



PATIENT

Bella Anthony

SPECIES

Canine

BREED

Yorkie

SEX

Spayed Female

AGE

13 Years 4 Months

WEIGHT

13 lbs

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Stoney Creek
 Veterinary Hospital

REFERRING VET

Dr. Eldred

INVOICE

72928

DATE

2/12/26

PRESENTING CLINICAL SIGNS

P presented for US due to enlarged liver on rads as well as increased liver enzymes.

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.

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 mineral or infarcts observed. Left kidney measures 4.58 cm with mild pyelectasia at 0.25 cm in the transverse view. Right kidney measures 4.84 cm with mild to moderate pyelectasia at 0.37 cm in the transverse view.

Adrenal Glands

The right adrenal gland is normal in size (0.77 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 (0.48 cm at cranial pole and 0.51 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size (1.5 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), except for an approximately 0.40 cm x 0.50 cm non-capsule disrupting hypo- to anechoic nodule in the mid spleen. 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. Focally, in the mid liver is a slightly more discrete 0.70 cm x 0.80 cm mildly heterogeneous nodule characterized by a slightly hyperechoic center surrounded by a hypoechoic rim. 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.

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.

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Pancreas

The pancreas is prominent in size, primarily characterized by a coarse hypoechoic pancreatic body with a more irregular hyperechoic remodeled right limb.

BREED

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Free Abdomen

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

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There is no apparent pathologic lymphadenopathy noted in these images.

Cardiac images are non-diagnostic owing to interfering artifact.

PRIMARY FINDINGS

AGE

13 Years 4 Months

- Diffusely 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. The subtly more discrete nodule described above could represent the same differentials just listed, although infiltrate neoplasia, including a metastatic nodule, can't be ruled out without tissue sampling.

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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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- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs. Early pancreatic fibrosis in the right limb is a possibility.

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SECONDARY FINDINGS

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- Age related kidney changes with mild to moderate bilateral pyelectasia.
- 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.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Given the pancreatic findings, a 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.

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Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the liver, both the diffuse changes and the focal nodule, could be considered if patient's coagulation status is appropriate.



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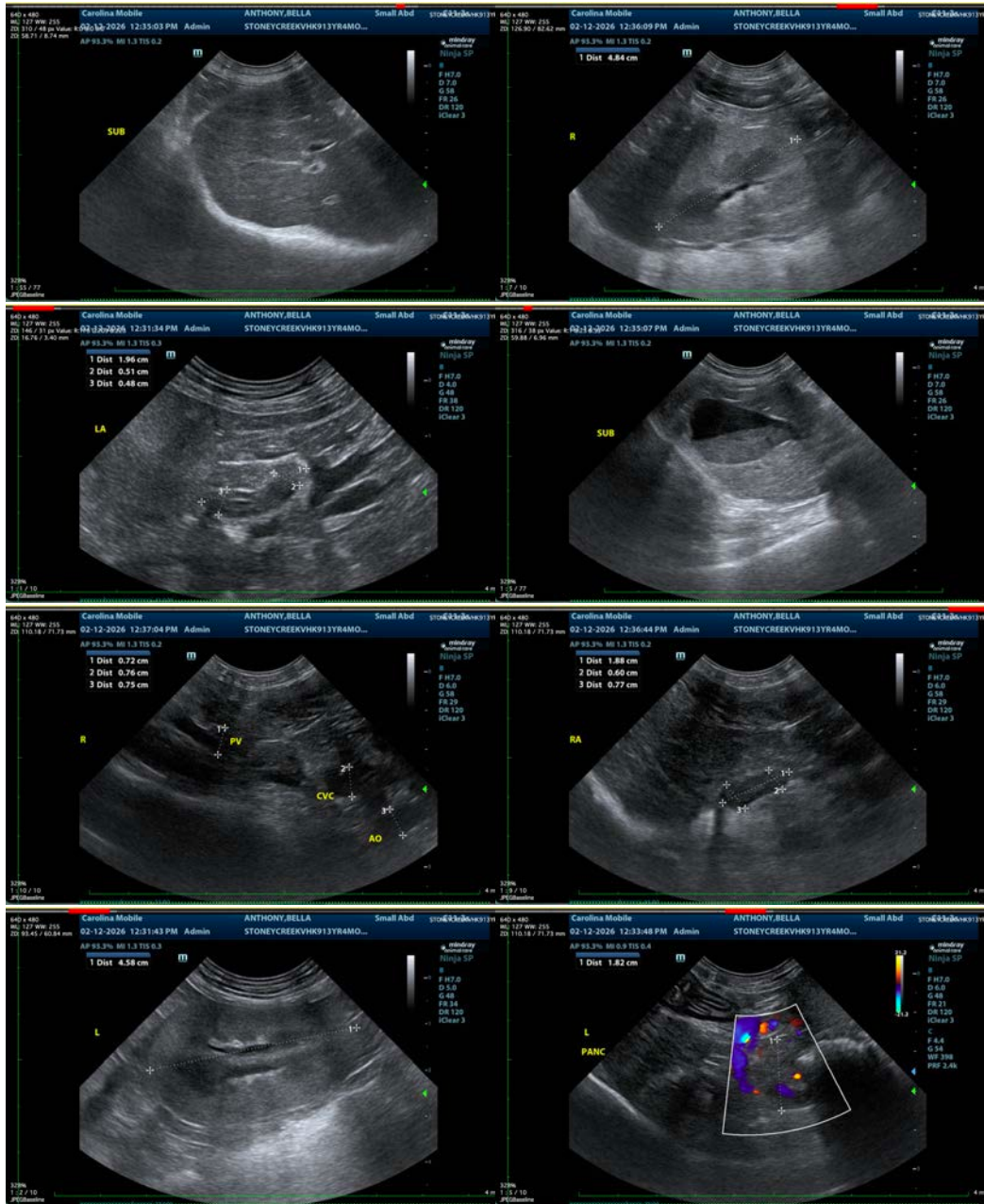
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Otherwise, further diagnostic and treatment recommendations are largely dependent on patient's clinical history as well as the specific liver enzyme pattern, degree of increase, etc.





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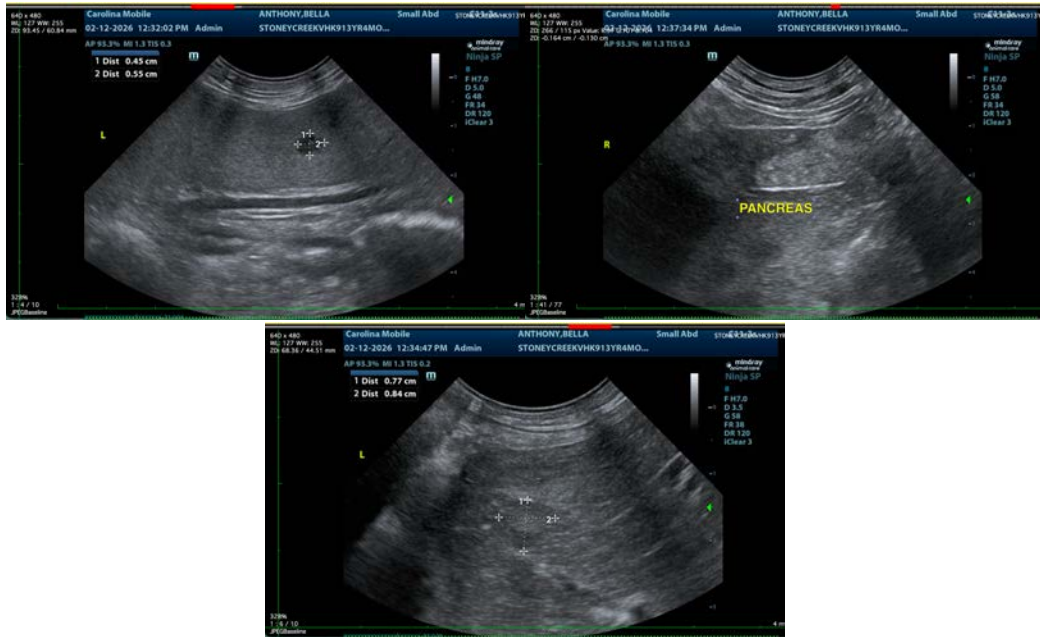
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
 info@sonopath.com