



PATIENT

Rio Driggers

SPECIES

Canine

BREED

Yorkie

SEX

Spayed Female

AGE

12 years

WEIGHT

20 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Jessica Boudreaux-
Milligan

HOSPITAL NAME

Dockside Veterinary
Imaging

REFERRING VET

Dr. Summer Jenks

INVOICE

10675

DATE

11/03/2025

PRESENTING CLINICAL SIGNS

Hepatomegaly on radiographs. Possible Cushings. Hx of bladder stones.

Abnormal PE/Chem/CBC/UA Results: Please see attached records.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, or echogenic sediment are observed. There is at least one 0.7 cm in diameter mineral shadowing density consistent with a 0.7 cm in size cystolith. Several small cystoliths clumped together can't be definitively ruled out. 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 5.18 cm, and the right kidney measures 5.45 cm.

Adrenal Glands

Adrenal glands are mildly plump/enlarged in size for a small dog. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left adrenal measures 0.66 cm at caudal pole, and the cranial pole is difficult to fully visualize in these images. Right adrenal measures 0.7 cm and 0.62 cm at the cranial pole.

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. 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. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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.



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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 of the small intestine is empty with 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 observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation. *See Free Abdomen*

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Free Abdomen

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

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Medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

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In the right cranial abdomen, there's an approximately 1.1 cm x 1.8 cm in size, anechoic/cystic density of unknown origin. Differentials include pancreatic cyst versus a cystic lymph node versus potentially liver cyst versus other.

PRIMARY FINDINGS

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- Subjectively mild bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.

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- 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.

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- Moderate gallbladder debris - 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. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

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- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

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- Reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

SECONDARY FINDINGS



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- Suspect incidental or benign pancreatic or potentially hepatic cyst, although as stated above, the origin of the suspected cystic structure can't be definitively determined. Other differentials include hematoma, abscess, thus likely infiltrative neoplasia.

- Age related kidney changes.
- A urinary bladder cystolith.

- Hyperechoic splenic nodules – 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

Differentials for a primary cholestatic liver enzyme pattern (increased ALP) are vast and non-specific. Differentials include, but are not limited to, benign nodular hyperplasia which occurs in 70% of older dogs and often does not result in an abnormal ultrasound, reactive or idiopathic/vacuolar hepatopathy, cholestasis and/or hyperadrenocorticism as well as many chronic non-hepatobiliary diseases such as chronic infections/inflammation from dental disease, IBD, neoplasia, hyperlipidemia, hypothyroidism, chronic pancreatitis, chronic stress, etc.

- Especially given the subjectively mild adrenomegaly, adrenocortical testing such as a low dose dexamethasone suppression test could be considered if clinical signs of hyperadrenocorticism are present.
- Given the concurrent gallbladder debris, empirical hepatic nutraceuticals including ursodiol could be considered while monitoring for improvement.
- A fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate. Additionally, sampling of the cystic structure could be considered.
- Otherwise, recommendations include addressing any other concurrent disease and monitoring. If values are progressive, recheck imaging is recommended.





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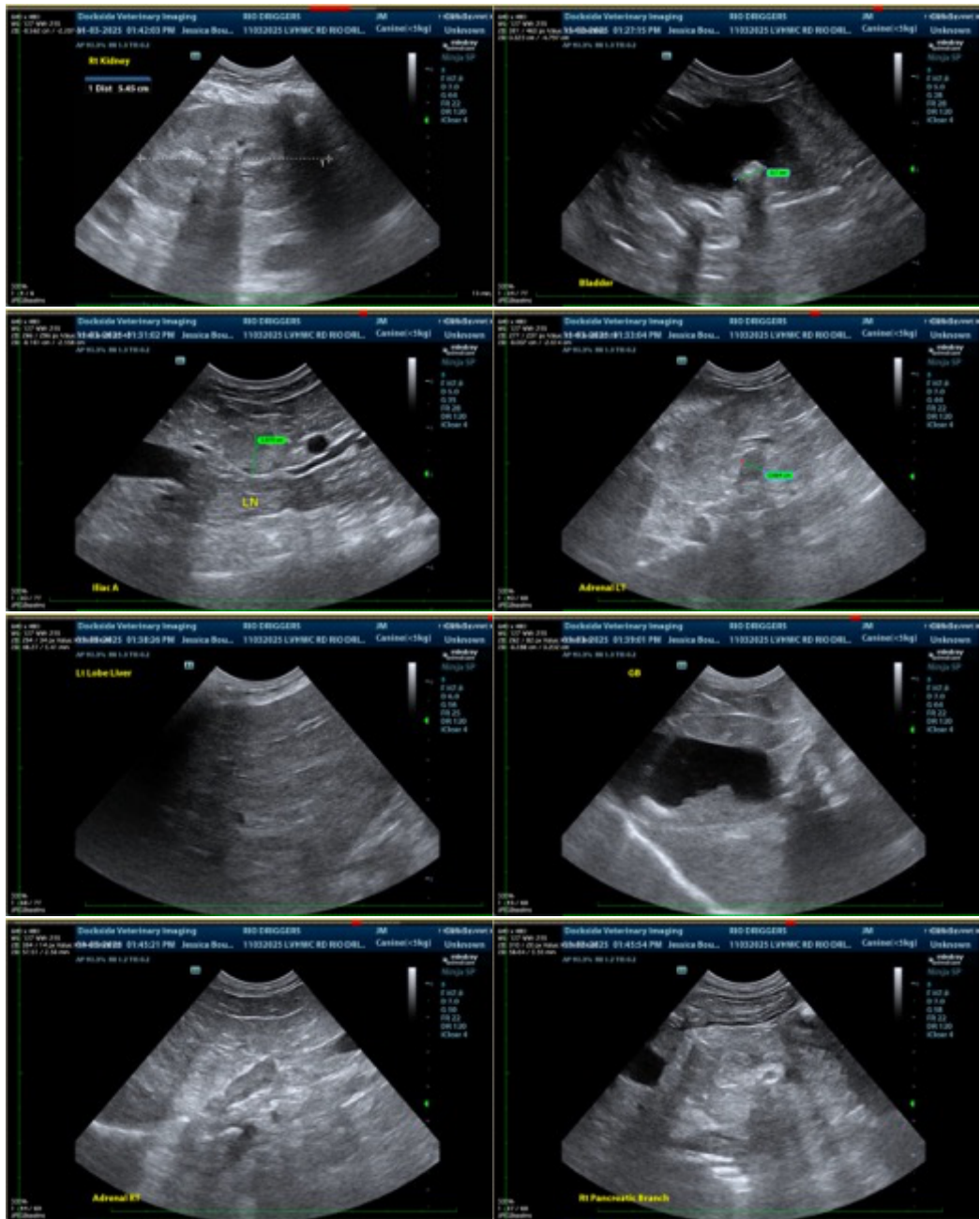
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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