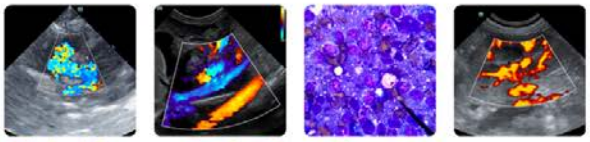


PATIENT

Bertram Tackeff

SPECIES

Canine

BREED

French Bulldog

SEX

Neutered Male

AGE

11

WEIGHT

35.5

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Michele Pfannenstiel

HOSPITAL NAME

Mill Brook Animal Clinic

REFERRING VET

Dr. Michele Pfannenstiel

INVOICE

73277

DATE

2/26/26

PRESENTING CLINICAL SIGNS

Came in for wellness today. Potbellied, losing hair, starting calcinosis cutis. Did a POCUS and switched to a AUS. Last ate at 9:30PM last night. On torb for AUS. Chronic anal sacculitis with a sacculectomy last July.

Abnormal PE/Chem/CBC/UA Results: BP was NSF- other labs going out today hx of low USF with high UCCR and did not supress on LDDS

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.

The prostate is unable to be well visualized in these images.

The right kidney is normal is size (5.4 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 (4.9 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

The adrenal glands are unable to be visualized in these images.

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.

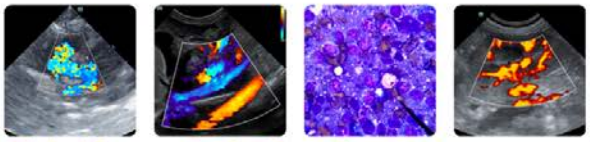
Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is 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.

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.



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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 of the small intestine is empty with no evidence of obstruction or foreign material.

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

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. 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.

ULTRASONOGRAPHIC 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.

- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If patient has been diagnosed with hyperadrenocorticism, adrenal versus pituitary dependent can't be differentiated without visualization of the adrenal glands. If differentiation was not able to be obtained from a low-dose Dexamethasone suppression test, imaging of the adrenal glands could be considered and/or submission of an endogenous ACTH level may be helpful.

The hepatobiliary changes described can be and are often seen with hyperadrenocorticism. Treating the reportedly diagnosed hyperadrenocorticism may result in some improvement in the biliary sludge, especially if combined with empirical hepatic nutraceuticals such as Ursodiol. Having said that, it doesn't always improve and can even progress. Therefore, close monitoring for clinical signs associated with a mucocele i.e., cranial abdominal pain, nausea, decreased appetite, change in liver enzymes or bilirubin, etc. is recommended to help determine if more aggressive intervention up and including a possible cholecystectomy may be indicated.

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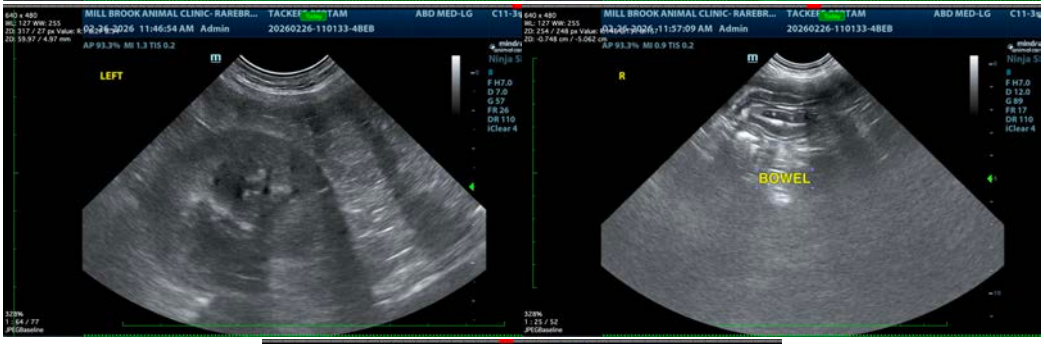
Gastrointestinal signs should be interpreted in combination with any clinical history of gastrointestinal disease.



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