



PATIENT

Ollie Grussberg

SPECIES

Canine

BREED

Shih Tzu

SEX

Neutered Male

AGE

11 Years

WEIGHT

13 Pounds

INTERPRETED BY

Beth Johnson, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

All Creatures Denville

REFERRING VET

Dr. Ashmore

INVOICE

37069

DATE

5/11/26

PRESENTING CLINICAL SIGNS

History: Per O Elev. appetite, pu pd
Abnormal PE/Chem/CBC/UA Results: alp-147

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.

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

Left kidney is normal in size (3.66 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. A hyperechoic band parallel to the corticomedullary border is present.

Right kidney is normal in size (3.74 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. A hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

Left adrenal gland is normal in size (0.44 cm at cranial pole and 0.44 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.66 cm at cranial pole and 0.52 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. 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.

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



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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.

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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.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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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.

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Free Abdomen

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

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There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

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Beth Johnson, DVM,
DACVIM (SAIM)

- Mild 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.
- 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.
- Bilateral medullary rim sign- This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Given reported PU/PD, if not recently evaluated, 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 ration is recommended.

A blood pressure is also recommended if not recently evaluated.



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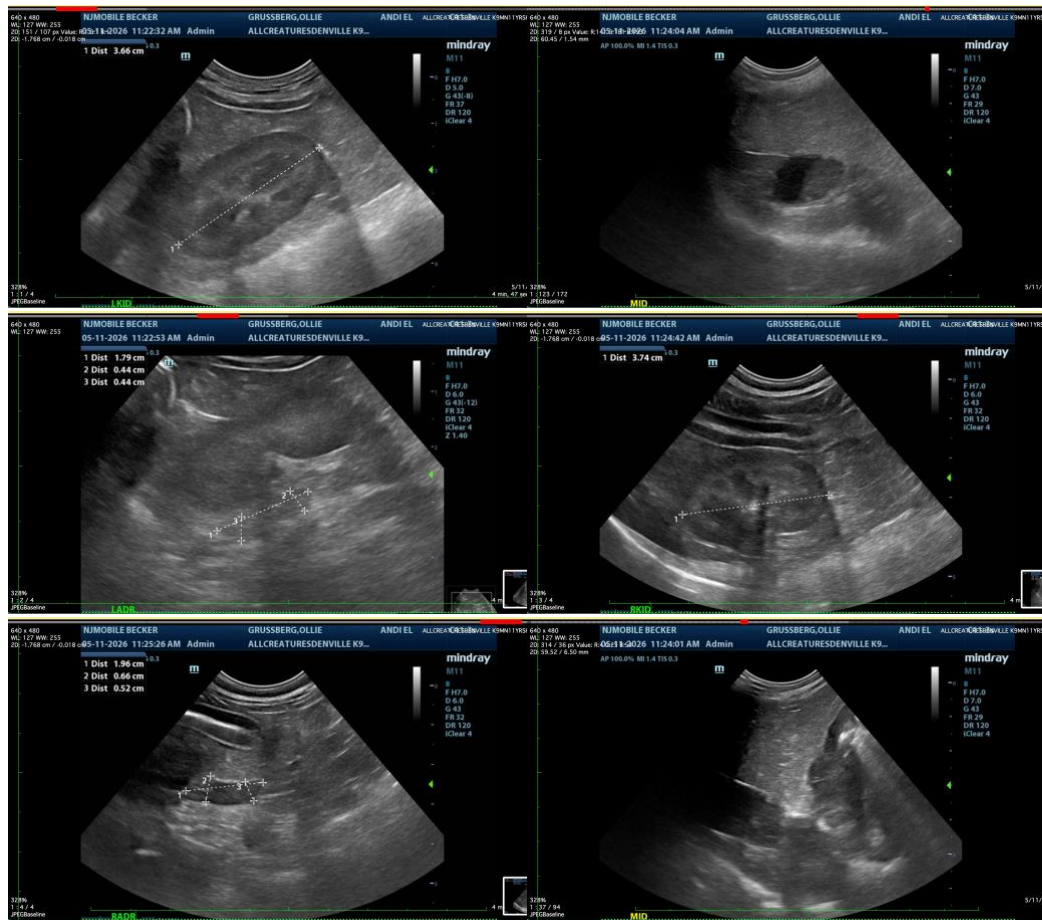
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There is not a definitive ultrasonographically visible intraabdominal explanation for reported polyuria, polydipsia, and/or increased appetite. Given the increased appetite, further evaluation of digestion and absorption is recommended, beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, for further evaluation of GI and pancreatic function.

Additionally, a routine fecal/Giardia exam can be considered if not recently evaluated.

Having said that, normal adrenal glands do not rule out emerging adrenal disease, including hyperadrenocorticism, so if another cause is not diagnosed and clinical signs persist, additionally, hormone testing could be considered, beginning with a low-dose dexamethasone suppression test.



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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



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