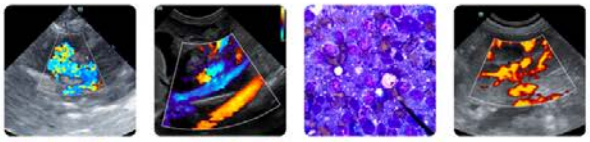


PATIENT

Oscar Harris

SPECIES

Canine

BREED

Shih Tzu x

SEX

Neutered Male

AGE

9 Years

WEIGHT

21 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Dr. Brittany Wolfe

HOSPITAL NAME

HomeVets

REFERRING VET

Dr. Brittany Wolfe

INVOICE

72349

DATE

1/21/26

PRESENTING CLINICAL SIGNS

P presented for US for elevated ALP and lipase. P is PU/PD.

Abnormal PE/Chem/CBC/UA Results: PE: Potbellied CBC normal Chem: ALP 1,244, Lipase 5,344 Checked a cPL and ACTH day of US, cPL elevated at 2,000 and ACTH consistent w/ HAC

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The prostate is normal in size (0.71 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (5.58 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is a small pinpoint mineralization in the caudal pole with a small anechoic surrounding region, most consistent with a small surrounding cyst measuring 0.28 cm. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.47 cm) with occasional small cortical cysts. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is large, measuring 0.73 cm at the caudal pole and 0.85 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

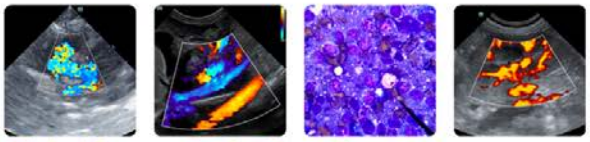
The right adrenal gland is borderline “plump”, measuring 0.60 cm at the cranial pole and 0.75 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect. There is a focal hyperechoic structure (suspected mineralizatin) associated with the cranial pole.

Spleen

The spleen is normal in size and shape, measuring 1.45 cm in height at the level of the hilus. The blood flow through the hilus and splenic parenchyma appears normal. There is a focal hyperechoic nodule at the periphery of the spleen measuring 0.65 cm, most consistent with a benign myelolipoma. Recommend continued monitoring.

Liver

The liver is large in size, and hyperechoic with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the



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vasculature and biliary tract appear normal. There are too numerous to count variably sized, somewhat poorly defined hypoechoic nodules in the parenchyma. Examples measure 0.50, 0.60, and 0.30 cm.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. Some of the debris appears adhered to the gall bladder wall. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.50 cm. Jejunum wall measures 0.37 cm. There is rare mucosal speckling visualized associated with the duodenum. Visualized peristalsis appears appropriate. 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 pancreas is visible/mildly mottled in the right limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Borderline bilateral adrenomegaly with a hyperechoic mineralization in the cranial pole of the right adrenal – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended. The significance of the focal mineralization is uncertain. Recommend continued monitoring.

- Large, heterogeneous, hyperechoic liver with numerous ill-defined hypoechoic nodules – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The nodules observed trend toward a more benign process, but underlying neoplasia cannot be ruled out.

- Moderate gallbladder debris with some debris adhered to the gall bladder wall – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a

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current issue. Recommend continued monitoring.

- Mildly thickened small intestine with rare mucosal speckling – Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.

- Pancreatic changes most consistent with chronic pancreatic remodeling.

SECONDARY FINDINGS

- Focal hyperechoic lesion at the periphery of the spleen, most consistent with a benign myelolipoma. Recommend continued monitoring.

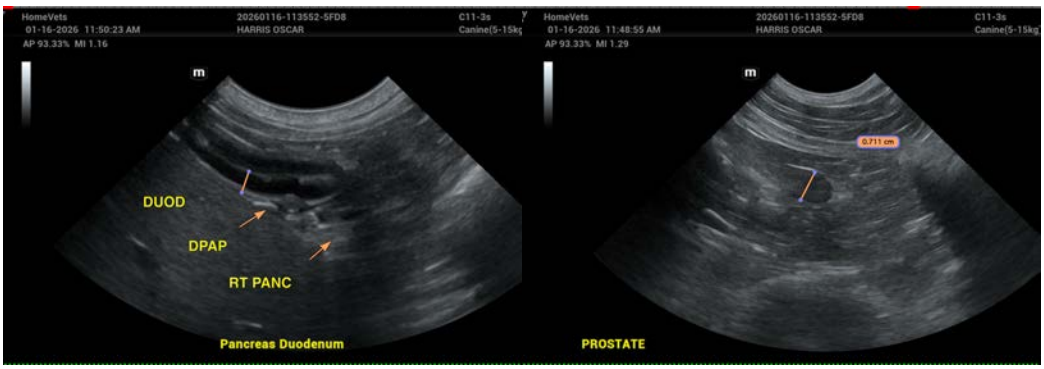
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is large and heterogeneous with ill-defined hypoechoic nodules. This generally has the appearance most consistent with a vacuolar hepatopathy and regenerative nodules, although other differentials are possible. If there is concern for a more significant hepatopathy, a fine needle aspirate and a liver function test should be considered. Additionally, there is some debris adhered to the gallbladder wall with no evidence of overt wall thickening. Consider starting chronic Ursodiol therapy and continued monitoring of the gallbladder.

Both adrenals are "plump", and there is a focal hyperechoic foci associated with the cranial pole of the right adrenal. Given the information provided, this is likely consistent with pituitary dependent hyperadrenocorticism. Recommend continued monitoring.

The small intestine subjectively appears mildly prominent and thickened, and there is some rare mucosal speckling. In the absence of underlying gastrointestinal symptoms, the significance of this is uncertain. If gastrointestinal symptoms develop, further evaluation may be warranted.

The pancreas is somewhat prominent in the right limb. This is most likely consistent with pancreatic remodeling, although given the lipase elevation, mild chronic pancreatitis may be a factor. Your plan for changing to a low fat diet is good, and recommend continued monitoring.



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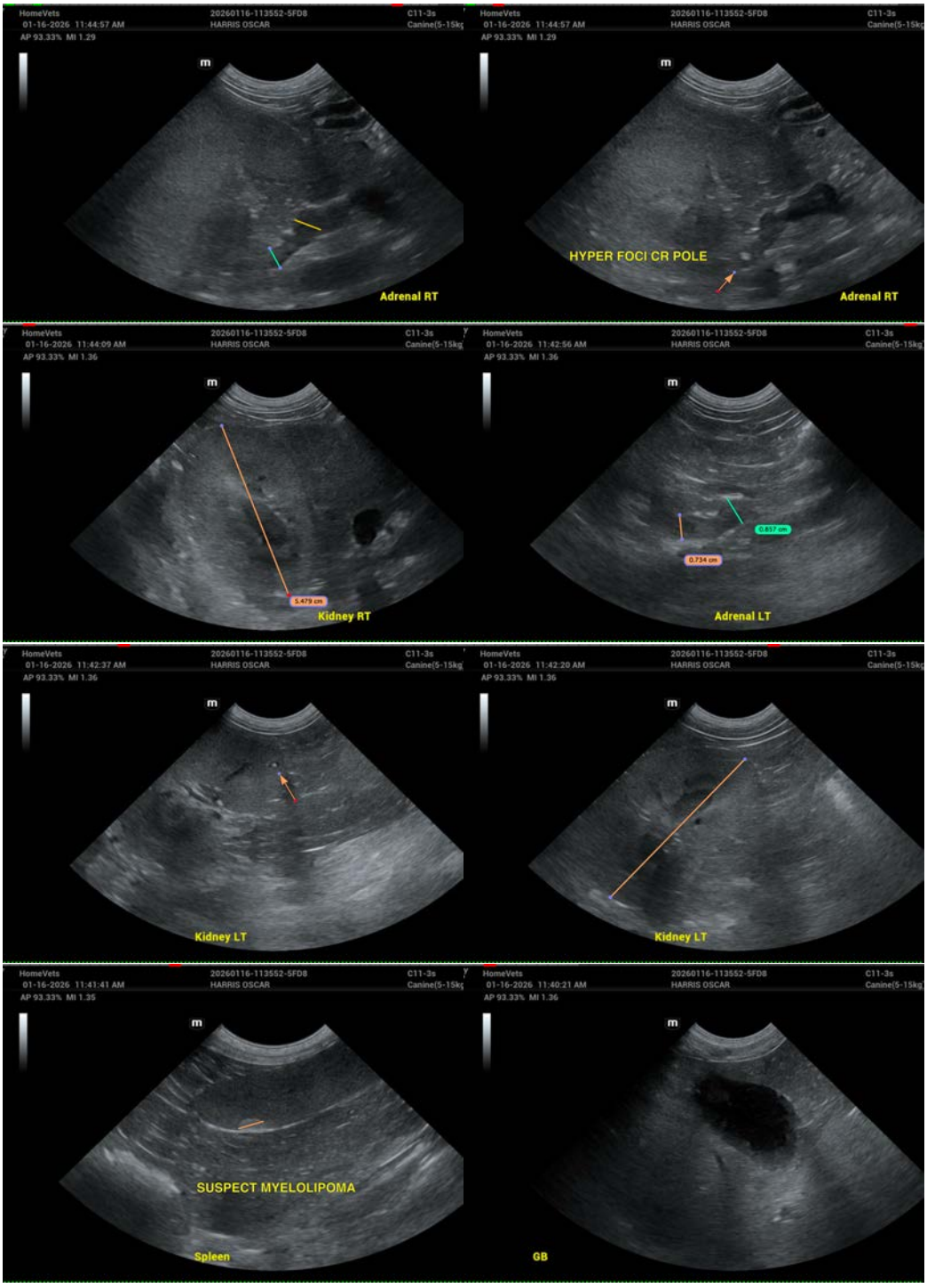

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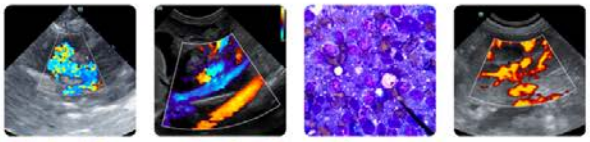

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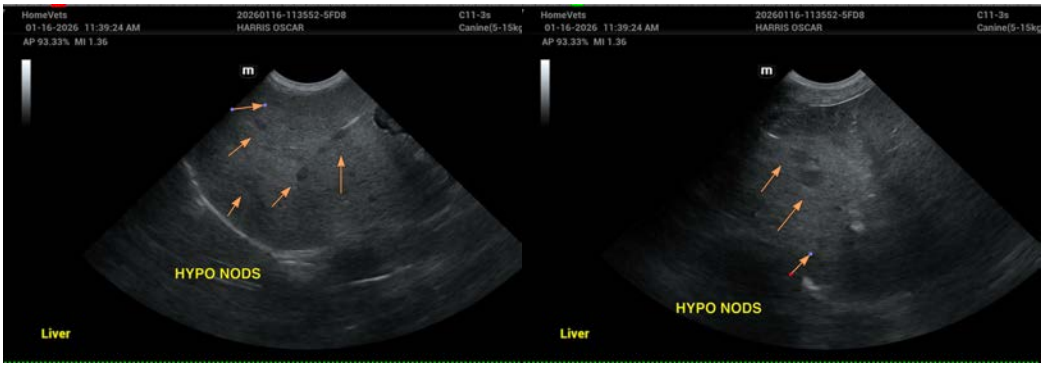

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com