



PATIENT

Luna Peka

SPECIES

Canine

BREED

Pit Bull

SEX

Spayed Female

AGE

12.5 Years

WEIGHT

64.6 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal
Hospital

REFERRING VET

Dr. Jen Makem

INVOICE

74443

DATE

4/14/26

PRESENTING CLINICAL SIGNS

Hx: 12.5 yo FS Pitbull Sedated with butorphanol

- Patient presented for evaluation of progressively elevated liver enzymes
- Patient has a chronic hx of mildly elevated ALT/ALP that has acutely worsened. Per O the patient is asymptomatic. No PU/PD, eating normally, no v/d, no weight loss.
- Chronic meds: Apoquel 16 mg PO SID for atopy, Dasuquin for OA
- Recent meds, started 3/28/26: Baytril 136 mg PO SID, Amoxicillin 250 mg PO BID, Hepatosupport

Abnormal PE/Chem/CBC/UA Results: 12/8/25 Full bloodwork: ALT 135, ALP 435, UA: USG 1.040, quiet sediment, T4 3.2, 4dx - historical lyme +, prev tx in 2017, low C6 this year 3/27/26 Liver panel: ALT 511, ALP 1460, tbili 0.3 4/14/26 Liver panel: ALT 850, ALP >2000, tbili 0.4 4/14/26 Chest rads: NSF, no evidence of metastatic disease

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.

The right kidney is normal is size (5.2 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.

The left kidney is normal is size (5.8 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 right adrenal gland is normal in size (0.89 cm at cranial pole and 0.74 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.48 cm at cranial pole and 0.69 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable 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

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is 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

- 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.
- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes described above are mild/subtle and non-specific, but given patient's history, potentially warrants sampling. Therefore, fine needle aspirates of the liver and spleen could be considered if patient's coagulation status is appropriate.

In the meantime, full comprehensive infectious disease evaluation including testing for Leptospirosis is recommended.

Bile acids could be considered if patient's total bilirubin is not increased.

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



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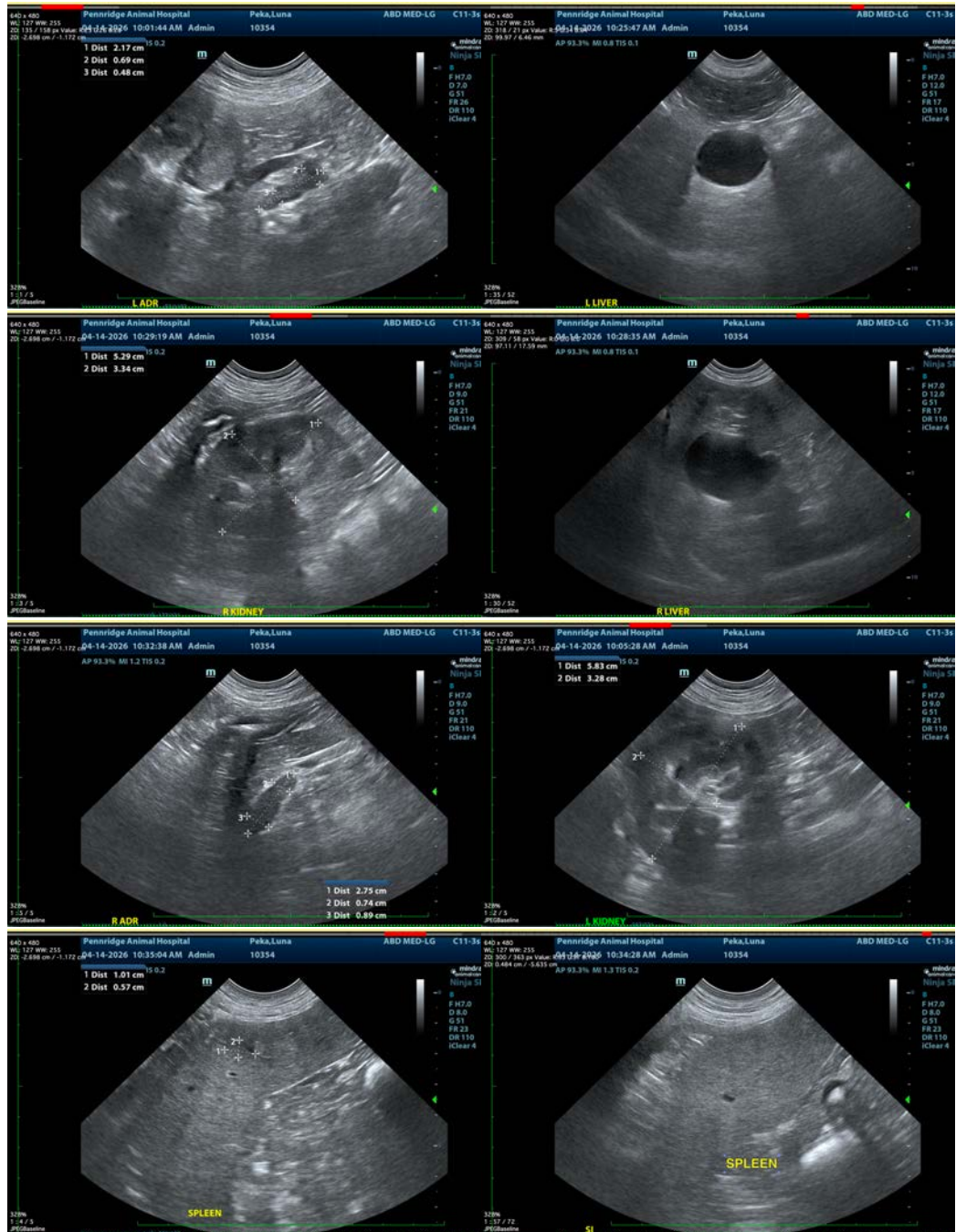
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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