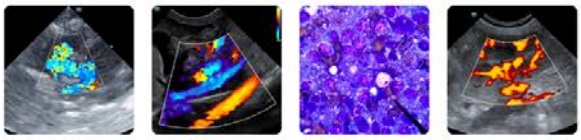


DATE

3/26/26

PATIENT

Murphy Bauer

SPECIES

Canine

BREED

Poodle x

SEX

Neutered Male

AGE

3/7/09

WEIGHT

27.3

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Fallston Veterinary Clinic

REFERRING VET

Dr. Lomax

INVOICE

74023

PRESENTING CLINICAL SIGNS

Patient History: Elevated liver enzymes. Selectively eats. Food falling out of his mouth. Owner not able to examine orally- tries to bite. He's always had an issue with the hair at the oral commissure curling into his mouth. Bilateral lenticular sclerosis, Grade 2-3/6 SHM

Current Medications: None listed.
Labwork Results: Labwork attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV Torb and midazolam.
Stat Report: STAT requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

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. Multiple small cortical cysts are present bilaterally, too numerous to count. Left kidney measures 5.23 cm. Right kidney measures 5.07 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.69 cm at cranial pole and 0.79 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.63 cm at cranial pole and 0.60 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 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.

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.

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

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Sublumbar lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

Images are provided of the anal glands, which reveal a mildly fluid filled right anal gland and in the area of the left anal gland there is a 2.8 cm x 4.2 cm mildly heterogeneous, hypoechoic mass.

PRIMARY FINDINGS

- Left anal gland mass.
- Aggressive sublumbar lymph nodes – concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- 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.
- 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.

- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

- Mild/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.

SECONDARY FINDINGS

- Age related kidney changes with multiple bilateral cortical cysts.

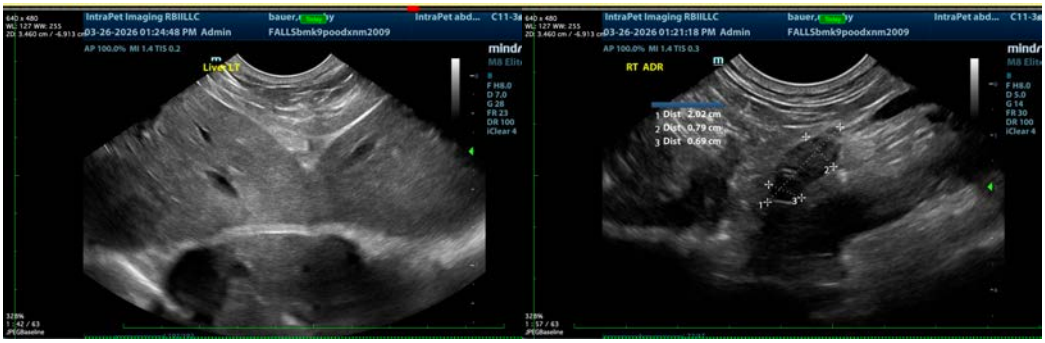
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

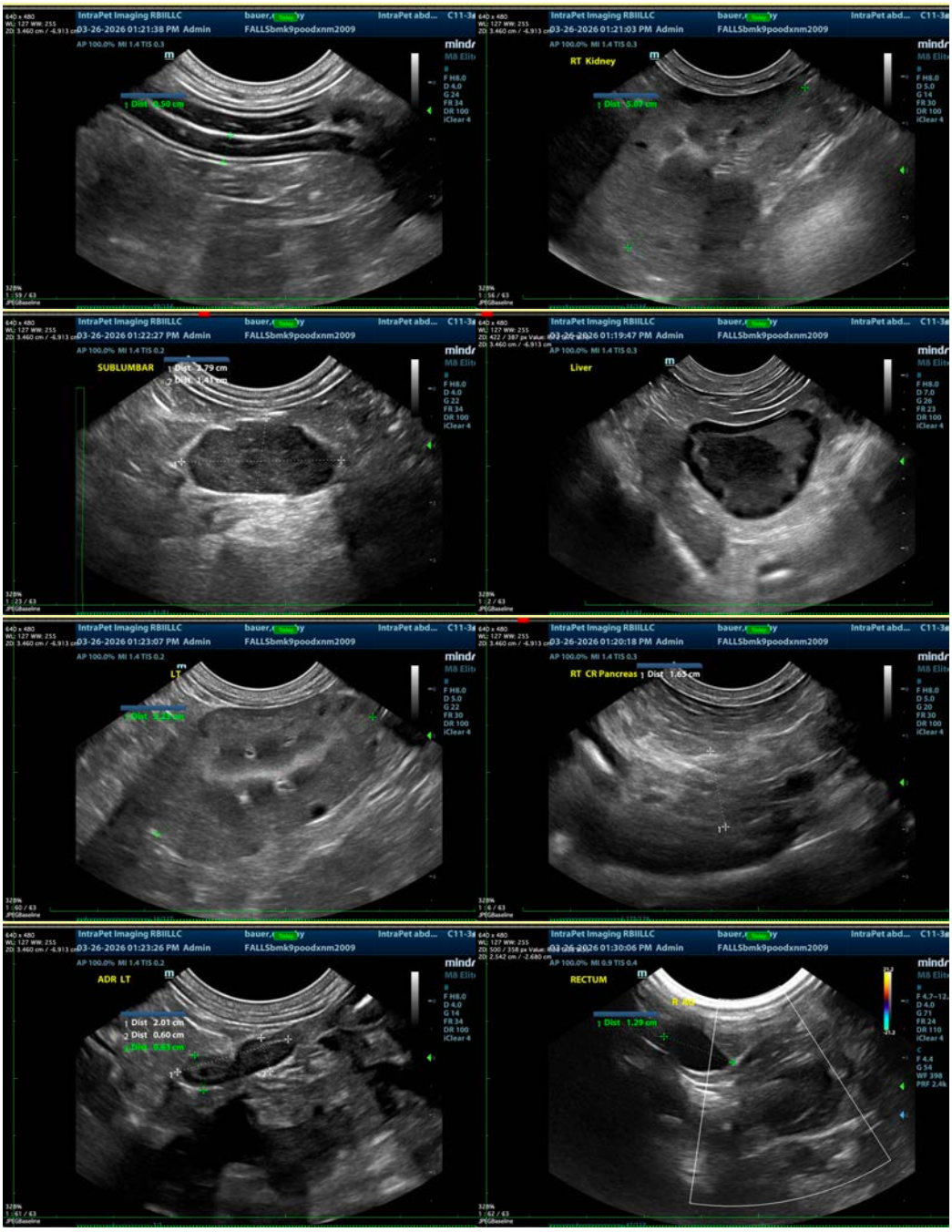
While of unknown if any relation to patient's reported liver enzyme changes or dysphagia, the anal gland mass and lymphadenopathy are the most concerning ultrasonographically visible problem, and therefore further recommendations include:

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 anal gland mass and the lymph nodes could be considered if patient's coagulation status is appropriate.

In the meantime, if patient is asymptomatic for the suspected emerging gallbladder mucocele, empirical hepatic nutraceuticals such as Ursodiol could be considered while monitoring liver enzymes for improvement. If, however, any of the dysphasia is believed to be secondary to nausea, abdominal pain (especially cranial), etc., the gallbladder could potentially be more significant and warrant further, more aggressive intervention. Having said that, patient's reported history is more consistent with dysphagia, which prompts an oral exam and potentially advanced imaging of the head and neck, versus nausea.

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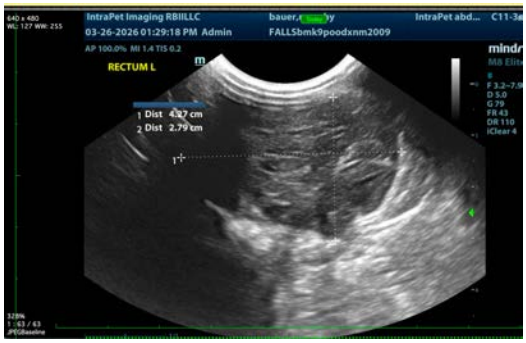

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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