



PATIENT PRESENTING CLINICAL SIGNS

Belle Petrey P presented for not eating for 3 days

SPECIES Abnormal PE/Chem/CBC/UA Results: BUN 32, ALT 2404, ALKP > 2000, GGT 58, Tbil 2.1, Chol 429 Neu 12.6, Eos 0.02

Canine

BREED

Beagle

SEX

Spayed Female

AGE

13 Years

WEIGHT

31.6 Pounds

INTERPRETED BY

Beth Johnson, DVM,
 DACVIM (SAIM)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Animal Hospital of
 Boone

REFERRING VET

Dr. Shutt

INVOICE

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2/16/26

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is not fully/adequately distended for thorough and accurate bladder wall pathology assessment. Having said that, there does appear to be a solitary, heterogeneous, partially mineralized, irregular, echogenic density/mass, measuring 1.26 cm x 1.54 cm in size, appearing to extend from the ventral apex area. No cystoliths are observed in these images at this time, and the contents are otherwise anechoic.

Left kidney is normal in size (4.96 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 (6.0 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 (0.63 cm at cranial pole and 0.77 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.4 cm at cranial pole and 0.67 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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. 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. Additionally, in the right caudal liver/right cranial abdomen, there is a hypo- to almost anechoic appearing density, measuring approximately 2.0 cm in diameter, that may represent a hepatic cyst, although mildly enlarged lymph node versus other, can't be definitively ruled out.

Gallbladder is moderately overdistended with organized, aggregated and centralized non-gravity dependent sludge. Striations of sludge separated by anechoic areas are noted extending from the lumen to the luminal wall. The wall is mildly thick, irregular and hyperechoic. The cystic and common



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bile duct are diffusely tortuous in appearance and prominent all the way to the level of the duodenal papilla with mildly irregular thick wall, but no substantial pathologic distention or evidence of obstruction.

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 is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted.

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

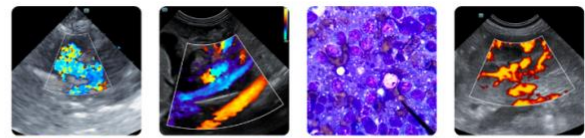
Primary Findings

- Gallbladder mucocele
- Mildly heterogenous liver with a suspect possible likely incidental hepatic cyst in the right caudal liver.
- Concurrent very mild acute pancreatitis, or potentially emerging versus resolving acute pancreatitis is suspected
- The urinary bladder density described above could represent a benign inflammatory change/cystitis, polypoid cystitis, although uroepithelial neoplasia or other infiltrative neoplasia can't be ruled out without additional information.

Secondary Findings

- 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



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Belle Petrey

If not recently evaluated, 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 ration is recommended.

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Submission of urine to look for BRAF gene mutation is also recommended to further investigate possible uroepithelial neoplasia, especially if reassessment of a more distended bladder results in a persistent suspicion for a mass lesion.

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A quantitative PLI is recommended if not already evaluated.

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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.

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In the meantime, supportive/symptomatic medical management of clinical signs, including medical management of possible mild acute pancreatitis, as well as hepatic nutraceuticals, potentially broad spectrum empirical antibiotic therapy, given the concurrent gallbladder mucocele, could be considered while monitoring for improvement, if a conservative or nonsurgical approach is elected. Having said that, given the appearance of the gallbladder, combined with the laboratory changes and clinical signs, an exploratory laparotomy for further assessment of the gallbladder, likely a cholecystectomy, a liver biopsy, is recommended. At that time, given the location of the urinary bladder wall mass, pending additional work up/evaluation of that area, removal of the urinary bladder wall lesion may also be possible.

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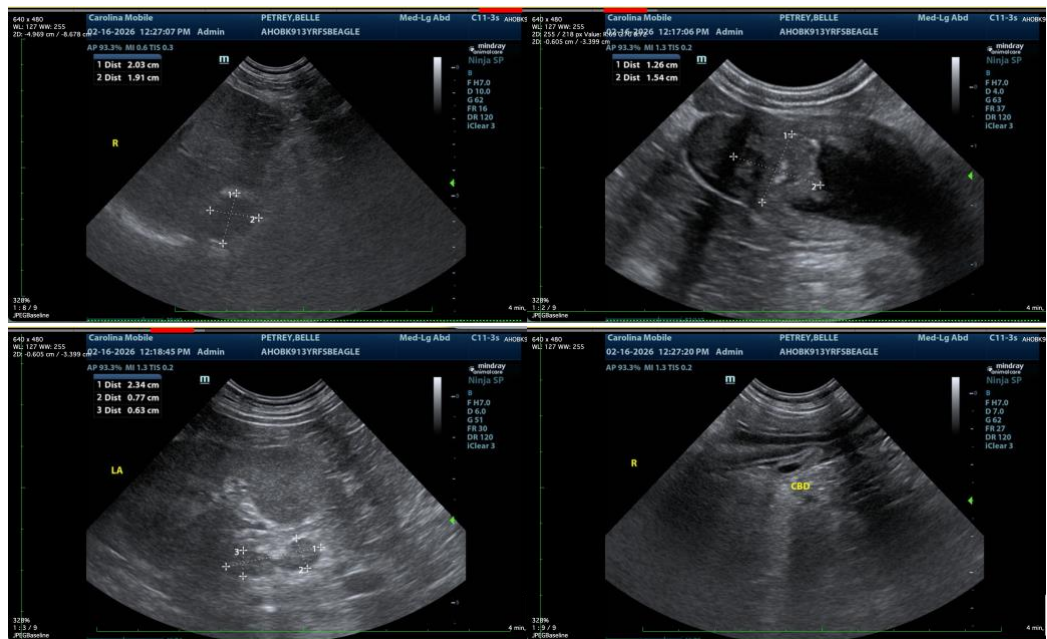
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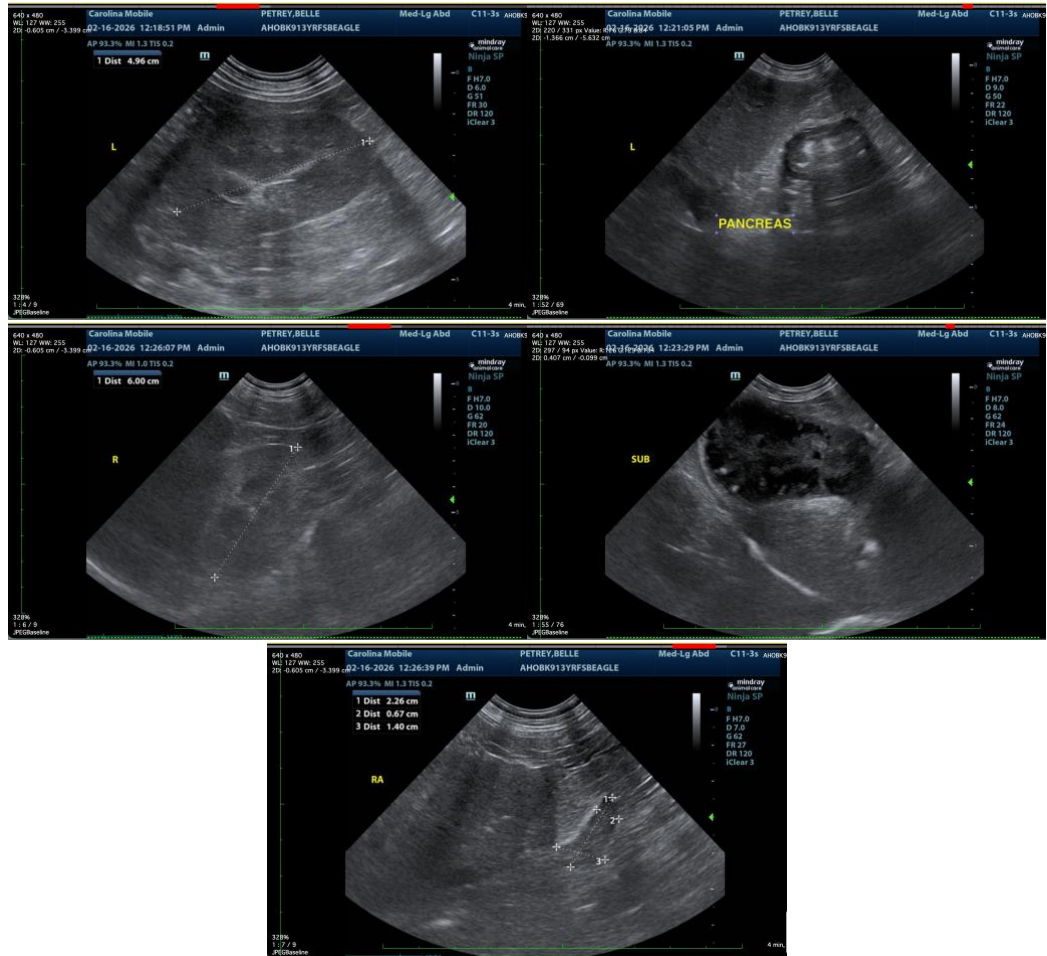
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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