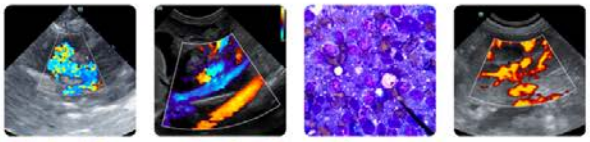


PATIENT

Lexi Murphy

SPECIES

Canine

BREED

Bichon

SEX

Spayed Female

AGE

13 Years

WEIGHT

15 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jessica Milligan, DVM

HOSPITAL NAME

Dockside Veterinary Imaging

REFERRING VET

Dawn Morgan-Winter

INVOICE

75073

DATE

5/12/26

PRESENTING CLINICAL SIGNS

Liver values increased and BUN elevated
Abnormal PE/Chem/CBC/UA Results: ALT 662, ALP 546, BUN 53, Glob 3.9

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick. Along the apex there is an approximately 0.30 cm x 0.50 cm echogenic density that appears to be an irregular pedunculated tissue density. Mucosa is hyperechoic and irregular with multiple pedunculated masses extending into the lumen of the bladder. No definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. Left kidney is normal in size at 4.63 cm. Right kidney is normal in size at 4.57 cm. Cortical cysts are noted bilaterally. Punctate non-obstructive nephroliths are present bilaterally. Mild to moderate pyelectasia is appreciated in the right kidney.

Adrenal Glands

Adrenal glands are mildly plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.41 cm at the cranial pole and 0.67 cm at the caudal pole. The right cranial pole is difficult to fully visualize/isolate for measurement. Right caudal pole measures 1.1 cm.

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.

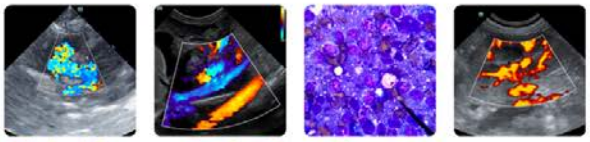
Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is markedly 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.



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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.

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.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The markedly heterogeneous liver could represent a benign process such as marked nodular hyperplasia, steroid or vacuolar hepatopathy, extramedullary hematopoiesis, or chronic inflammatory disease. However, infiltrative neoplasia such as round cell neoplasia or even metastatic neoplasia can't be ruled out without tissue sampling.

- 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 bilateral chronic kidney disease changes with bilateral non-obstructive nephroliths and mild to moderate pyelectasia noted in the right kidney.

- Suspect polypoid cystitis – Urinary bladder wall changes are most consistent with polypoid cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely given the appearance of the polyps.

- Mild bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the mildly plump adrenal glands, emerging hyperadrenocorticism could be contributing to patient's reported liver enzyme changes. However, the pattern presented is atypical as a hyperadrenocorticism pattern, being a primarily hepatocellular injury pattern versus a cholestatic

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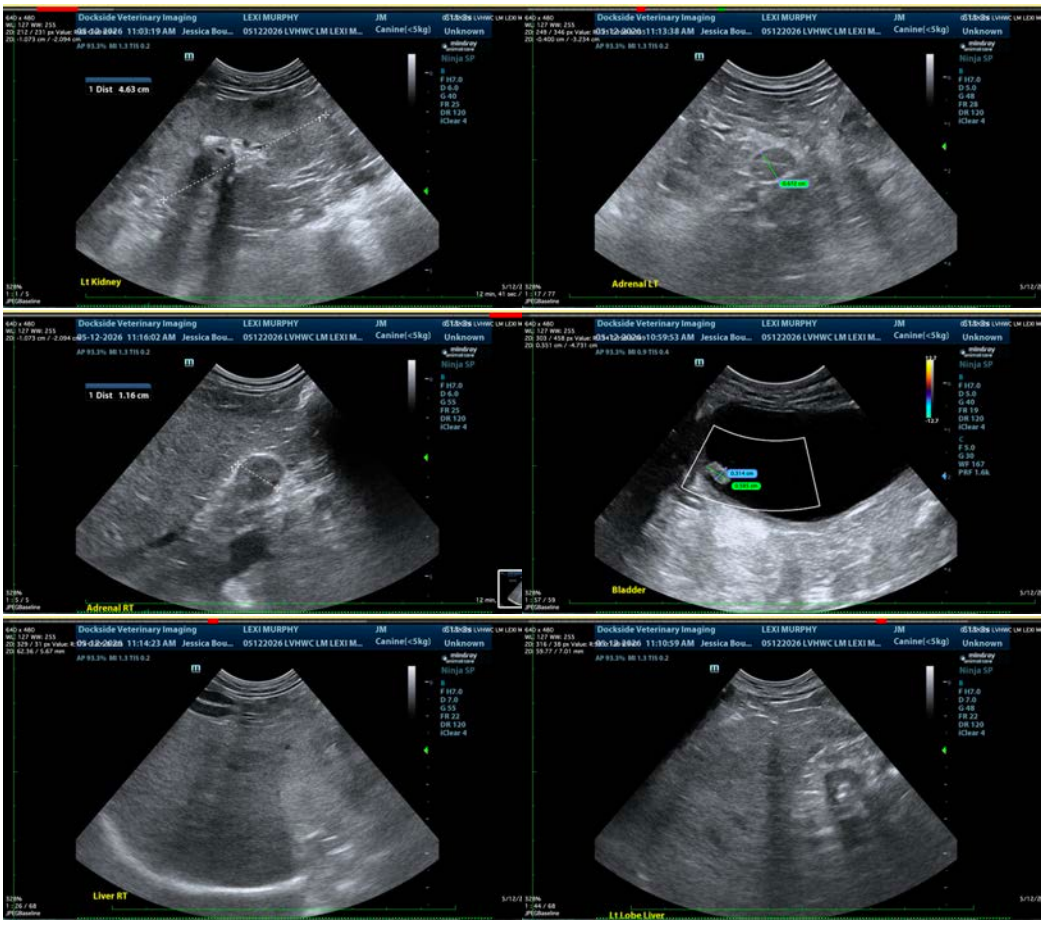
pattern. Therefore, unless the patient is overwhelmingly clinical for hyperadrenocorticism and it is suspected clinically, recommendations are to primarily evaluate the kidneys and rule out a concurrent primary hepatopathy prior to hormone testing.

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.

Testing for Leptospirosis is recommended. Bile acids could be considered if patient's total bilirubin is not increased. Liver sampling could be considered, beginning with a fine needle aspirate if patient's coagulation status is appropriate.

The gallbladder changes should be interpreted in combination with patient's clinical signs. Ultimately, pending results of above, if patient is clinical for hyperadrenocorticism, testing could be considered beginning with a low-dose Dexamethasone suppression test. In the meantime a blood pressure is also recommended if not recently evaluated.



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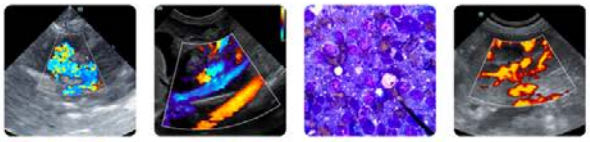

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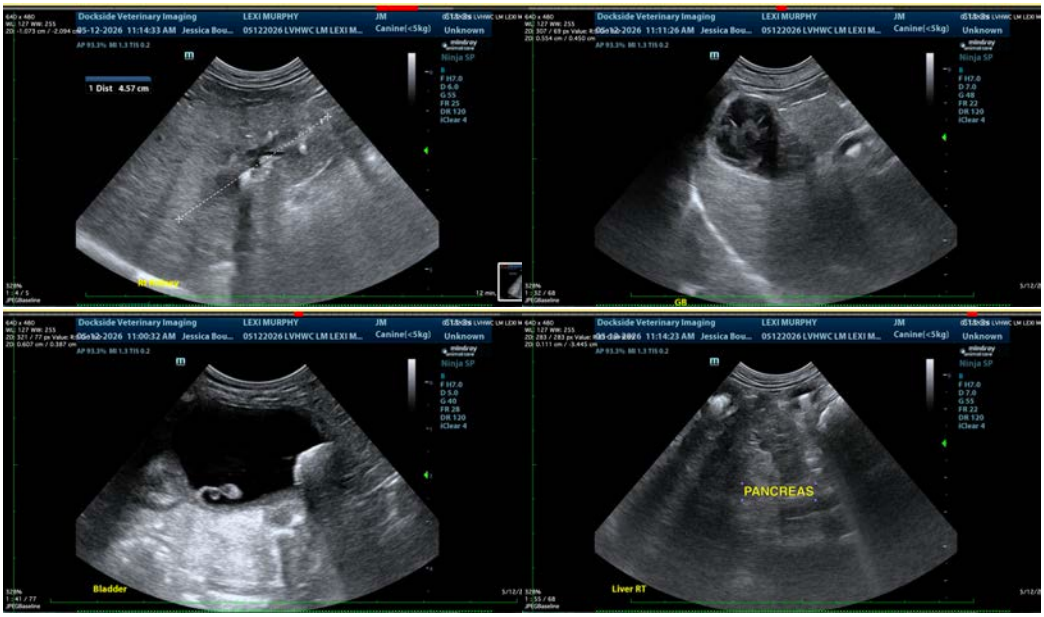

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com