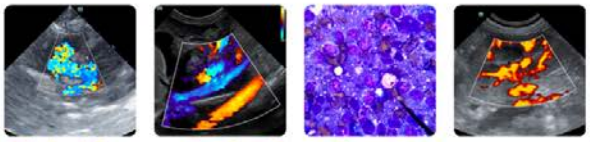


PATIENT

Bella Holden

SPECIES

Canine

BREED

Toy Poodle

SEX

Spayed Female

AGE

5.5 Years

WEIGHT

10.6 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Julia Bakker, DVM

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Josie Hamilton, DVM

INVOICE

72418

DATE

12/9/25

PRESENTING CLINICAL SIGNS

Bella is a 5.5yo FS toy poodle that was adopted a few years ago; however, the more we get to know Bella - the older I think she is (ie maybe potentially 10-12 yrs old? - Nuclear sclerosis OU, P never plays/gets excited (maybe d/t being a puppy-mill dog vs d/t age?). P has a history of recurrent E.coli infections urinary tract infections, chronic pancreatitis, allergic dermatitis, mild hepatopathy & non-obstructive nephroliths (noted on AUS at Cornell). On recent BW, ALP continues to climb, but now GGT is elevated as well. Clinically, P had been lethargic and had a couple urinary accidents recently. We will get a cysto urine sample to send for C&S today at AUS.

Abnormal PE/Chem/CBC/UA Results: ALP 586 GGT 35

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 a mild amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths 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. Punctate non-obstructive nephroliths are noted bilaterally. Left kidney measures 3.94 cm. Right kidney measures 4.67 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.64 cm at cranial pole and 0.60 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.61 cm at cranial pole and 0.75 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

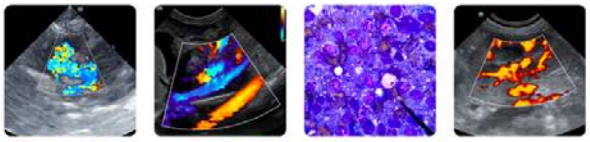
Spleen

The spleen is subjectively normal in size (1.0 cm thick at the hilus) 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 mildly 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.



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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. Hyperechoic mucosal fogging or speckling is noted. 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.

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

- 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.
- 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.
- 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.
- Subtle mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.

SECONDARY FINDINGS

- Age related kidney changes with punctate non-obstructive nephroliths bilaterally.
- Mild amount of echogenic urinary bladder debris.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

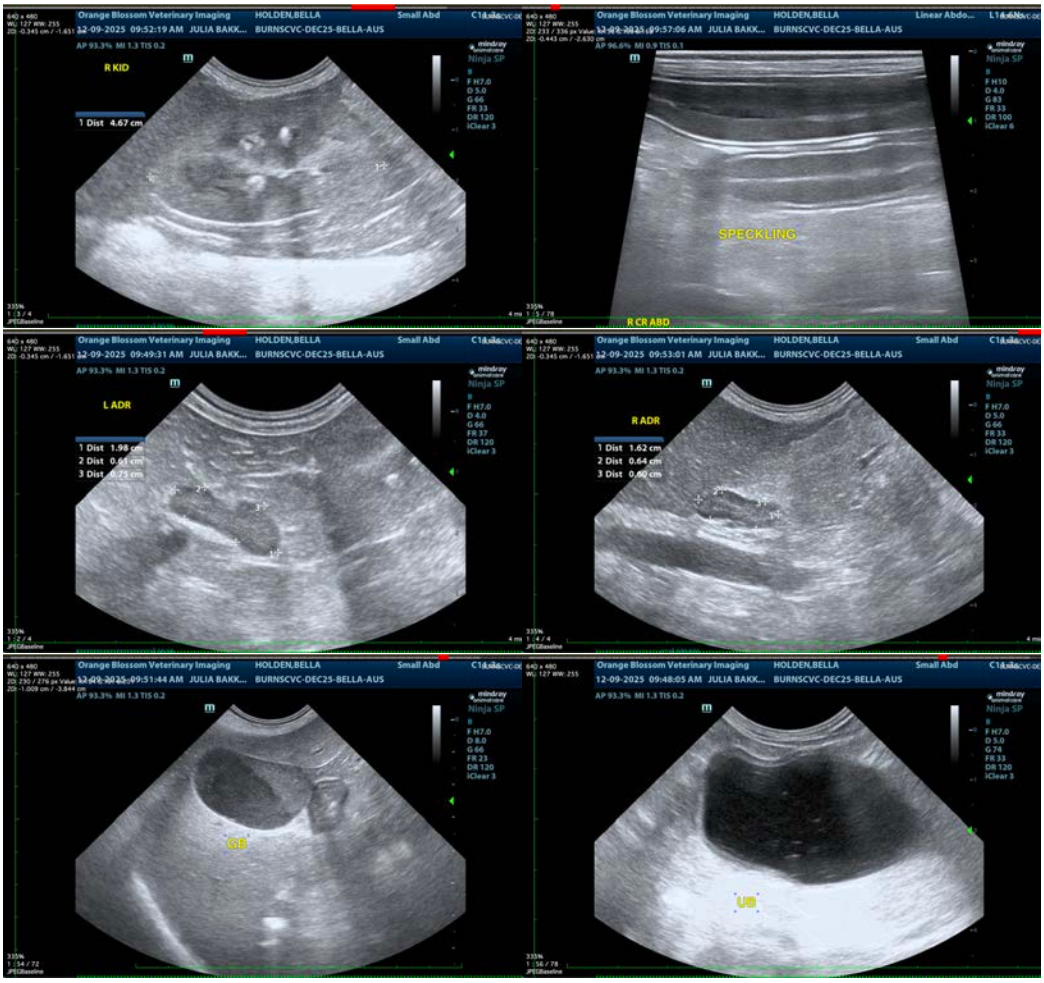
As is reportedly already planned, a follow up urine culture is recommended.

Underlying chronic or mild potentially emerging bowel disease and/or chronic low-grade smoldering pancreatitis can't be ruled out and could be contributing to patient's clinical signs. Therefore, additionally recheck gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Having said that, however, in my opinion based on these images the primary contributing factor to the reportedly increasing ALP is likely progressive gallbladder debris.

Supportive/symptomatic medical management of clinical signs combined with empirical hepatic nutraceuticals such as Ursodiol +/- empirical antibiotics could be considered while monitoring ALP +/- the appearance of the gallbladder for improvement. However, progression is also possible and could warrant more aggressive intervention up to and including possible eventual cholecystectomy.

Additionally, while the adrenal glands are largely normal, underlying or emerging hyperadrenocorticism could also be contributing to the liver enzyme changes as well as the gallbladder debris, and if clinically suspected, could warrant further intervention or workup.



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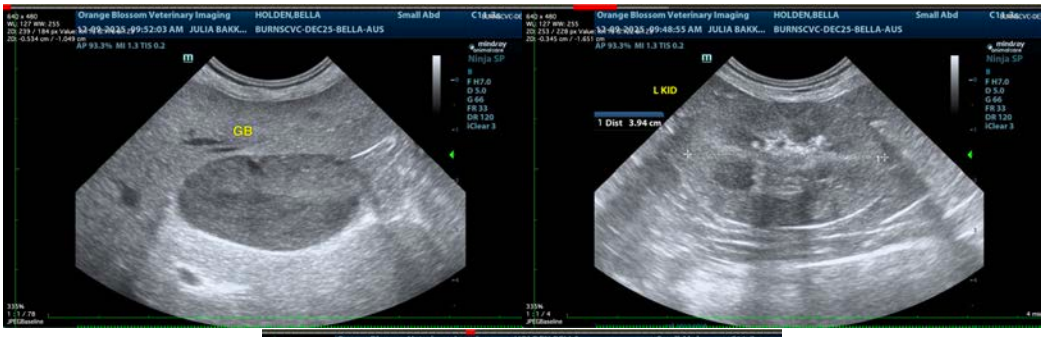

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com