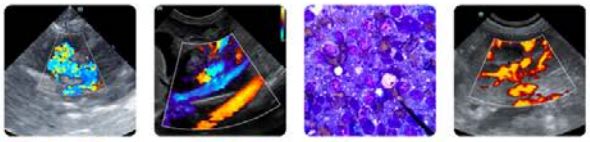


PATIENT

Lucy Jarvis

SPECIES

Canine

BREED

Beagle

SEX

Spayed Female

AGE

15 Years

WEIGHT

12.1 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Oley Valley Animal Clinic

INVOICE

72699

DATE

2/4/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate marked liver enzyme elevation and a decreased appetite. O noting decreased appetite in the morning but normal appetite in the evening. O suspecting poss related to medications. Marked progressive LES elevation noted on 6 month NSAID BW check. Recent Dx of UTI with resistant Staph Pseudintermedius, sensitive to Doxycycline on UC. PHM is extensive - PDH Cushings (no meds), chronic HL paresis, IVDD, IBD (with recent flare)- prev managed with meds at prev vet, hepatomegaly.

Meds: Doxycycline (last dose recently), Gabapentin, Galliprant (recent vs chronic?), Apoquel, Denamarin, Melatonin SID and Ligan, Fortiflora, Tramadol PRN, Methocarbamol PRN

Abnormal PE/Chem/CBC/UA Results: 2/3/26: - NSAID panel: Cr 0.9, BUN 19, ALT 2282 H (prev 343), ALP 3298 H (prev 842), AST 276 H Jan 2026: - UA: USG 1.030 - UC: Staph pseudintermedius, resistant to most abx AXR: No radiopaque bladder stones. Hepatomegaly with rounded liver margins. Spleen, stomach, kidneys, and intestines appear unremarkable. Mild formed feces in colon. Spine: Significant spondylosis deformans in the lumbar spine. Collapsed disc space between L4 and L5.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is not quite fully distended, resulting in an overall diffuse mildly thick, irregular, hyperechoic appearance to the wall. Having said that, however, along the ventral apex to mid urinary bladder is a solitary heterogeneous, echogenic density measuring approximately 0.70 cm x 0.90 cm, protruding into the lumen of the bladder. No cystoliths are observed.

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 measured 5.18 cm. Right kidney measures 5.31 cm.

Adrenal Glands

The right adrenal gland is normal in size (1.1 cm at cranial pole and 0.68 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

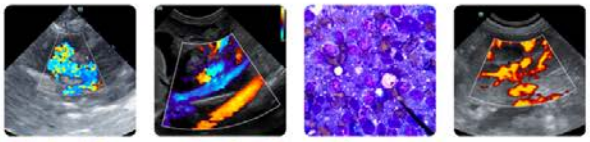
The left adrenal gland is normal in size (0.52 cm at cranial pole and 0.51 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size 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



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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.

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 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.

PRIMARY FINDINGS

- The urinary bladder wall density appears to be tissue, with differentials including both a benign inflammatory lesion such as polypoid cystitis, as well as infiltrative uroepithelial neoplasia, which can't be differentiated without additional information.
- Moderate 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.
- Otherwise, an obvious cause for the subtle liver changes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia (considered unlikely), etc. cannot be definitively ruled out.

SECONDARY FINDINGS

- Age related kidney changes.

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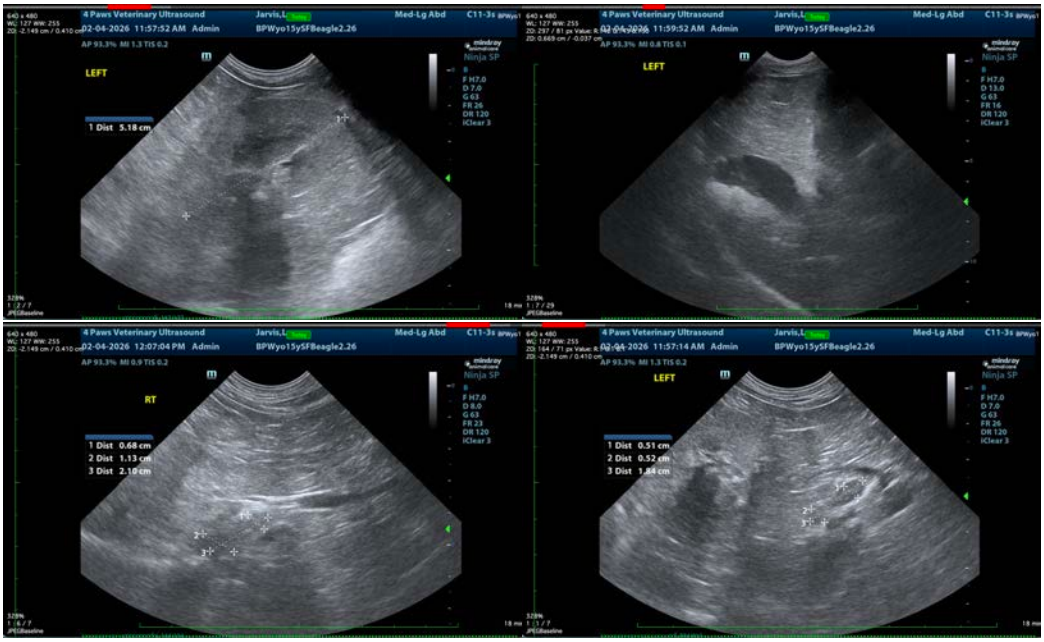
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinalysis and urine culture, if indicated based on urinalysis results, are recommended. Submission of urine to look for BRAF gene mutation, which is associated with urinary bladder/prostate cancer, could be considered. Other diagnostic options include traumatic catheterization, fine needle aspirate (with small risk of tumor seeding/trailing) or cystoscopy for further sampling. In the meantime, empirical therapy with a broad-spectrum antibiotic (or ideally an antibiotic based on culture and sensitivity results) as well as an anti-inflammatory (unless otherwise contraindicated based on patient co-morbidities) may begin to help alleviate clinical signs.

Pending results of above, 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.

Given patient's recent reported completion of a course of Doxycycline, supportive/symptomatic medical management of clinical signs and hepatic nutraceuticals, etc. could be considered since discontinuing Doxycycline while monitoring liver enzymes for improvement to help rule out an idiosyncratic medication reaction. If liver enzymes don't improve and/or a more aggressive intervention is elected sooner, tissue sampling could be considered, beginning with fine needle aspirates of the liver if patient's coagulation status is appropriate.

Additionally, if not already evaluated, and if patient's total bilirubin is not increased, bile acids could be considered.



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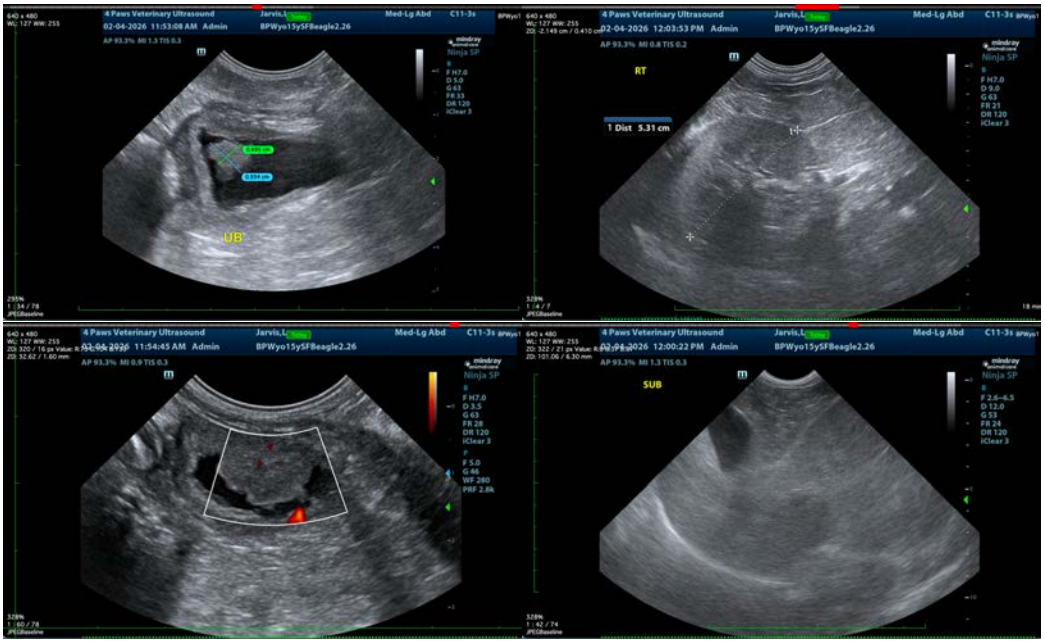

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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