

PATIENT

Sadie Amon

SPECIES

Canine

BREED

St. Bernard x

SEX

Spayed Female

AGE

10 Years

WEIGHT

62 lbs

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Faithful Friends Animal
 Clinic

REFERRING VET

Dr. Stender

INVOICE

72035

DATE

1/7/26

PRESENTING CLINICAL SIGNS

Vomiting, anorexia, pale mm, lethargy. Meds: just discontinued Cyclosporine, was getting 150 mg po BID, still on Prednisone 60 mg po SID, Omeprazole

Abnormal PE/Chem/CBC/UA Results: Regenerative anemia, strong autoglutination. Pet started to feel better but past 3 week worse and labs getting worse. Both HCT and Liver enzymes. HCT 27%, then 34 %, and now 28 %. ALT was 144 and now 517, GGT was 12 and now 121, ALP was 547 and now > 2000, Tbili was 1.1 and now 3.2

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.

The right kidney is normal is size (6.07 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (7.6 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.34 cm at the cranial pole and 0.29 cm at the caudal pole. Right measures 0.79 cm at the cranial pole and 0.47 cm at the caudal pole.

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). No focal nodules or masses are observed. Splenic vasculature appears normal.

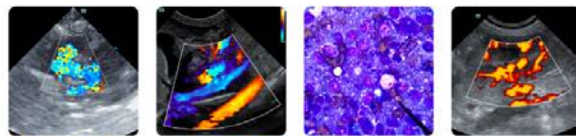
Liver

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, in what appears to be the let caudal liver is an approximately 1.0 cm in diameter anechoic density/suspect cyst. Visible vasculature and biliary tree appear normal without distension or congestion

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no



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evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

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If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

BREED

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The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

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

Pancreas

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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.

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Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

IMAGING PERFORMED BY

Rebecca Hamilton

ULTRASONOGRAPHIC FINDINGS

- Moderately Heterogenous Liver with a suspect incidental benign hepatic cyst – 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.
- The flat adrenal glands are consistent with patient's steroid history.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This is a largely unremarkable study for a patient receiving steroids, without a definitive ultrasonographically visible intraabdominal explanation for either the relapse in anemia or the acute increase in liver enzymes. A microscopic hepatopathy can't be ruled out and includes differentials such as infectious disease i.e., Leptospirosis and/or bacterial infection, especially given patient's reported immunosuppression. Chronic active hepatitis, copper associated hepatotoxicity, other hepatotoxicity including potentially idiosyncratic drug reactions, other reactive hepatopathy, infiltrative neoplasia (considered unlikely), etc. Therefore, adjusting/tapering/changing patient's immunosuppressive protocol while adding hepatoprotective nutraceuticals, etc. could be considered, +/- empirical treatment of a possible secondary infection.

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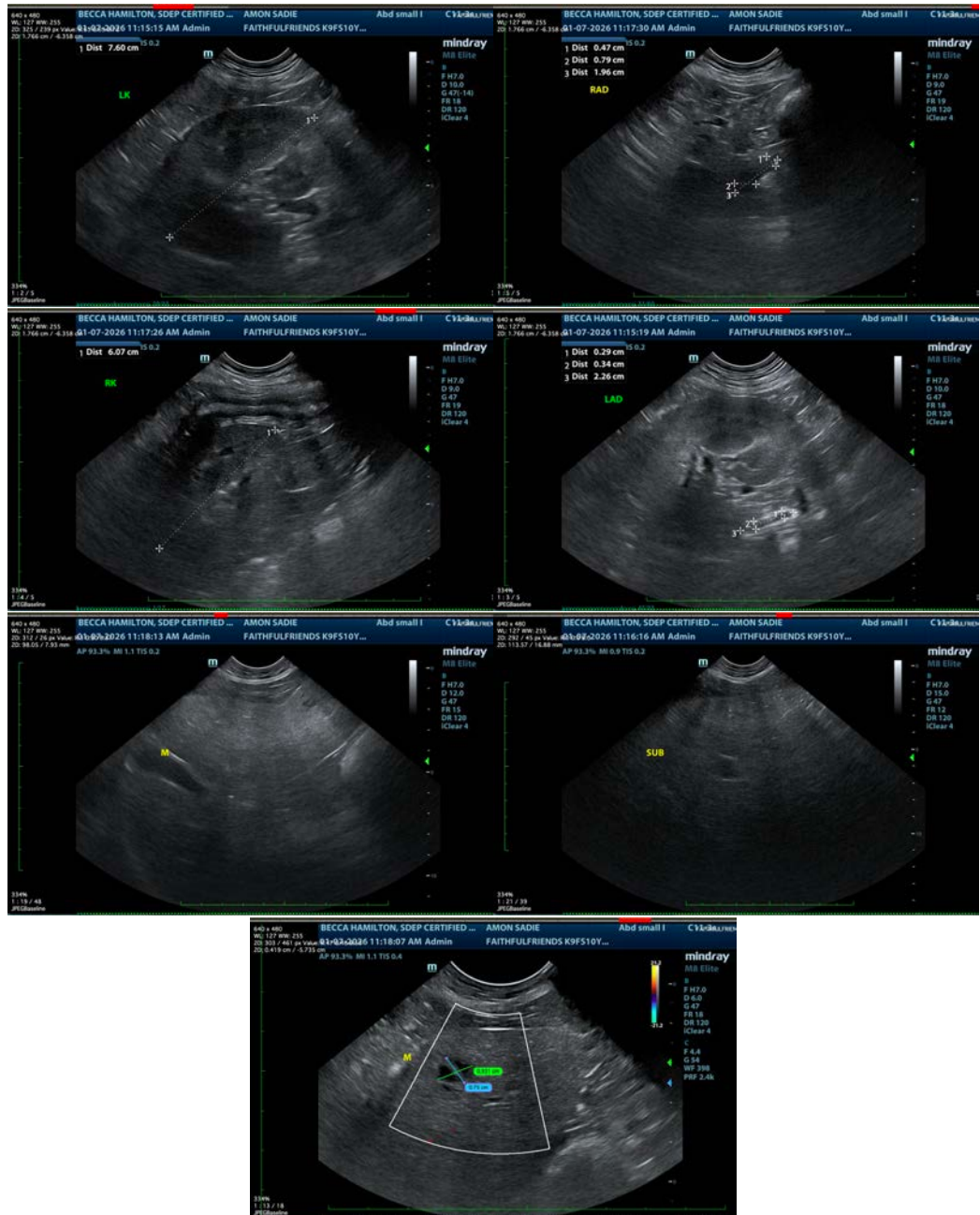
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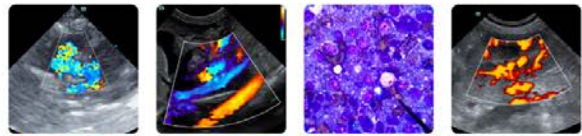
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Ultimately, however, if improvement is not noted and/or either problems persists, full consultation and/or referral to a veterinary internist could be considered for the suspected hemolysis and/or liver sampling pursued if patient's coagulation status is appropriate.





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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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