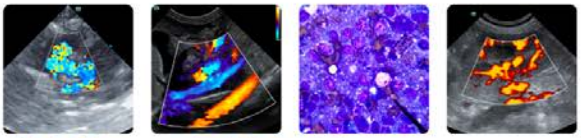


PATIENT

Balboa Alward

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

11 Years

WEIGHT

49 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Meghan Morse, LVT, CVT

HOSPITAL NAME

All Animal Veterinary Services

REFERRING VET

Dr. Acworth

INVOICE

73267

DATE

2/25/26

PRESENTING CLINICAL SIGNS

Elevated liver and glucose, was seen at urgent care. No reported medications

Abnormal PE/Chem/CBC/UA Results: CBC: WBC 40.64K, RBC 4.9, Neuts high, mono high, eos low Chem: Elevated; ALP, GGT, T ibli, BUN, Phos, glucose (>686) Decreased; Amylase, Na/CL U/A: protein, glucose, USG 1.020

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.97 cm). Mucosa is hyperechoic and irregular with multiple pedunculated masses extending into the lumen of the bladder. No definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The right kidney is normal is size (7.5 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.

The left kidney is normal is size (7.1 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

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 1.0 cm at the cranial pole and 0.94 cm at the caudal pole. Right measures 1.3 cm at the cranial pole and 0.77 cm at the caudal pole.

Spleen

The 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.

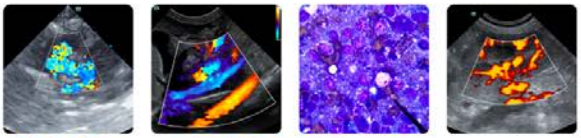
Liver

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

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

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

- Polypoid Cystitis – Urinary bladder wall changes are most consistent with polypoid cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely given the appearance of the polyps.
- Mild 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.
- 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.
- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

While the appearance of the urinary bladder is most consistent with a benign process, submission of urine to look for BRAF gene mutation could be considered for further investigation of possible uroepithelial neoplasia.

A blood pressure is recommended if not recently evaluated.

Given the appearance of the pancreas, especially combined with the reported history of newly diagnosed possible diabetes mellitus, 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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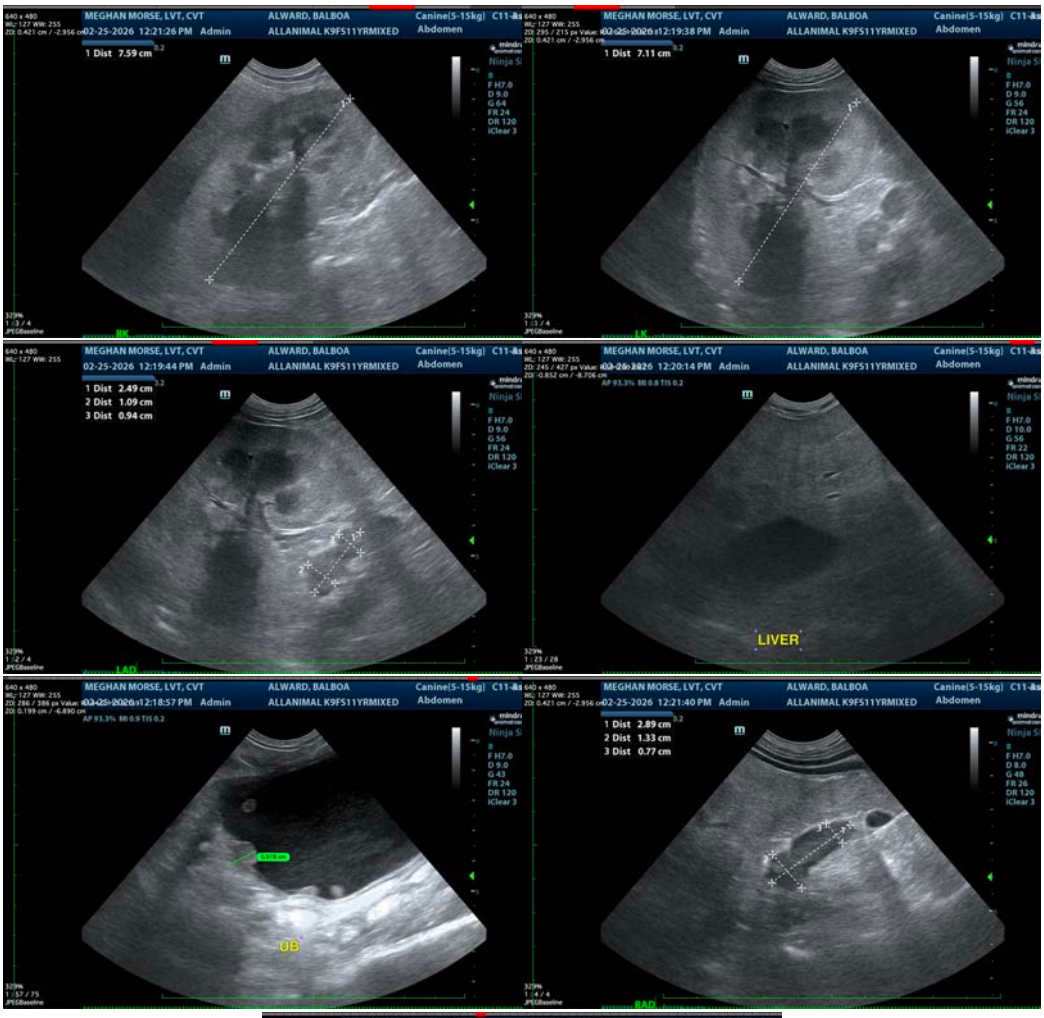
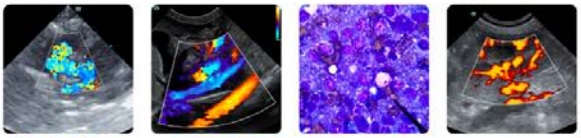
In the meantime, further therapeutic and diagnostic recommendations are largely dependent on patient's clinical status, results of the above, and whether diabetes mellitus is diagnosed and warrants treatment, etc.



New Jersey Mobile
FUELED BY SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
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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