

PATIENT PRESENTING CLINICAL SIGNS

Riley Renato Anorexia vomiting April 22, given cerenia, is no longer vomiting. Is eating chicken and is more active.

SPECIES Current Medications: Mirtazapine prescribed April 24, 2026 in clinic, Emavert injection given April 24, then prescribed Cerenia for 2 days, Sulcrate (3 mL BID x 8 days)

Canine

BREED Abnormal PE/Chem/CBC/UA Results: MCHC 38.4 g/dl (32-37.9) RETIC-HGB 19.9 pg (22.3-29.6) WBC 20.30 x 10⁹/L (5.05-16.76) NEU 17.63x10⁹/L (2.95-11.64) PLT 531 K/uL (148-484) PCT 0.57% (0.14-0.46) CREA 186 umol/L (44-159) UREA 15.1 mmol/L (2.5-9.6) ALT 1211 U/L (10-125) Diluted result as Catalyst couldn't read normal sample ALKP 1838 U/L (23-212)

Shih Tzu x

SEX ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Spayed Female

Urinary System

AGE

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.

9 Years

WEIGHT

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. No infarcts observed. Left kidney measures 4.26 cm. Right kidney measures 4.5 cm. Mild pyelectasia and pinpoint non-obstructive nephroliths are noted bilaterally.

7.3 kg

INTERPRETED BY

Adrenal Glands

Beth Johnson, DVM
DACVIM

The right adrenal gland is normal in size (0.53 cm at cranial pole and 0.37 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

IMAGING PERFORMED BY

The left adrenal gland is mildly plump/rounded with no evidence of capsular escape in the cranial pole, which measures 1.0 cm. The caudal pole is normal in size and shape and measures 0.63 cm.

Amanda Stewart

Spleen

HOSPITAL NAME

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.

Dundas Animal Hospital

REFERRING VET

Liver

Dr. Middleton

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

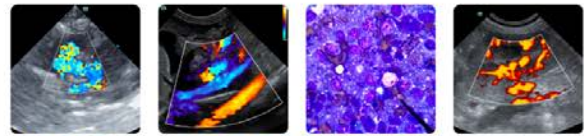
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74764

DATE

4/28/26

Gallbladder is moderately overdistended with organized, aggregated and centralized non-gravity dependent sludge. Striations of sludge separated by anechoic areas are noted extending from the lumen to the luminal wall. The wall is mildly thick, irregular and hyperechoic. There is no evidence of CBD dilation. Subjectively enhanced, hyperechoic tissue is noted surrounding the gallbladder.



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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, visualization is partially inhibited by gas.

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

- Gallbladder mucocele with changes consistent with subtle focal inflammation around the gallbladder and throughout the cranial abdomen. Some association with the pancreas or bowel can't be definitively ruled out.

SECONDARY FINDINGS

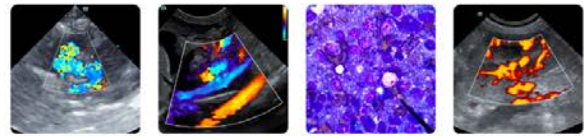
- Mild left cranial pole adrenomegaly should be interpreted in combination with patient's clinical history, as early or emerging adrenal disease can't be ruled out. Infiltrative neoplasia is possible but considered less likely.
- Mild age related kidney changes with mild pyelectasia and non-obstructive mineral densities noted bilaterally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the reported azotemia, if not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

A blood pressure is also recommended.

While I suspect patient's reported ALP are at least in part related to the suspected gallbladder mucocele, given the marked ALT increase a concurrent unrelated hepatopathy can't be ruled out. Therefore, additionally given patient's concurrent azotemia, testing for Leptospirosis could be considered.



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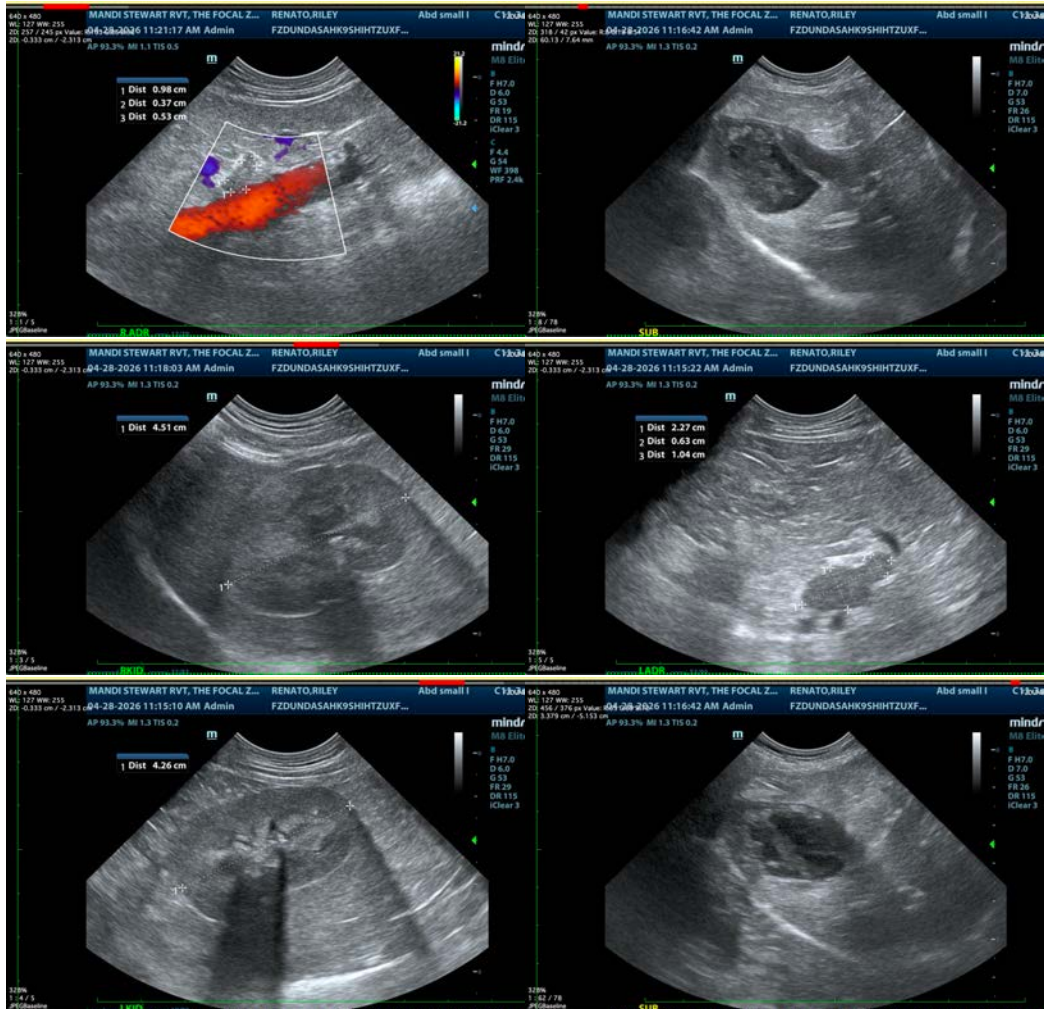
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Bile acids could also be considered if patient's total bilirubin is not increased. Bile acids are not recommended if total bilirubin is increased.

Ultimately, however, if continued supportive/symptomatic medical management does not result in continued improvement in clinical signs, more aggressive intervention up to and including a possible cholecystectomy and liver biopsy may be indicated.



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