



PATIENT

Copper Rosen

SPECIES

Canine

BREED

Havanese

SEX

Neutered Male

AGE

15 Years 11 Months

WEIGHT

14 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Marsh AH

REFERRING VET

Dr. Armani

INVOICE

35872

DATE

2/16/26

PRESENTING CLINICAL SIGNS

- New murmur
- Meds: Gaba and Trazadone
- Abnormal PE/Chem/CBC/UA Results: BUN 48

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents, as well as a small pile of dependent mineral debris. No masses, inflammatory changes, or sizeable cystoliths are observed, but tiny punctate cystoliths within the pile can't be definitively ruled out. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

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. The left kidney measures 4.58 cm. The right kidney measures 4.31 cm. Small nonobstructive nephroliths are noted bilaterally.

Adrenal Glands

Left adrenal gland is normal in size (0.37 cm at cranial pole and 0.45 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal, except for a mildly plump, rounded cranial pole, measuring 1.2 cm. The caudal pole measures 0.43 cm. 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). No focal nodules or masses are observed. 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



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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.

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The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

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Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Hyperechoic pancreas- This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present.
- Mild 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.
- Mildly plump right adrenal gland- this should be interpreted in combination with clinical history to further determine normal patient variant, early or emerging adrenal disease, etc.
- 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.

Secondary Findings

- Age-related kidney changes with nonobstructive nephroliths bilaterally
- A small pile of dependent urinary bladder mineral/sand debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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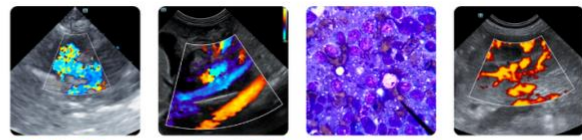
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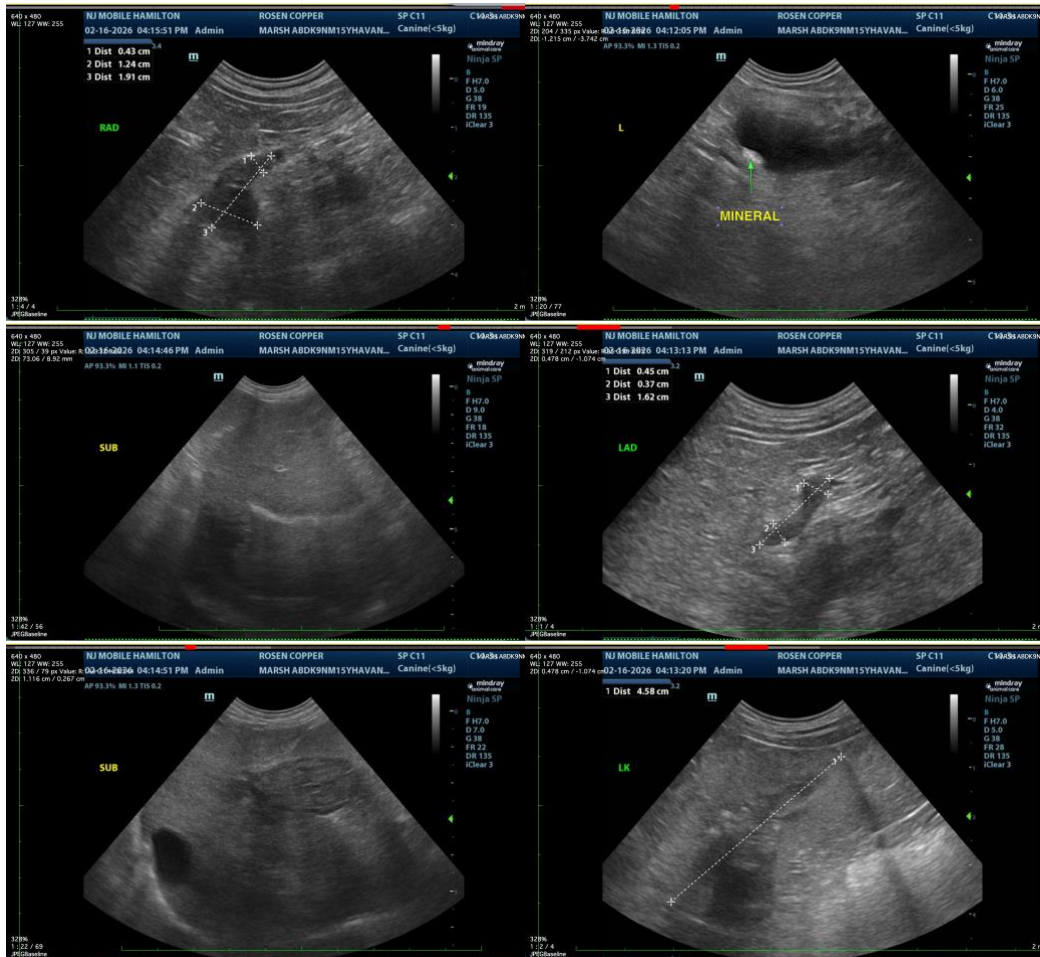
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Given the patient's reported azotemia, if not recently evaluated, a urinalysis, and if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

A blood pressure is also recommended.

Beyond that, recommendations are largely dependent on clinical history, etc., but if there is any gastrointestinal history, especially, given the subtle pancreatic changes, 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.

Similarly, additional adrenal or hormone evaluation may be indicated if clinically appropriate.





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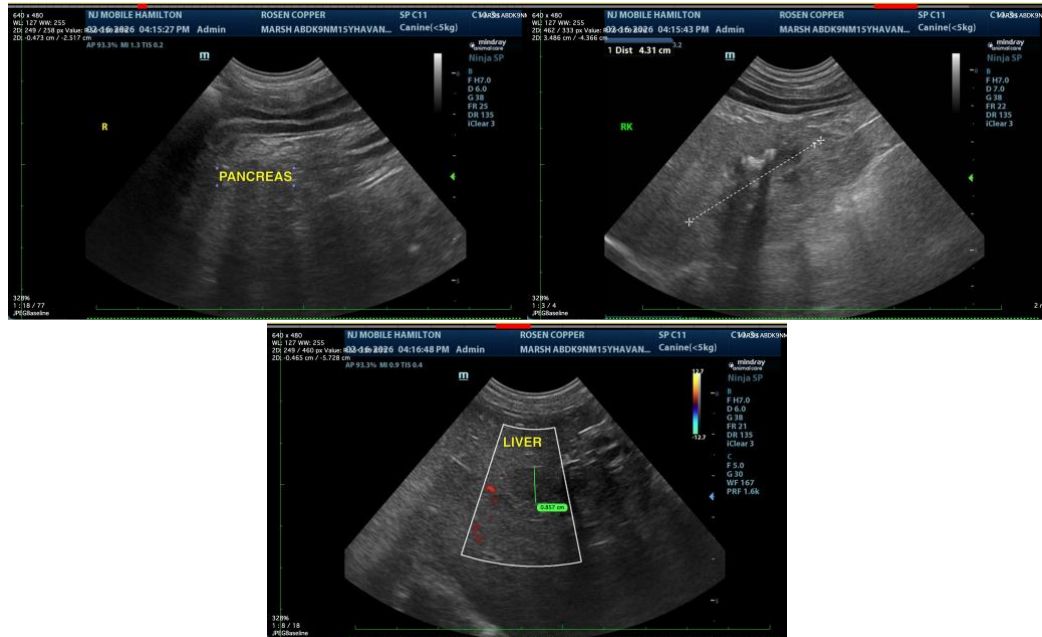
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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