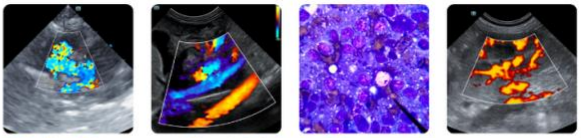




**PATIENT**

Dixie Kraus

**SPECIES**

Canine

**BREED**

Retriever X

**SEX**

Spayed Female

**AGE**

12 Years

**WEIGHT**

40.4 pounds

**INTERPRETED BY**

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

**IMAGING PERFORMED BY**

Meghan Morse LVT, CVT

**HOSPITAL NAME**

Park Ridge Animal Hopsital

**REFERRING VET**

Dr. Doyle

**INVOICE**

12425

**DATE**

11/21/25

## PRESENTING CLINICAL SIGNS

Elevated LEZ, PU/PD, panting excessively

Current meds: Simparica trio, Dasuquin

Abnormal PE/Chem/CBC/UA Results: ALT 23718, ALT 671, AST 76, GGT 46, 4xs pos anaplasma and lyme (chronic)

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is adequately distended with anechoic urine. The bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. There are no uroliths or sediment noted. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure, with appropriate cortex to medulla ratio. The cortices are hyperechoic with a loss of corticomedullary definition. No significant pyelectasis or pelvic dilation present. There is mild dystrophic mineralization bilaterally with renal pelvic mineralization and shadowing nephrolithiasis with no evidence of obstructive disease at this time. The left kidney measures 5.18 cm. The right kidney measures 5.02 cm.

### *Adrenal Glands*

The adrenal glands are bilaterally enlarged and prominent with slightly heterogenous parenchyma. There is no evidence of capsular expansion or vascular invasion noted. The phrenic vasculature is normal. The left adrenal gland measures 0.86 cm x 1.73 cm. The right adrenal gland measures 0.80 cm x 2.59 cm.

### *Spleen*

The spleen is slightly prominent with a slightly heterogenous remodeled reticular pattern. There are several hyperechoic foci within the parenchyma that do not distort the smooth splenic capsule. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. The spleen measures 2.37 cm at the hilus.

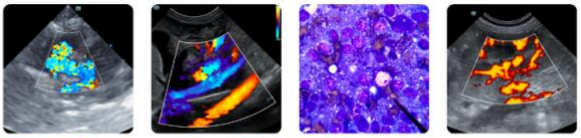
### *Liver*

The liver is subjectively enlarged and diffusedly hyperechoic with scattered hypoechoic nodular changes throughout. Vasculature is within normal limits with no evidence of congestion.

The gallbladder is mild to moderately over distended with echogenic suspended organizing debris. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. There is no overt structural evidence of inflammation around the gallbladder wall which is appropriately thin.

### *Gastrointestinal*

The stomach and intestines are free of stasis and peristaltic activity, with no significant dilation noted. There is normal wall thickness and acceptable curvilinear mural detail. The pyloric-duodenal junction and ileocecocolic junction are patent, and the colon contains normal shadowing feces. There is no



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evidence of shadowing obstructive material or overt infiltrative disease noted. No associated abnormal lymphatic activity is documented.

### *Pancreas*

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

### *Free Abdomen*

There is no significant lymphadenopathy or free fluid.

## ULTRASONOGRAPHIC FINDINGS

- The kidneys are relatively normal in size and structure, and cortex:medulla ratio (cortex 1/3 of medulla) is essentially maintained. There is age-related loss of the normal smooth capsular contour and C/M junction definition. The cortices are largely uniform in texture with mild hyperechogenicity expected for this patient's age. Dystrophic mineralization was noted and appears non-obstructive at this time, with no evidence of pyelectasis.
- The adrenal glands are mildly enlarged with no evidence of focal capsular expansion or vascular invasion noted. The parenchyma is uniform and there is no overt suspicion of neoplasia. This is considered likely a hyperplastic change associated with stress or adrenal endocrinopathy (PDH).
- The mildly enlarged spleen with a coarse/mottled reticular pattern is most consistent with a reactive spleen, or possible splenitis. Round cell neoplasia is considered less likely but cannot be definitively excluded.
- There are hyperechoic splenic foci throughout the splenic parenchyma consistent with myelolipomas. These are likely incidental and not overtly pathologic.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory, immune-mediated, metabolic, or endocrine disease. Infiltrative neoplasia or acute hepatitis cannot be ruled out.
- The gallbladder is over distended with largely suspended, organized debris. This is most consistent with an emerging mucocele. There was no evidence of inflammation noted at this time. This is not likely causing overt clinical signs.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection. An ACTH stimulation test and low dose dexamethasone suppression test are indicated to evaluate for potential pituitary dependent hyperadrenocorticism. Fine needle aspirates of the spleen and liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

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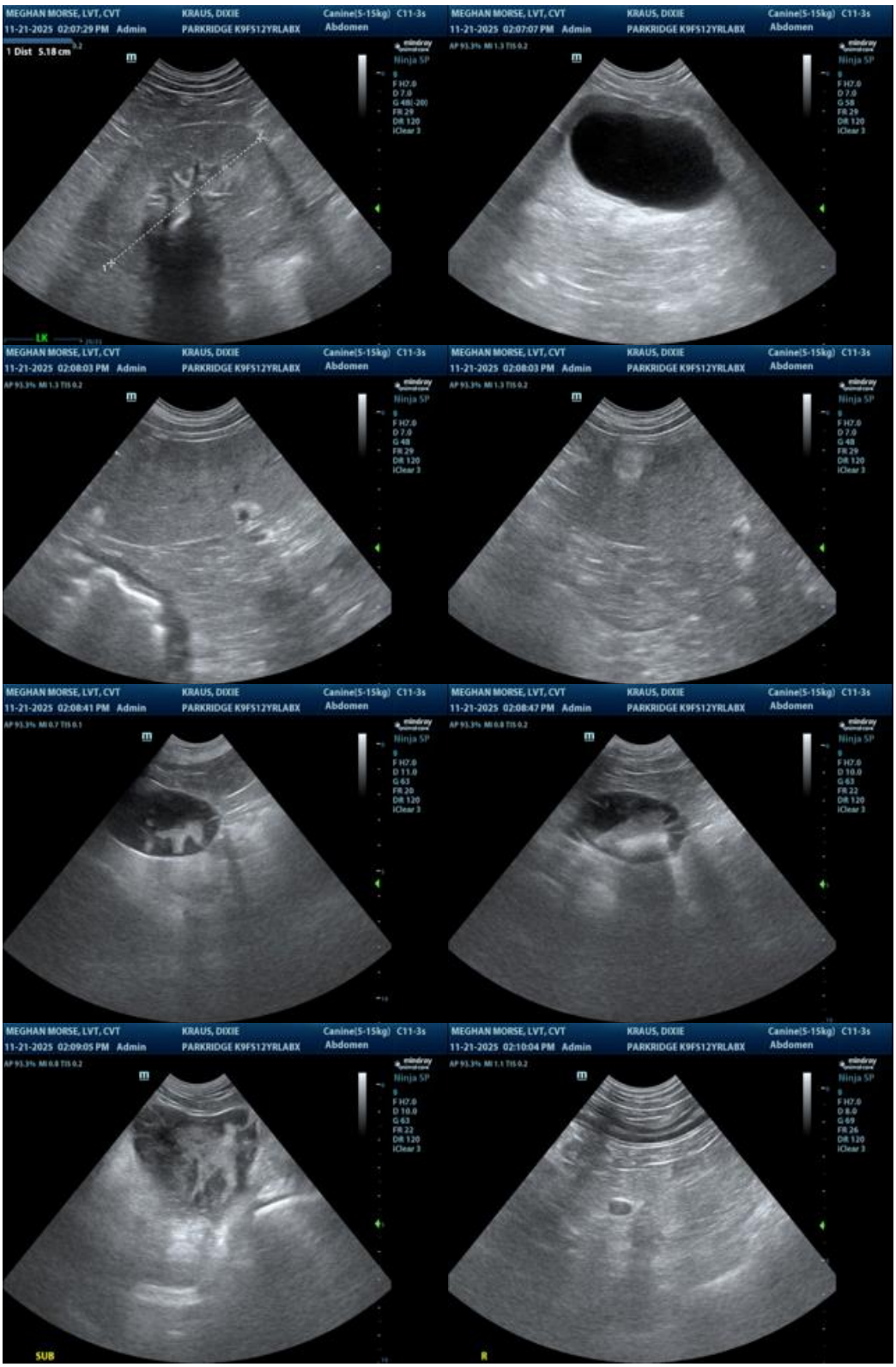
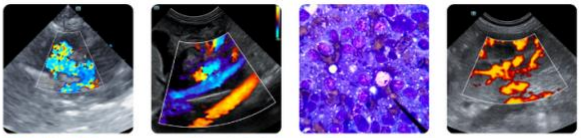


New Jersey Mobile
FUELED BY SONOPATH VETERINARY ULTRASOUND



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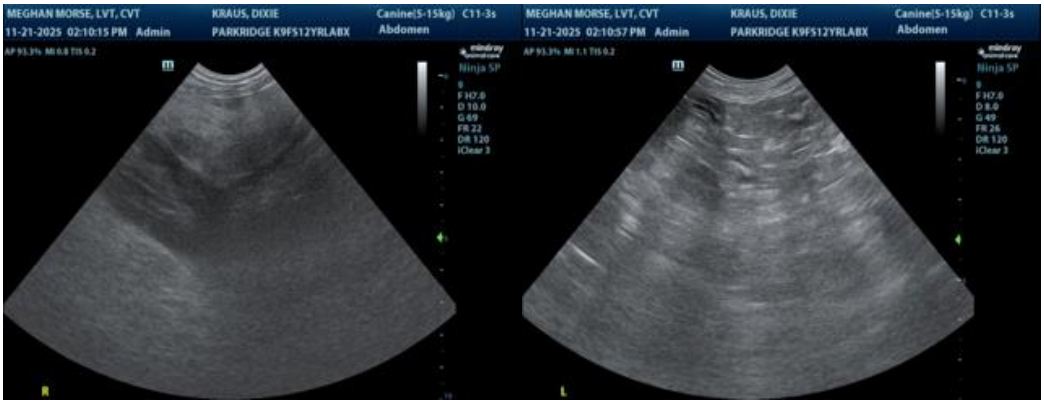


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**Bradley Harris**, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com