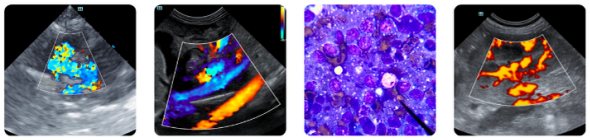


PATIENT

Blaze Savolidis

SPECIES

Canine

BREED

Dachshund

SEX

MN

AGE

9 years

WEIGHT

16 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Julia Bakker

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Dr. Arthur Newman

INVOICE

12073

DATE

6/3/2026

PRESENTING CLINICAL SIGNS

Elevated liver enzymes. Current medication: ursodiol.

Abnormal PE/Chem/CBC/UA Results: ALP > 2400 ALT 694.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen.

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 measures 4.6 cm in length, and the right kidney measures 4.7 cm in length.

Adrenal Glands

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 5.2 mm and the caudal pole measures 5.5 mm.

The right adrenal gland is mildly enlarged, presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 1.0 cm and the caudal pole measures 5.7 mm.

Spleen

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

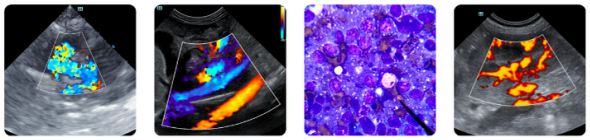
Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion. In what appears to be the left liver, there is a hypoechoic cyst with no mass associated with it, measuring 3.8 mm in width. There is a second ill-defined hypoechoic lesion present measuring 5.0 mm in width.

Gallbladder is moderately overdistended with organized, aggregated and centralized non-gravity dependent sludge. Striations of sludge separated by anechoic areas are noted extending from the lumen to the luminal wall. The wall is mildly thick, irregular and hyperechoic. There is no evidence of CBD dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.



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If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

The small intestines have normal wall layering and thickness.

Colon contains normal contents with normal wall thickness.

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

ULTRASONOGRAPHIC FINDINGS

- 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.
- Age related kidney changes.
- 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. In what appears to be the left liver, there is a hypoechoic cyst with no mass associated with it, measuring 3.8 mm in width. There is a second ill-defined hypoechoic lesion present measuring 5.0 mm in width. The cyst is most likely a benign cystic lesion, and the hypoechoic lesion is most likely a regenerative nodule.
- Mildly enlarged right adrenal gland. This is most likely a normal patient variant, as hyperadrenocorticism seems likely.
- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consider fine needle aspirates and submission of cytology for the cystic lesion and hypoechoic lesion to further evaluate and to rule out neoplastic causes.

Due to the mildly enlarged right adrenal, if clinically appropriate, recommend low dose dexamethasone suppression test.

Given the appearance of both kidneys recommend full staging, and if warranted monitoring and managing per IRIS guidelines.

Patient's elevated liver values appear to be due to gallbladder mucocele. The presence of the gallbladder mucocele is most likely causing the appearance of the liver as well and is less likely due to

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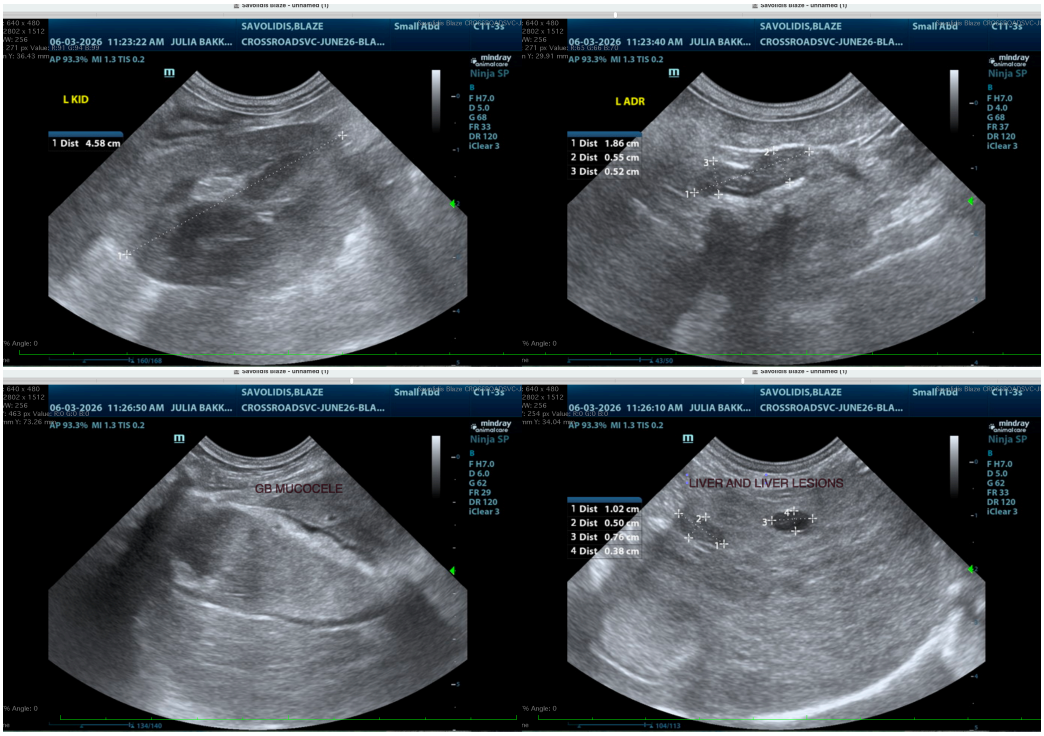
either an infiltrative disease such as lymphoma or mast cell, or a primary liver disease such as copper storage disease, or chronic active hepatitis. At this time, given the gallbladder appearance, cholecystectomy could be considered. If surgery is not elected, then recommend continuing ursodiol for 2-3 months and adding in an antibiotic such as amoxicillin, then recheck imaging via ultrasound as well as rechecking liver values. If cholecystectomy is elected, then recommend liver biopsies during that time.



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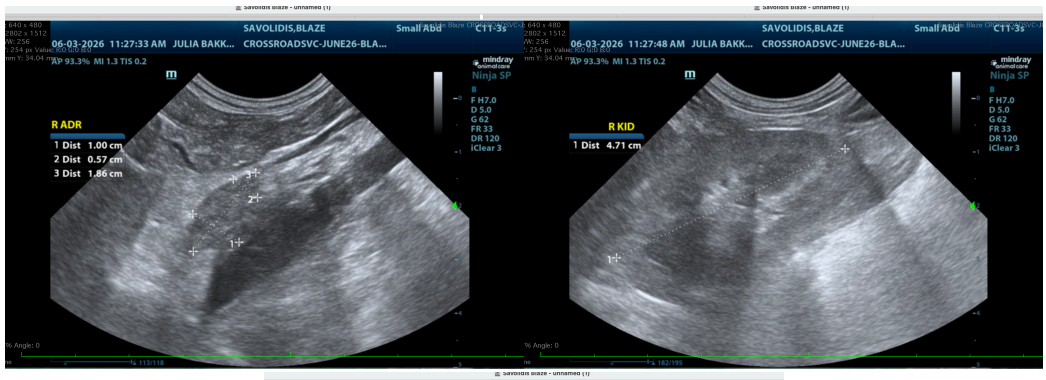

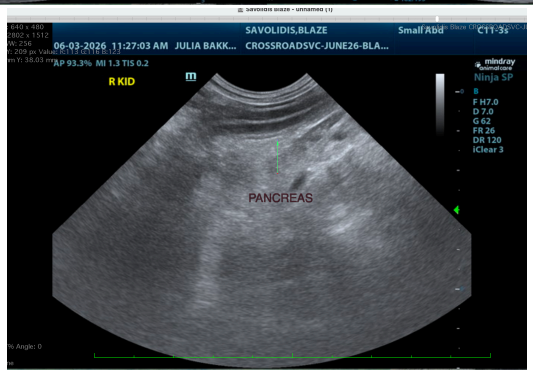

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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