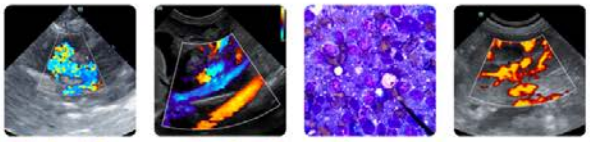

PATIENT

Delilah Sawyer

SPECIES

Canine

BREED

American Bully

SEX

Spayed Female

AGE

11 Years 7

WEIGHT

25 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

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INVOICE

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6/3/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate progressive elevation of liver enzymes, now marked elevation. Still eating but with some hyporexia. O noted weight loss. Chronic intermittent vomiting, no diarrhea. Was on denamain and urosodiol, urosodiol is now held. Sedated for AUS: Butorphanol 0.35 mg/kg IV. Tolerated well. Appeared nauseous, drooling and defecated (normal stool with grass mixed in). Cerenia 1 mg/kg SQ given. HR 120 bpm

Abnormal PE/Chem/CBC/UA Results: Prev AUS 10/8/25: Benign hepatopathy pattern, Mild edematous gallbladder with congealed, mineralized bile debris, Mild subjective non-obstructive proximal common bile duct dilation, Pancreatic remodeling, Normal gastric intestinal tract with gastric ingesta, Chronic renal changes, Borderline right adenomegaly, Subtle splenic nodule – tend to trend benign, subtle lymphoid hyperplasia or hematopoiesis probable rDVM 6/2026 (prev 12/2025) - CBC: Hct 44.6%, Plts 199-n, remainder NSF - Chem: Alb 2.5 L, ALT 1,340 H (prev 155 H), ALP 1,021 H, AST 149 H, GGT 19 H, T. bili 0.4 H, Chol 417 H, remainder NSF

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.

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. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 5.5 cm. Right kidney measured 6.4 cm.

Adrenal Glands

The right adrenal gland is mildly plump/swollen in size, measuring 0.87 cm at the cranial pole and 0.88 cm at the caudal pole. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

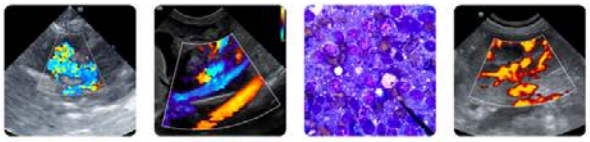
The left adrenal gland is normal in size (0.60 cm at cranial pole and 0.70 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.9 cm thick at the hilus) with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. Additionally, multifocal pinpoint mineral densities are noted throughout the spleen. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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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

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.

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.

What I believe to be the very proximal ascending colon is mildly thick, measuring 0.59 cm thick with normal intact layering. The remaining colon is normal in wall thickness (< 0.2 cm) and layering, and the lumen is empty.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is a scant amount of free fluid.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- An obvious cause for the significant liver changes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia (considered unlikely), etc. cannot be definitively ruled out.

- 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. *This change is subjectively improved from the previous study.

- 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.

- Subtle spleen mineralization – This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism.

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- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- The trace free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- The mild suspected proximal colon thickening trends in appearance toward benign, as is seen with parasitic or infectious, dietary related, other benign inflammatory colitis, although infiltrative neoplasia, while considered less likely, cannot be definitively ruled out.
- The mild previously noted right adrenomegaly is unchanged.
- Mild to moderate bilateral age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's history, bile acids are recommended if patient's total bilirubin is not increased.

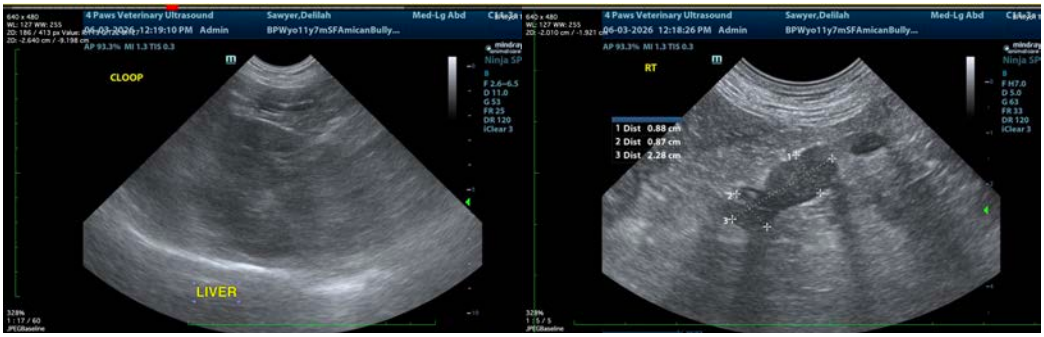
Fine needle aspirates of the liver and spleen could be considered if patient's coagulation status is appropriate.

Pending results of above, testing for Leptospirosis could be considered.

Given patient's other history, if a diagnosis is not made, 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 fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

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



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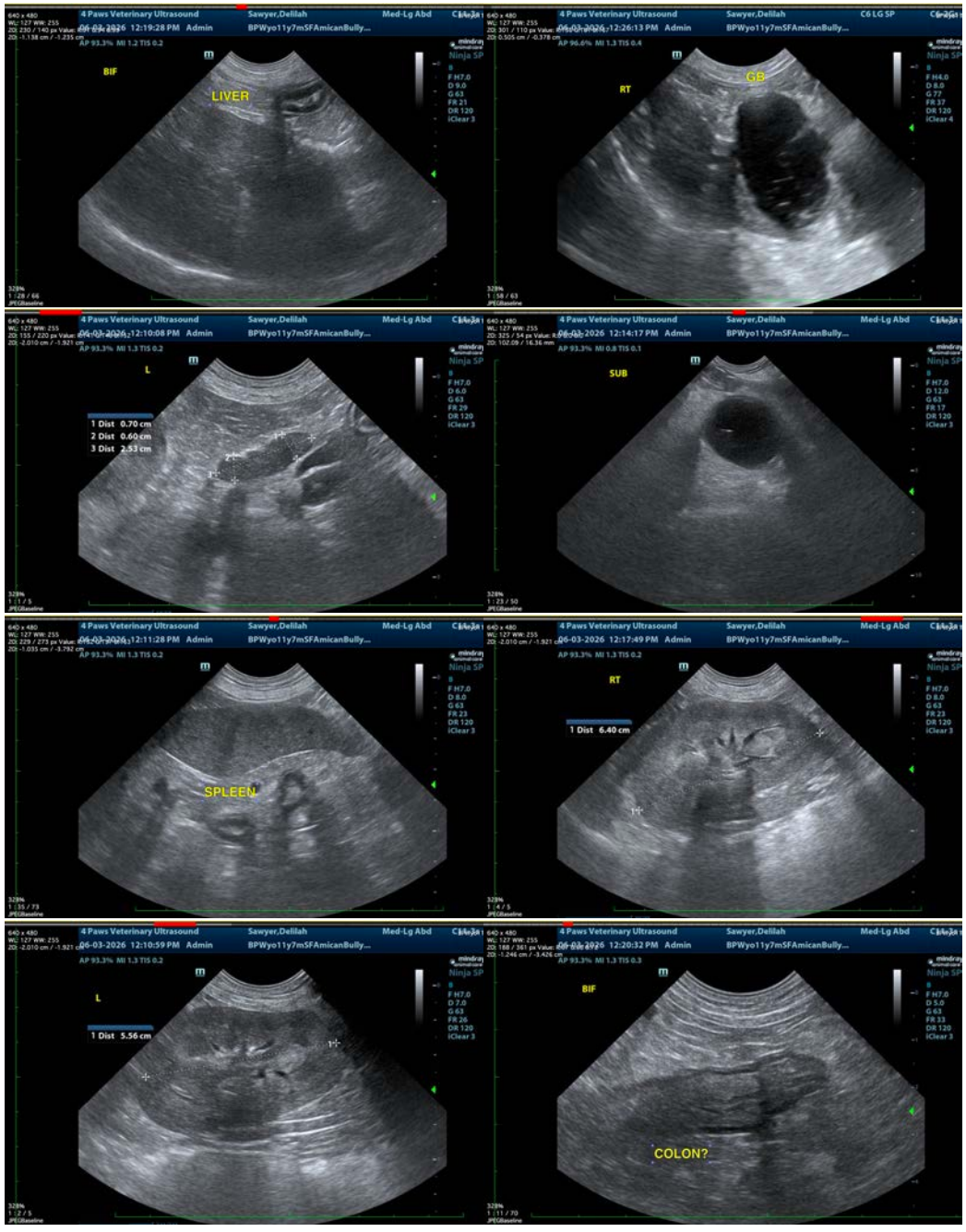

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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