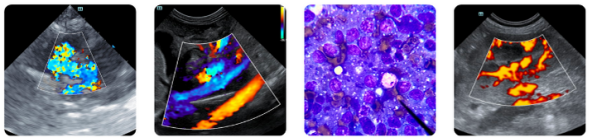


PATIENT

Maeve Lacina

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

12 years

WEIGHT

14 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Julia Bakker

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Dr. Jonathan Shivers

INVOICE

11459

DATE

3/11/2026

PRESENTING CLINICAL SIGNS

- Relevant Patient History and Primary Purpose for this Exam: 02/06/2026 9:00 AM: Reason for visit: Pt presented for exam. O states pt has had diarrhea twice, but its only parts of her poop has mucus in it. O tried taking pt off cerenia 2 days ago and after pt had breakfast pt vomited 3 times. O states pt is eating slower, still eating all her food but taking longer to eat than normal, usually she scarfs her food down per O.
- Diet: I/D dry, gastro biome wet, organic pumpkin puree and sweet potatoes treats. How much/Often: 1/4 cup TID dry, spoonful wet BID.
- Prevention: Simparica Trio.
- Medications/Supplements: Vetoryl 5mg 1 cap BID- 7:30 AM today, Ursodiol 0.45ml BID, Denamarin 1 SID, Wonder Paw milk thistle supplement 1ml SID, Ferra Pets fish oil 1/2 tsp in PM, Famotidine 10mg 1/2 BID, cerenia 16mg 1/2 SID, Proden plaqueoff dental treat 1/2 SID.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a moderate amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The 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. Multiple small cortical cysts noted bilaterally. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 4.5 cm, and the right kidney measures 5.1 cm.

Adrenal Glands

The right adrenal gland is normal in size (1.1 cm at cranial pole and 0.49 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

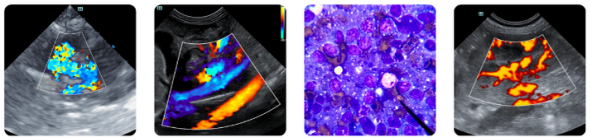
The left adrenal gland is normal in size (0.67 cm at cranial pole and 0.78 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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. Multifocal mineral foci are noted. Splenic vasculature appears normal.

Liver

The liver contains at least two separate discrete masses including an approximately 7.0 cm in diameter, mildly mixed, primarily hyperechoic, partially cystic mass in the mid cranial liver. As well as a second similar appearing, but much smaller 1.5 cm x 3.0 cm hyperechoic mass in the left caudal liver.



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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 observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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.

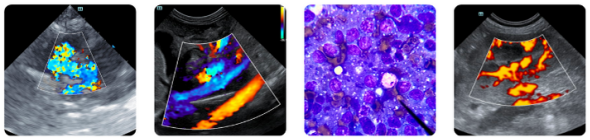
There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Multiple liver masses could represent a benign process such as nodular hyperplasia, fibrosis of old hematomas, or granulomas, even myelolipomas, chronic inflammatory disease, etc. Or infiltrative neoplasia including primary hepatic neoplasia, round cell neoplasia, metastatic disease, etc., and can't be ruled out without tissue sampling.
- 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.

SECONDARY FINDINGS

- A moderate amount of echogenic urinary bladder debris.
- Age related kidney changes with bilateral cortical cysts.
- Spleen mineralization – This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism.



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- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Fine needle aspirates of the liver are recommended if patient's coagulation status is appropriate.

Given patient's reported clinical history, additionally, a routine fecal/giardia exam is recommended if not recently evaluated.

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.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Assessment of patient's cortisol levels is recommended if not recently evaluated.

In the meantime:

- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.
- Additionally, empirical deworming with a 5-day course of Panacur is recommended.
- A full course of empirical Helicobacter triple therapy could be considered.
- A probiotic, such a visbiome or proviable, may be helpful.
- Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.

Discontinuation of Vetoryl may be appropriate until patient is no longer displaying clinical signs of illness and clinical signs of hyperadrenocorticism return.

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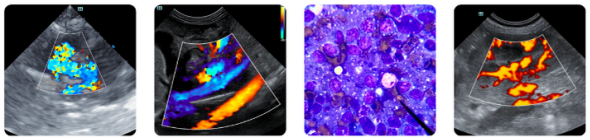

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SonoPath.com | info@sonopath.com | 1.800.838.4268

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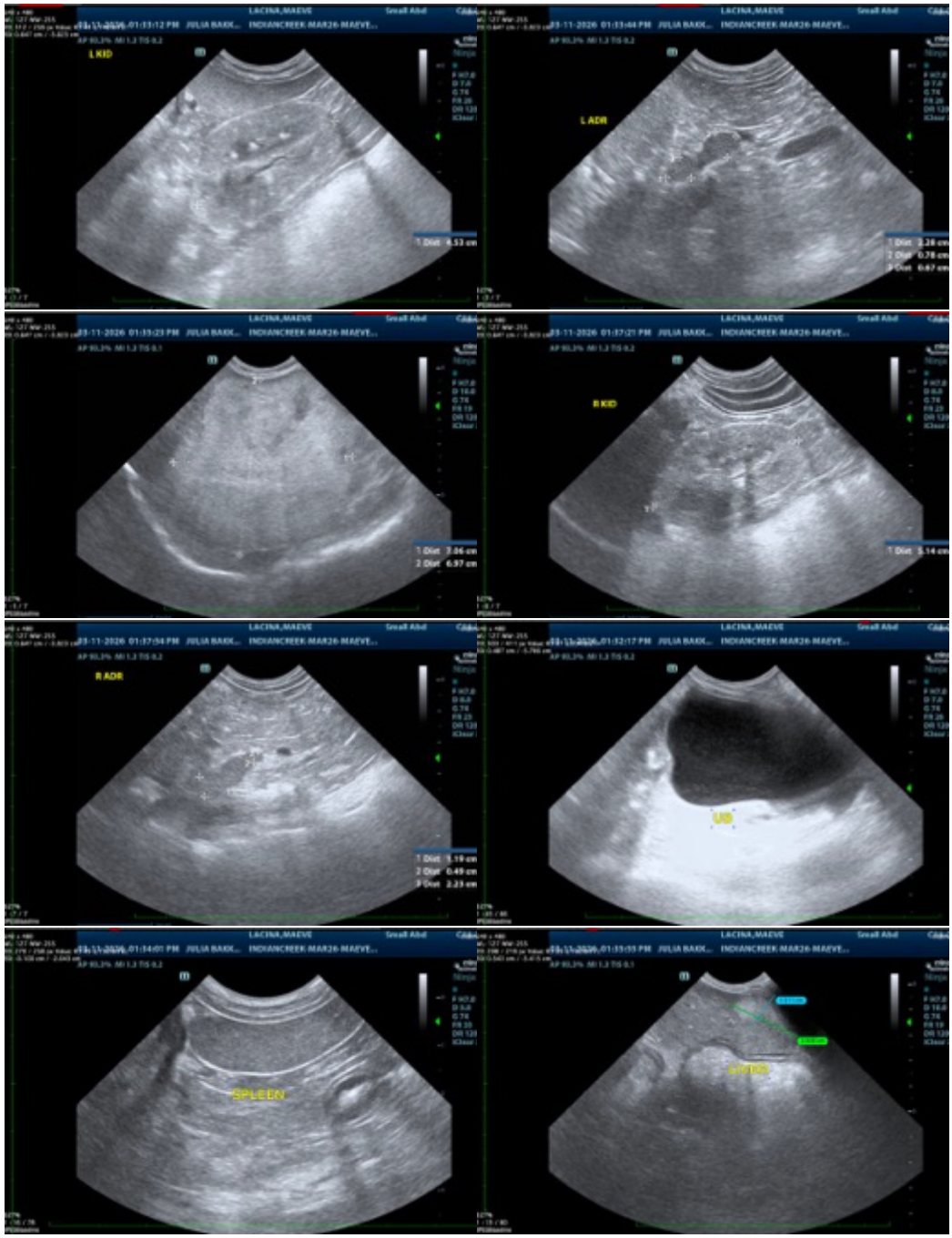

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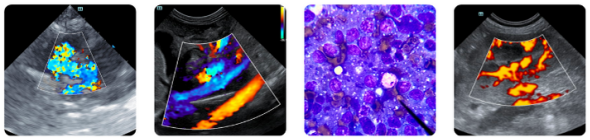

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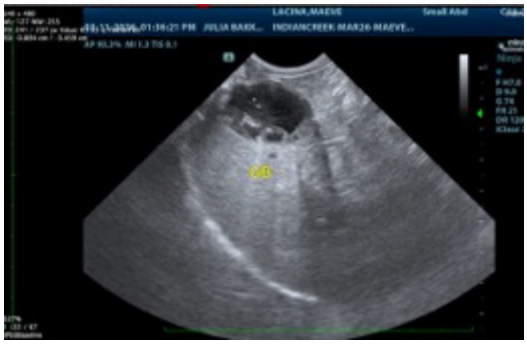

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com