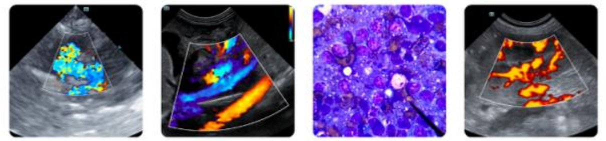


PATIENT

Clover Sparklin

SPECIES

Canine

BREED

Beagle

SEX

Spayed Female

AGE

12 Years

WEIGHT

37.4 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Brittany Wolfe

HOSPITAL NAME

HomeVets

REFERRING VET

Dr. Brittany Wolfe

INVOICE

14186

DATE

03/09/26

PRESENTING CLINICAL SIGNS

- P presents for intermittent anorexia for about 3 months, very occasional vomiting. P was diagnosed w/ a mulch FB and IBD (via biopsy) about 1 year ago. FB was removed and P has been managed on GI diet and low dose prednisone.
- P also has recent hind end weakness

Abnormal PE/Chem/CBC/UA Results: Recent cPL was borderline elevated. New mild anemia (HCT33%) Stable liver enzyme elevations Pain with pressure of the US probe in the upper right quadrant.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Left kidney is normal in size, 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. *I cannot provide a size because the only image of the left kidney can only be measured for some reason in pixels.*

Right kidney is normal in size (6.1 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 areas of the adrenal glands are examined without evident adrenal gland pathology.

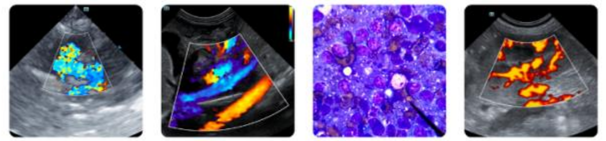
Spleen

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. 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. In some clips in the mid caudal liver, there's a very subtle focally slightly more rounded liver edge that measures approximately 1.5 cm in diameter based on view and has a homogenous isoechoic appearance.

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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. 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.

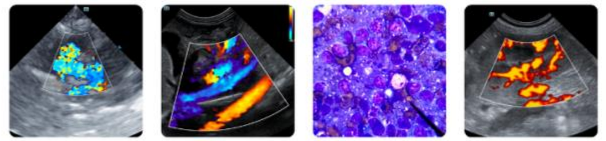
ULTRASONOGRAPHIC FINDINGS

- Emerging gallbladder 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. The appearance of the slightly rounded area trends in appearance toward benign especially in a patient receiving steroids but an early or emerging neoplasia including a benign hepatoma/adenoma or even malignant well differentiated hepatocellular carcinoma, round cell neoplasia, other well thoughtless likely, can't be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There's no definitive gastric or pancreatic pathology noted in these images at this time. However, given the gas as well as patient’s reported discomfort, thorough imaging of the area is partially limited. Therefore, early mild pancreatic and/or gastric or bowel inflammation/pain can't be definitively ruled out.

The emerging gallbladder mucocele could be contributing to cranial abdominal pain and should be suspected, especially in the face of laboratory changes and/or lack of improvement to supportive/symptomatic medical management, etc. Additional diagnostic considerations include a



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routine fecal/Giardia exam if not recently evaluated.

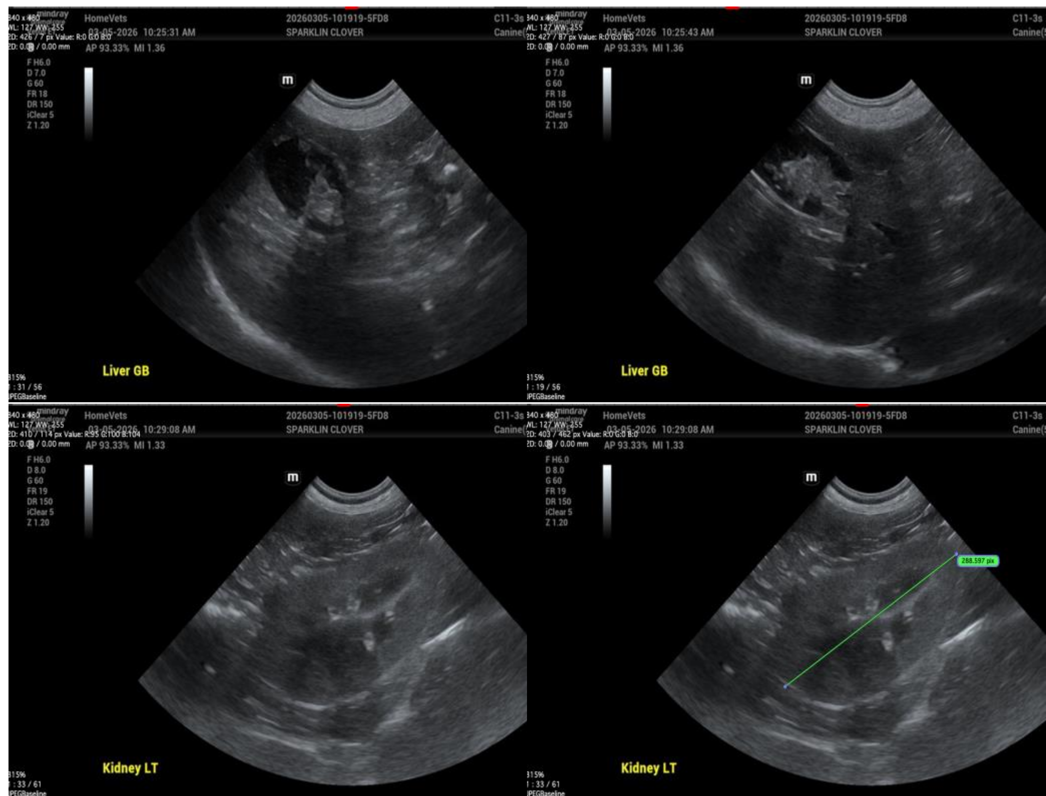
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.

Addendum:

Upon further review, subtle liver changes are described and fine needle aspirates could be considered patient's coagulation status is appropriate.



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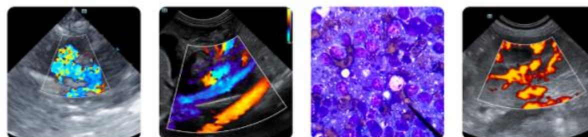

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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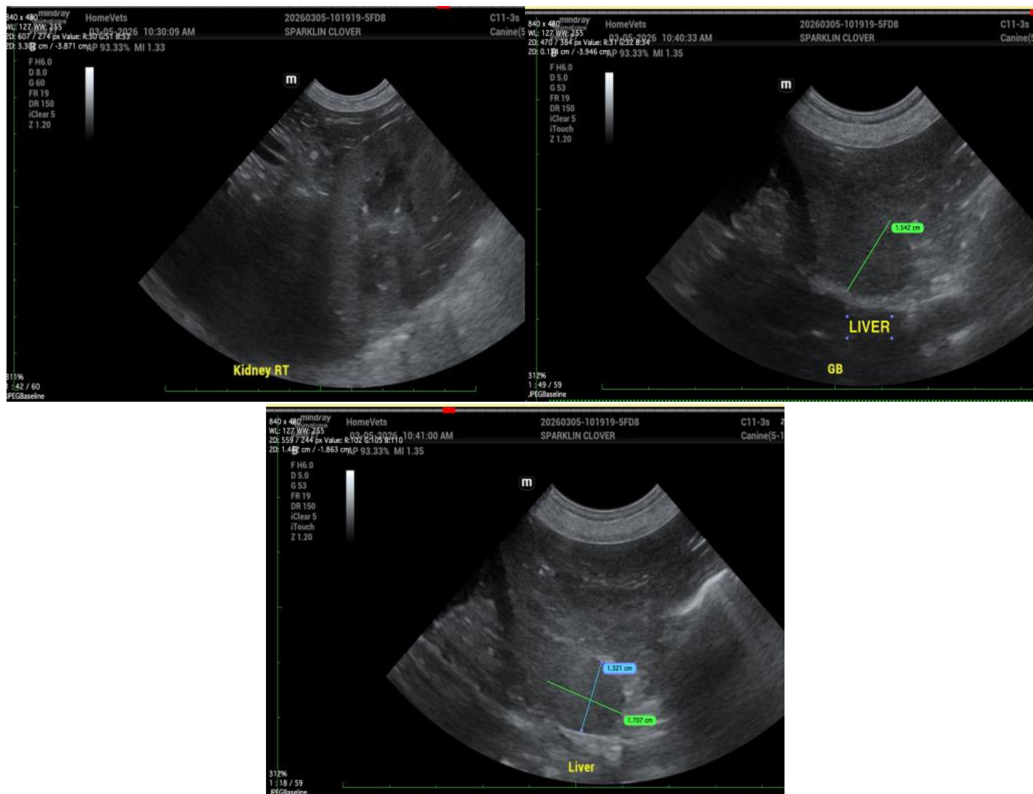

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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