



PATIENT

Canela Ramon

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

11 Years

WEIGHT

30 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Mario Roman

INVOICE

72496

DATE

1/27/26

PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound due to Hx of increased liver and gallbladder enzymes, vomiting, and lethargy. Severe generalized ictericia. rDVM reports normal abdominal palpation. Heart and lungs WNL

Hospitalized last week with IV NaCl 0.9% + Vitamin B-12/Baytril and Ampicillin + Dex Phosphate IV and Cerenia. PET and Liver enzymes improved over 72 hours. Px was sent home with Denamarin, Actigall, Metronidazole, weaning off of Prednisone, Doxycycline (150mg PO SID), Cerenia (1.4mL SQ), and Vitamin B12

Abnormal PE/Chem/CBC/UA Results: Bloodwork attached below for your reference: High WBC (24.30K/uL) High NEU (20.53K/uL) High MON (1.24K/uL) Low EOS (0.03K/uL) High GLOB (4.8g/dL) High ALT (793 U/L) High TBIL (8.5mg/dL) High CHOL (481mg/dL)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 5.73 cm. Right kidney measures 6.67 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.47 cm at cranial pole and 0.40 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.41 cm at cranial pole and 0.42 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver), except for an approximately 1.0 cm x 1.4 cm non-capsule disrupting hypo- to anechoic density near the caudal aspect of the spleen. Splenic vasculature appears normal.

Liver

Diffusely, the liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Additionally, several discrete homogeneous, hyperechoic nodules are noted throughout the parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion



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Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Emerging mucocele – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.
- Moderately heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Hypo to anechoic splenic nodule(s) – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

SECONDARY FINDINGS

- Age related kidney changes.



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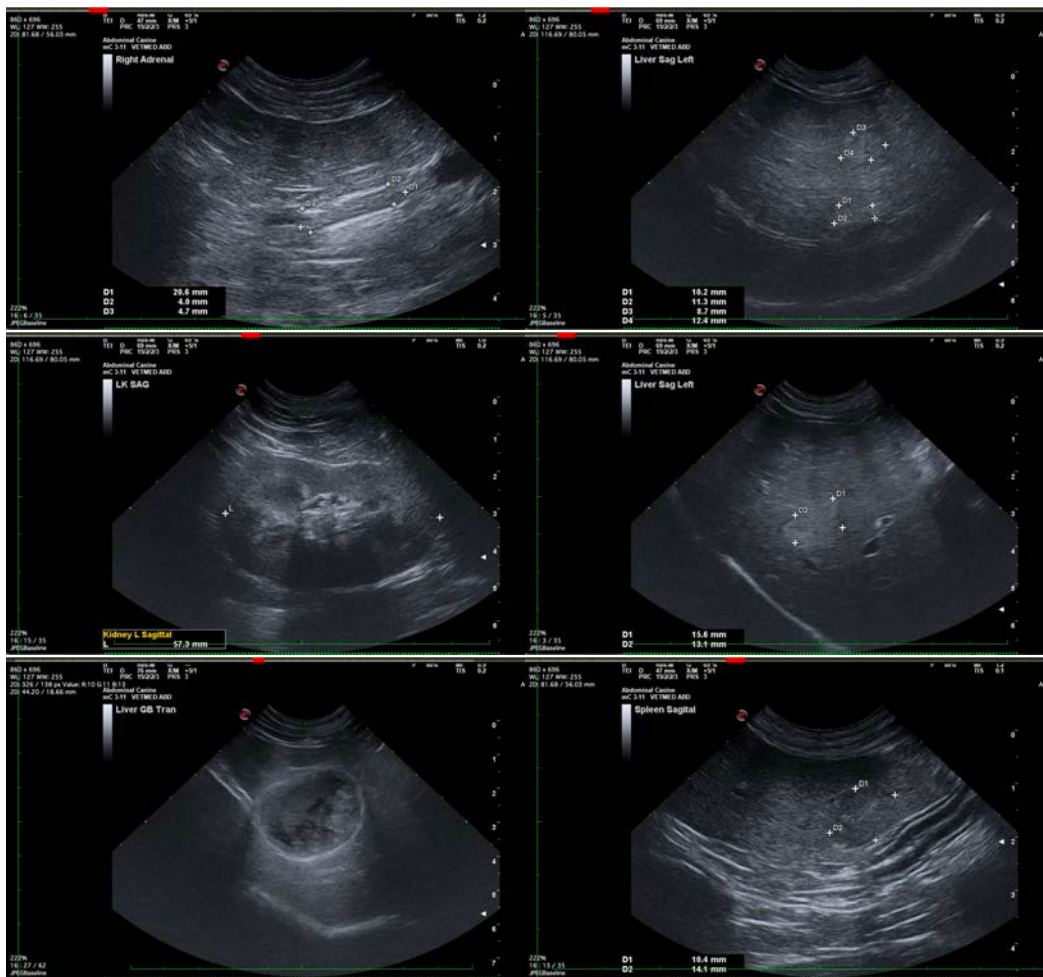
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, fine needle aspirates of the spleen and liver are recommended if patient's coagulation status is appropriate.

In the meantime, given the reported improvement in liver enzymes over 72 hours of treatment, continued supportive/symptomatic medical management of clinical signs and medical management empirically of potentially infectious or bacterial cholangitis/cholangiohepatitis, etc. could be considered. If not already in place, Ursodiol may also be helpful. Having said that, if improvement does not continue, and/or relapses occur, more aggressive intervention up to and including possible cholecystectomy, liver biopsies, etc. may be indicated in the future.





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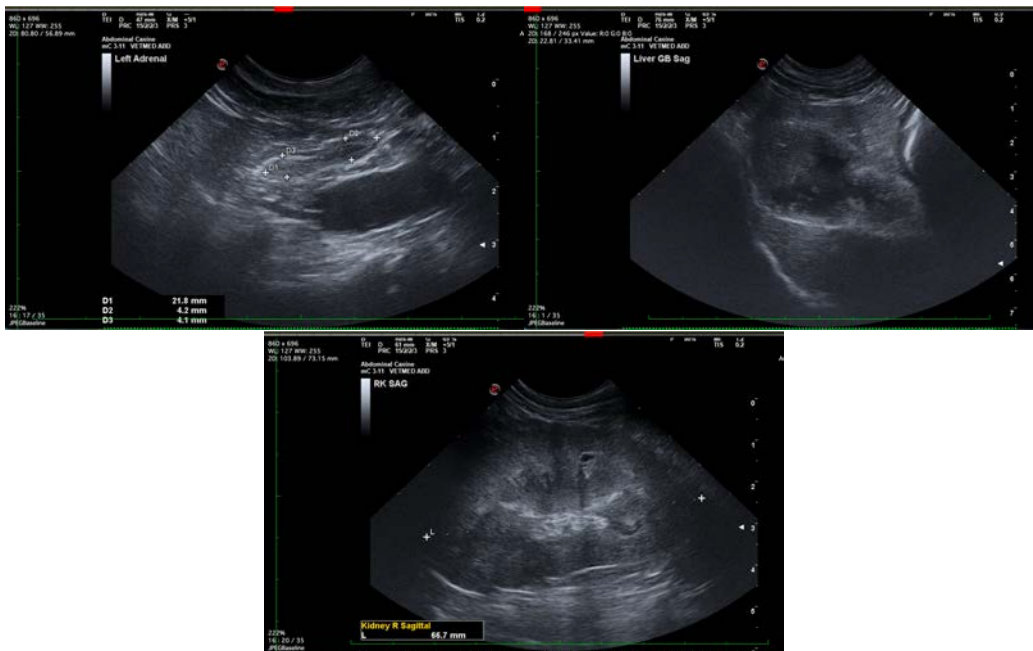
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
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