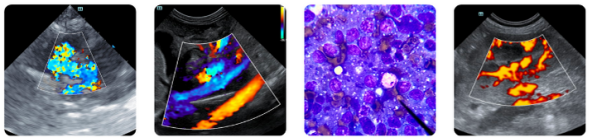


PATIENT

Gracie Gonzalez

SPECIES

Canine

BREED

Shis Tzu

SEX

FS

AGE

7 years

WEIGHT

29 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Julia Bakker

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Dr. Kylie Marr

INVOICE

11890

DATE

5/6/2026

PRESENTING CLINICAL SIGNS

P presented for panting and being uncomfortable. Bloodwork results showed increased ALP and Cpl was abnormal indicating pancreatitis. Rec to treat for pancreatitis and schedule an abd u/s + LDDST for further diagnostics. Discussed findings on radiographs- enlarged liver with rounded edges. Discussed differentials such as cushings vs inflammation vs mass effect. Rec supportive care for poss pancreatitis. -Cerenia SQ inj -B12 inj- SQ 0.25ml -Low fat diet- informed O to stop giving table scraps. Continue Gabapentin (sent home with O from BP last night)-Discussed delayed CPs could be related to poss neuropathy secondary to cushings vs. primary neuro vs. obesity.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a marked amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The left kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. The left kidney measured 4.9 cm in length.

The right kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. Mild non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted. No pyelectasia or ureteral dilation. The right kidney measured 4.8 cm in length.

Adrenal Glands

The left adrenal gland is mildly enlarged for a patient of this size, normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 7.3 mm and the caudal pole measures 6.9 mm.

The right adrenal gland is mildly enlarged for a patient of this size, normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 5.3 mm and the caudal pole measures 9.3 mm.

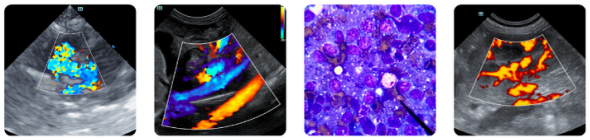
Spleen

The spleen is normal in size, shape, margination and echogenicity. No masses are seen.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. 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.



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Gastrointestinal

The stomach and intestines have normal wall layering and thickness. Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas is diffusely hypoechoic and mildly enlarged, measuring 1.7 cm in width. There is mild surrounding hyperechoic fat.

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic hepatomegaly – This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.
- Mild non-obstructive dystrophic mineralization noted in the right kidney.
- 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.
- Hypoechoic and mildly enlarged pancreas.
- Marked amount of echogenic urinary bladder debris.
- Mild amount of gallbladder debris – Appears clinically incidental.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the patient's liver may be due to hyperadrenocorticism. Consider screening patient via low dose dexamethasone suppression test. If this is ruled out then I recommend screening for hypertriglyceridemia, hypothyroidism, pancreatic or GI disease as the possible cause of vacuolar hepatopathy.

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, and culture is recommended.

Recommend submission of cPLI to determine if patient has clinically significant pancreatic inflammation. If patient is diagnosed with hyperadrenocorticism, this could potentially be a cause of patient's pancreatic inflammation. If hyperadrenocorticism is ruled out as the cause of patient's apparent vacuolar hepatopathy, then consider chronic intermittent pancreatic disease as a cause of the appearance of the liver, and elevated alkaline phosphatase. At that time, recommend initiating an ultra-low fat diet to manage patient's pancreatitis, and resolve the benign hepatopathy.

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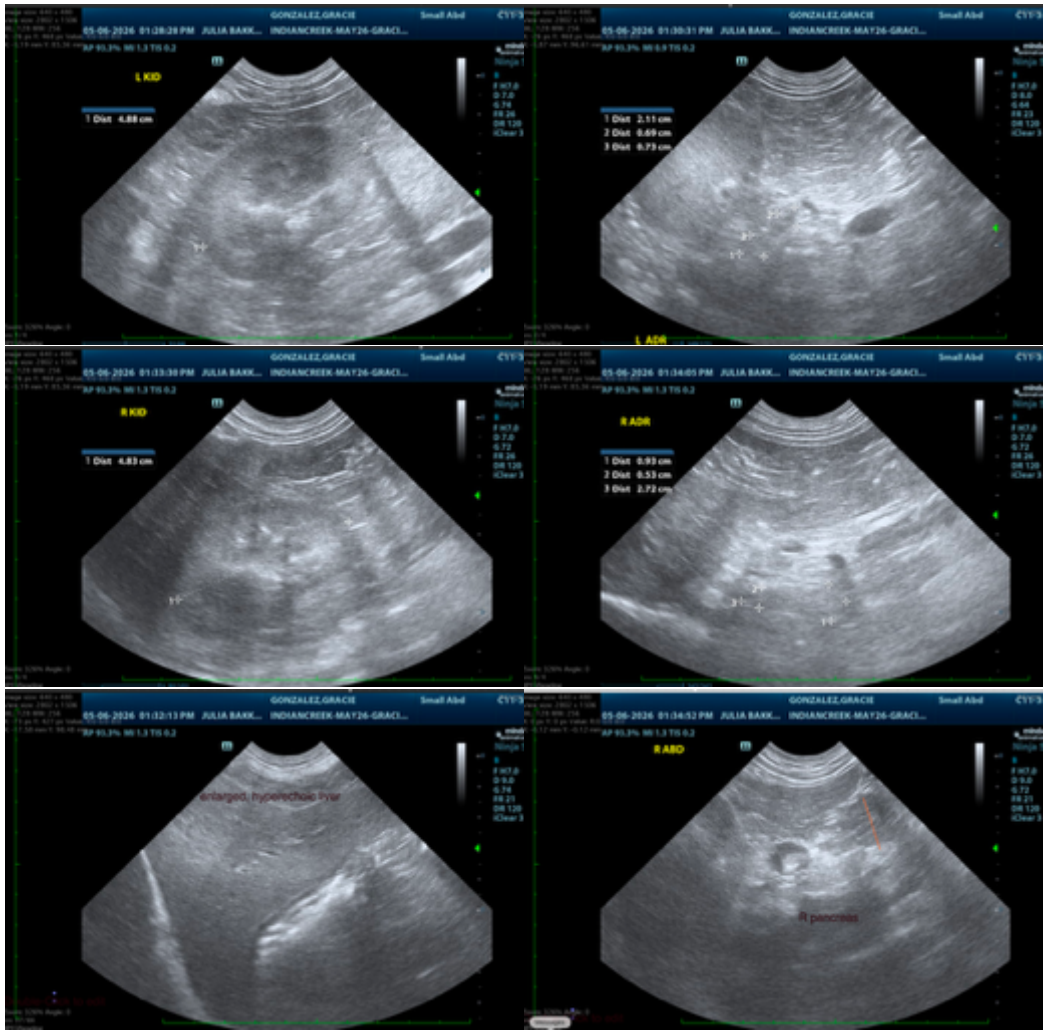

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com