



PATIENT

Charlie Banjo Olafson

SPECIES

Canine

BREED

Bichon x

SEX

Neutered Male

AGE

14 Years 7 Months

WEIGHT

12.7 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Bridgeland Vet Clinic

REFERRING VET

Dr. Rachel

INVOICE

72276

DATE

12/2/25

PRESENTING CLINICAL SIGNS

Investigation of a worsening hepatopathy and clinical signs suggestive of Cushing's disease, with other chronic conditions including degenerative mitral valve disease and a history of calcium oxalate bladder stones. BW in Feb/24 revealed mildly elevated liver enzymes (ALP 222, ALT 146). By September of this year, these values had significantly increased (ALP 686, ALT 289). After a four-week trial of Zentinel, repeat labs showed further worsening (ALP 916, ALT 335, GGT 16). Concurrently, the owner has recently observed new clinical signs including PU, PD, polyphagia, a pot-bellied appearance, panting, and urinary accidents overnight. Also reports signs of cognitive dysfunction, such as getting lost in the house and stumbling. An abdominal ultrasound, low-dose dexamethasone suppression test, and bile acids are planned for today to investigate for Cushing's disease. Hx of calcium ox. bladder stones, previously removed via urohydropropulsion. On Hill's t/d diet and Hill's urinary treats to prevent recurrence, and an ultrasound to recheck the bladder is planned for today. Diagnosed with Stage B1 degen. mitral valve disease June/25 Other chronic conditions include a past right cranial cruciate ligament repair, progressive night vision and hearing loss with bilateral immature cataracts, and osteoarthritis managed with monthly Librela injections. A neoplastic mass was removed from his chest at age four, and he has a slow-growing gingival mass that is being monitored.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots, as well as very large amount of dependent mineral "sand" (crystals) debris. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. Additionally, there is at least one definitive cystolith measuring 0.40 cm in size. No masses are observed. The 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 or infarcts observed. Left kidney measures 5.7 cm. Right kidney measures 5.5 cm. Punctate non-obstructive nephroliths are noted bilaterally.

Adrenal Glands

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.53 cm at the cranial pole and 0.81 cm at the caudal pole. Right measures 0.89 cm at the cranial pole and 0.69 cm at the caudal 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.



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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 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 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.

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

- 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.
- Mildly 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.
- 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.



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SECONDARY FINDINGS

- 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.
- 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.
- Age related kidney changes with punctate non-obstructive nephroliths bilaterally.
- Large amount of echogenic urinary bladder sand debris and at least one cystolith.

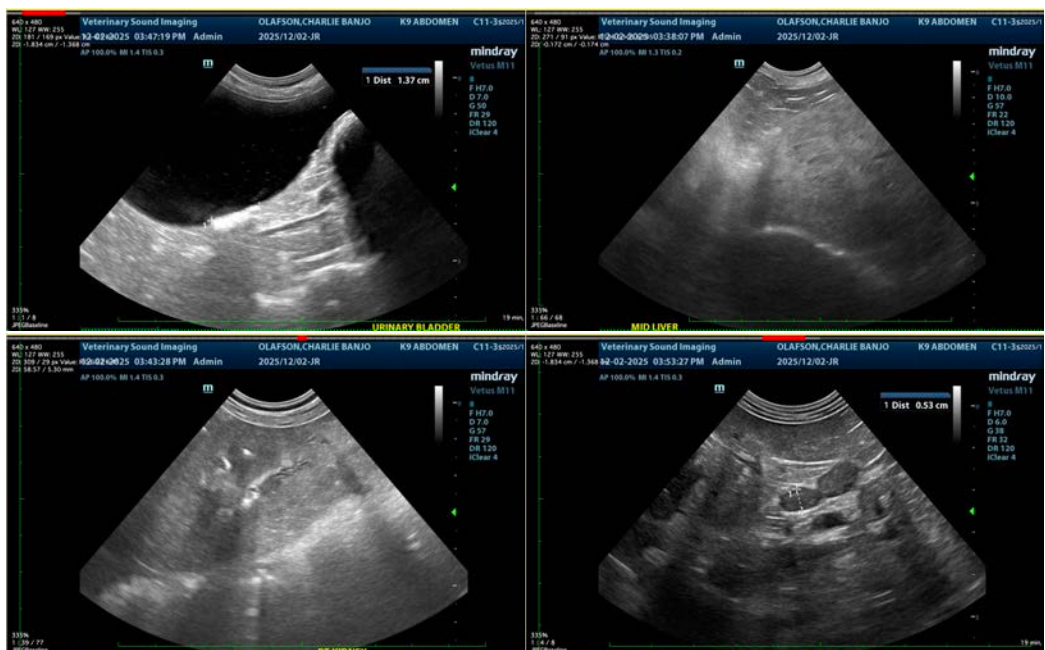
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already planned, given patient's appropriate clinical history, a low-dose Dexamethasone suppression test could be considered.

A blood pressure is recommended if not recently evaluated.

If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

If patient is diagnosed with hyperadrenocorticism, and medical management is initiated, gallbladder debris may improve. However, in the meantime, empirical hepatic nutraceuticals including Ursodiol could be considered while monitoring for progression, as not all gallbladder debris improves with treatment, and can progress.





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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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