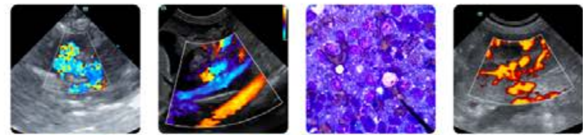


PATIENT
Pepper Coombs

SPECIES
Canine

BREED
Beagle x

SEX
Spayed Female

AGE
10 Years

WEIGHT
23.9 kg

INTERPRETED BY
Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY
Kelly Reschny

HOSPITAL NAME
BPH Ancaster

REFERRING VET
Dr. Matea

INVOICE
72283

DATE
12/3/25

PRESENTING CLINICAL SIGNS

Significant pain and guarding noted on palpation, particularly in the cranial abdomen just behind the rib cage. Tenderness is present throughout the entire abdomen on both the left and right sides, with the patient reacting even to light pressure. -chronic pancreatitis -polydipsia Current Medications Gabapentin, Cerenia

Abnormal PE/Chem/CBC/UA Results: CBC - wnl (MPV mildly elevated) -Chem - ALT mildly increased, ALP moderately increased, GGT wnl, bilirubin wnl

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with generally anechoic urine. On the ventral apical surface there are two broad based structures with irregular surfaces protruding into the urinary bladder lumen, most consistent with urinary bladder polyps. There is another more broad based irregular structure originating from the mid ventral aspect of the urinary bladder body wall, also protruding into the lumen. The trigone has no abnormal thickening or visible masses.

The left kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. A cortical cyst is noted. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measured 6.04 cm.

The right kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measured 6.34 cm.

Adrenal Glands

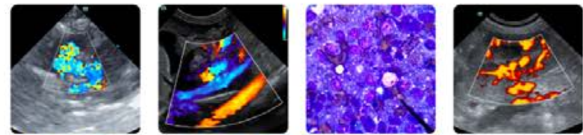
Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Left measured 2.66 cm in length x 0.66 cm at the caudal pole and 1.16 cm at the cranial pole. Right measured 2.7 cm in length x 0.74 cm at the caudal pole and 1.85 cm at the cranial pole.

Spleen

The spleen had a generally smooth homogeneous parenchyma and a smooth capsule with a solitary hyperechoic nodule visualized most consistent with benign myelolipoma. There was normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. The parenchyma is heterogenous with a coarse appearance. There are multifocal, variably sized, generally relatively small, hypoechoic nodules noted throughout the parenchyma. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.



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Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

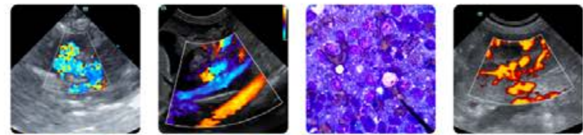
- Urinary bladder growths – polyps versus other.
- Splenic myelolipomas.
- Degenerative renal changes.
- Coarse liver with multifocal nodules.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no obvious cause of reported abdominal pain on abdominal ultrasound. GI and pancreatic disease cannot be ruled out despite relatively normal appearance on ultrasound. Referred back pain is also a differential.

Liver changes are a common benign age related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. No significant disruption of architecture noted to suggest significant pathology. In the face of elevated liver enzymes, fine needle aspirate is recommended to further characterize parenchymal changes, and bile acid profile to assess liver function, especially if any weight loss is noted or for baseline cytological assessment. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol if bilirubin elevated or gallbladder sludge) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued.

Splenic changes are a common age related change and hyperechoic areas are most consistent with benign myelolipoma, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. No significant disruption of architecture noted to suggest significant pathology. Fine needle aspirate



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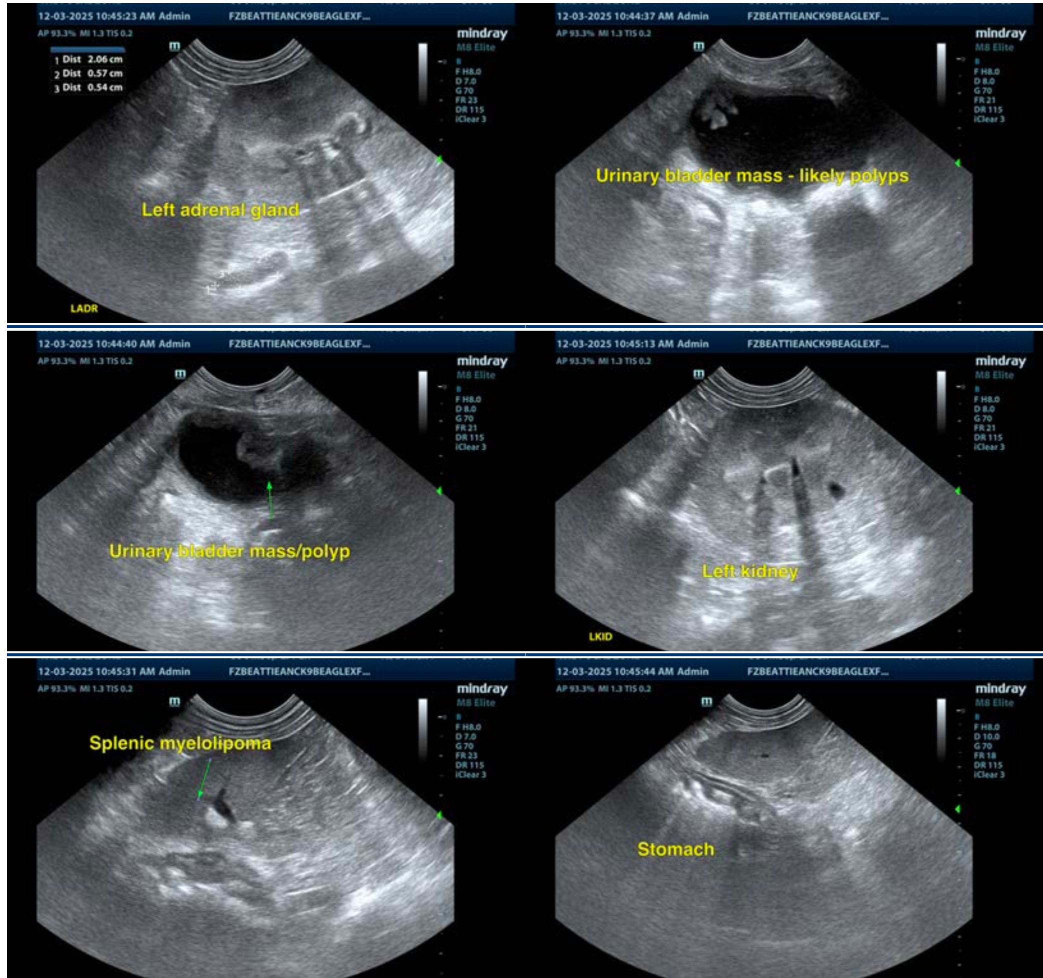
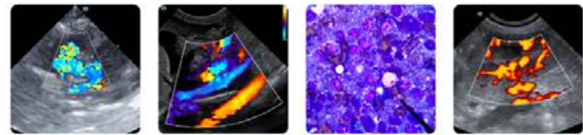
could be considered to further characterize parenchymal changes if clinically indicated, especially if any weight loss is noted or for baseline cytological assessment.

Urinary bladder wall changes are most consistent with a bladder wall mass with a benign polyp being considered most likely based on appearance and location. Transitional cell carcinoma cannot be definitively ruled out and submission of urine for a CADET BRAF to further investigate is recommended. FNA could be attempted but has a risk of seeding neoplastic cells in the abdomen.





SonoPath
www.thefocalzone.com
info@thefocalzone.com
289.808.2608

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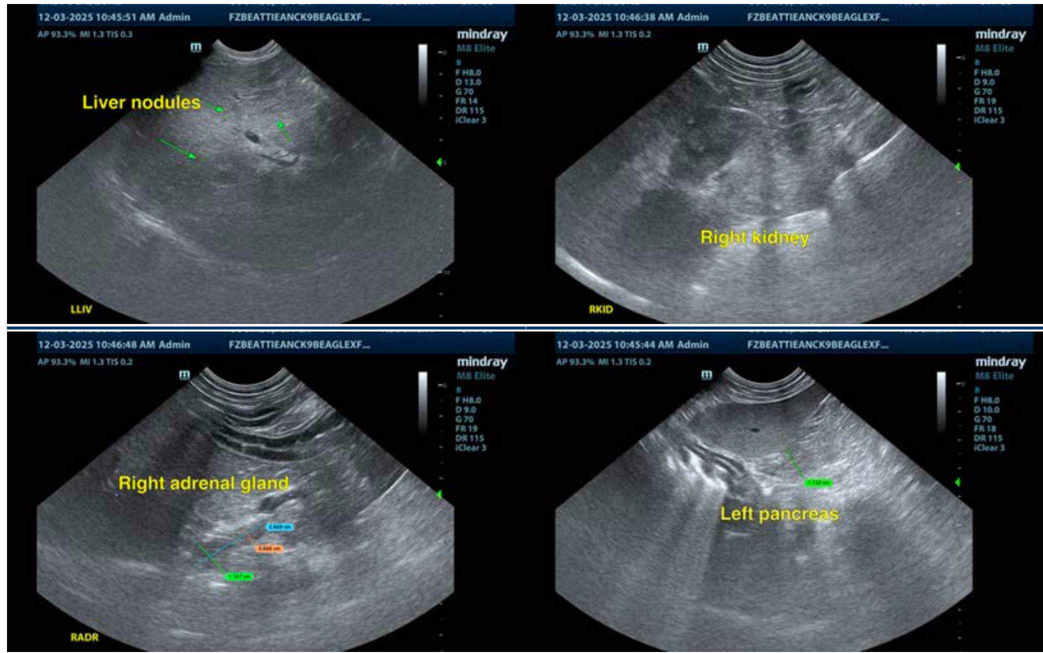

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com