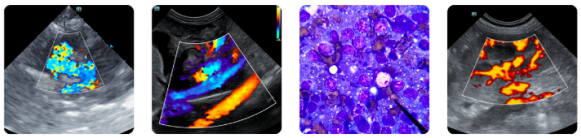


DATE

11/17/25

PATIENT

Sophie Jordan

SPECIES

Canine

BREED

Pekingese Mix

SEX

Spayed Female

AGE

9/22/13

WEIGHT

22.2 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Everhart VH

REFERRING VET

Dr. Menefee

INVOICE

35552

PRESENTING CLINICAL SIGNS

Patient History: Pt's last exam in 5/2025. Heart murmur of 3-4/6. O requesting 6 month echo recheck. Double check liver- no problems just monitoring

Current Medications: HYDROCODONE 5MG TABLETS 8/28/2025, VETMEDIN 2.5MG TABLET 50CT BOTTLE 7/2/2025, URSODIOL 250MG TABLET 7/2/2025
Labwork Results: Labwork attached.
Date of Previous IntraPet Ultrasound: 4/29/24. See attached.
Sedation: Torbugesic.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Left kidney is normal in size (4.73 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.

Right kidney is normal in size (5.03 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

Left adrenal gland is normal in size (0.7 cm at cranial pole and 0.7 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.7 cm at cranial pole and 0.6 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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 0.7 cm x 0.8 cm in size non-capsule-disrupting hypo- to anechoic nodule, as well as an additional discrete homogenous hyperechoic 0.8 cm in diameter nodule are noted. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is diffusely mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver

parenchyma. Additionally, in the left caudal liver, an approximately 1.3 cm in diameter anechoic density. Visible vasculature and biliary tree appear normal without distension or congestion.

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.

ULTRASONOGRAPHIC FINDINGS

- Emerging gallbladder 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.

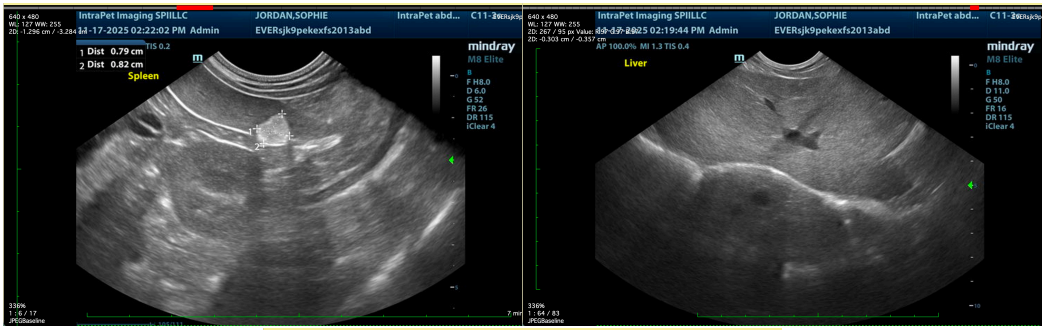
- Diffusely mildly heterogenous liver with a suspect incidental hepatic cyst in the left liver- These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

- Hypo- to anechoic splenic nodule, as well as hyperechoic splenic nodules- The hypo to anechoic splenic nodule 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. The hyperechoic splenic nodules are most

consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the gallbladder debris is slightly subjectively progressive in nature. The other changes, cysts, nodules, etc., involving the liver and spleen, are largely static and trend in appearance toward benign. Therefore, further recommendations are largely dependent on clinical signs. Having said that, empirical hepatic nutraceuticals, including ursodiol could be considered.



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

info@sonopath.com