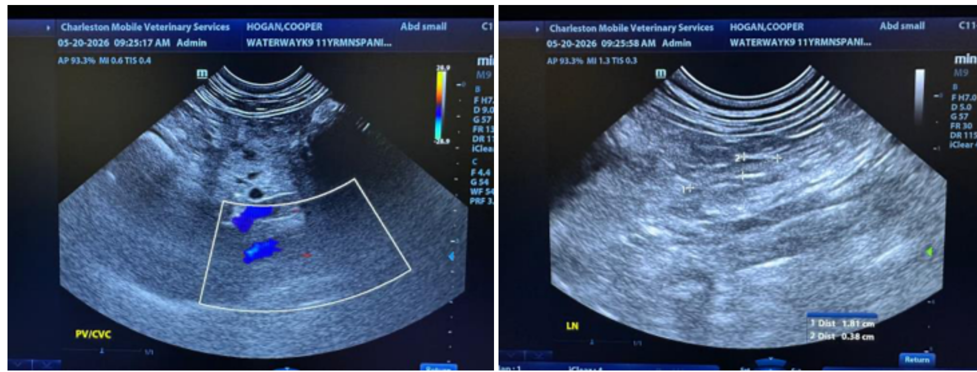

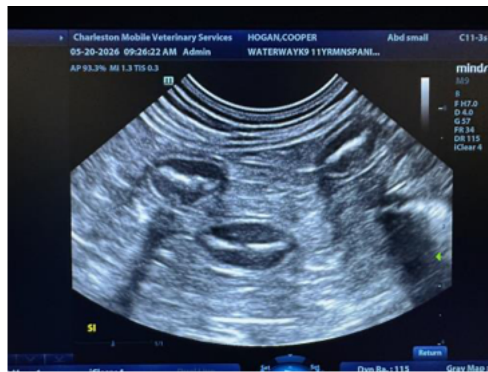

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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