



PATIENT

Mayla Rosado

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

12 Years

WEIGHT

18.8 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Maricarmen Vega

INVOICE

72653

DATE

2/3/26

PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound due to Hx of increased hepatic enzymes. rDVM notes that dental prophylaxis has been cancelled 3 times due to elevated enzyme values since December 11, 2025. Px is currently taking Denamarin. rDVM states that there has been no significant improvement on BW values since starting the Denamarin. No vomiting reported. No inappetence reported.

Abnormal PE/Chem/CBC/UA Results: Bloodwork attached below for your reference

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 pyelectasia, mineral or infarcts observed. Left kidney measures 4.75 cm. Right kidney measures 4.77 cm. A hyperechoic band parallel to the corticomedullary border is present bilaterally.

Adrenal Glands

The right adrenal gland is normal in size (0.53 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.45 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 (1.2 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). 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 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.



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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.

Pancreas

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The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

Free Abdomen

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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

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- 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. Having said that, some of the hyperechoic pancreas may be focally enhanced fat/focal peritonitis versus truly hyperechoic parenchyma. Therefore, concurrent chronic low-grade smoldering pancreatitis can't be ruled out.
- 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.
- 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.
- Subtle bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Differentials for a primary cholestatic liver enzyme pattern (increased ALP) are vast and non-specific. Differentials include, but are not limited to, benign nodular hyperplasia which occurs in 70% of older dogs and often does not result in an abnormal ultrasound, reactive or idiopathic/vacuolar hepatopathy, cholestasis and/or hyperadrenocorticism as well as many chronic non-hepatobiliary diseases such as



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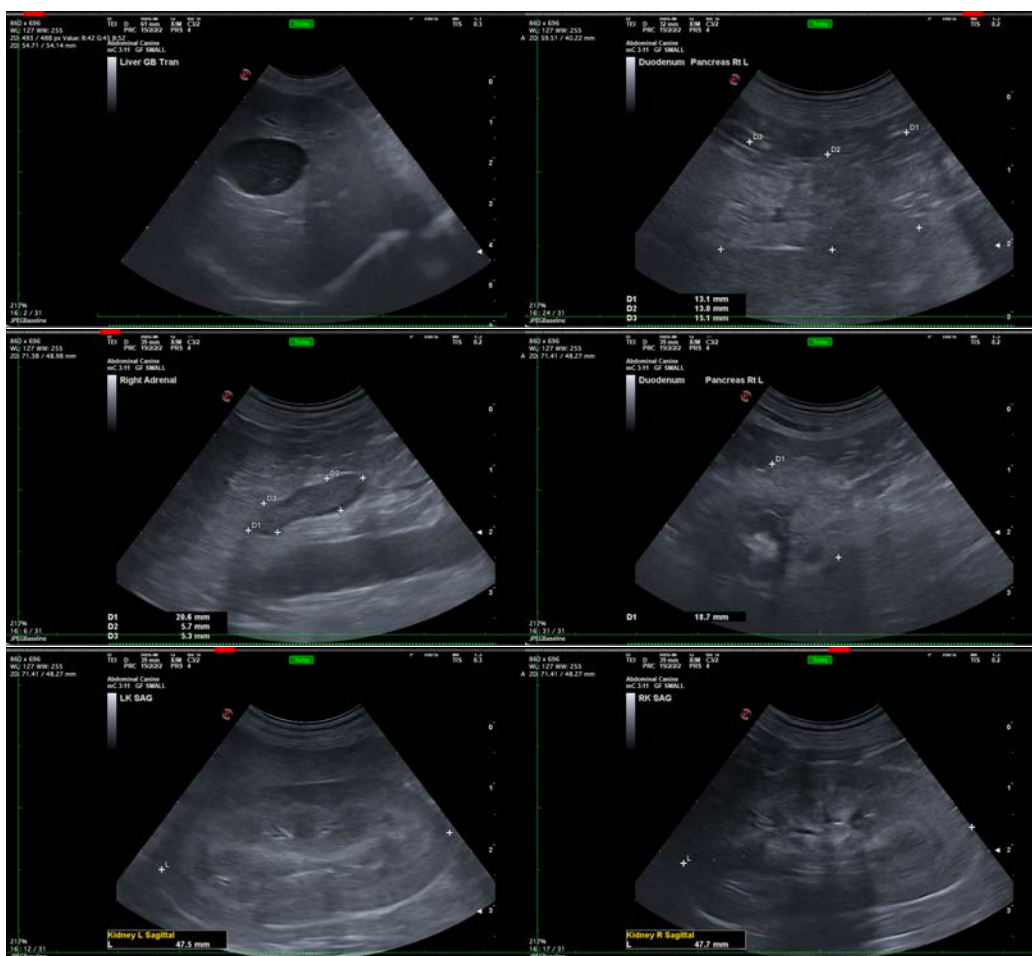
2/3/26

chronic infections/inflammation from dental disease, IBD, neoplasia, hyperlipidemia, hypothyroidism, chronic pancreatitis, chronic stress, etc.

- Adrenocortical testing such as a low dose dexamethasone suppression test could be considered if clinical signs of hyperadrenocorticism are present.
- Ursodiol could be considered if gallbladder sludge is noted as a finding.
- A fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate.
- Otherwise, recommendations include addressing any other concurrent disease and monitoring. If values are progressive, recheck imaging is recommended.

Specific treatment recommendations, etc. regarding the pancreatic changes are largely dependent on patient's clinical history, but could include, if tolerated, a transition in diet is recommended, based on trial-and-error response.

Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.





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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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