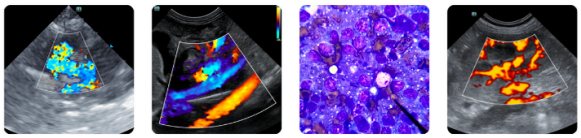


DATE

1/30/2026

PATIENT

Gianna Disney

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

10 years

WEIGHT

80 lbs

INTERPRETED BY

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

HOSPITAL NAME

Hickory Veterinary Hospital

REFERRING VET

Dr. Silcox

INVOICE

11212

PRESENTING CLINICAL SIGNS

Patient History: Seen 1/5/2026 for non-weight bearing lameness on left hind. Suspected cruciate ligament disease with positive drawer and stifle effusion. Patient had elevated ALP and ALT on labs for anti-inflammatory. Treated with Metronidazole, Amoxicillin and Denamarin for 2 weeks. ALP and ALT were worse on recheck.

Current Medications: Metronidazole - 500mg Q12hr, Amoxicillin 500mg Q12hr, Gabapentin 300mg Q12 hr Denamarin, Dasuquin.

Labwork Results: Labwork attached, reported as: 1/5/2026 - ALP = 1435, ALT = 348. 1/28/2026 - ALP = 1982, ALT = 827.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed by: Stephanie Warga RDCS, RVT.

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 left kidney has a normal shape and size (6.76 cm). Overall echogenicity is slightly hyperechoic with poor 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.

The right kidney has a normal shape and size (7.56 cm). Overall echogenicity is slightly hyperechoic with poor 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 borderline plump in size measuring 0.61 cm at the cranial pole and 0.83 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. There is a hyperechoic foci in the caudal pole, most consistent with a small mineralization.

The right adrenal gland is borderline plump in size measuring 0.62 cm at the cranial pole and 0.84 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.

Spleen

The spleen is borderline large in size (3.1 cm) and normal in size, shape, and appearance. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is large in size, and hyperechoic. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are too numerous to count ill-defined, hypoechoic nodules generally varying between 0.5 cm and 1.5 cm.

The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

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 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. The duodenum measured as normal (between 0.3-0.5 cm in wall thickness) and the jejunum measured as normal (0.41 cm.) 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 mineralized foci in the left adrenal. Findings could be consistent with anatomic variation or mild hyperplasia. Mineralized foci is likely incidental. Recommend continued monitoring.

- Borderline large spleen. The spleen is prominent but normal in shape and appearance. Possible differentials include anatomic variation, congestion, lymphoid hyperplasia, splenitis, less likely infiltrative neoplasia.
- Large, heterogenous, hyperechoic liver with 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.
- Large gallbladder debris with some hyperechoic debris consistent with sandy mineralized material. A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of lab work and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.

SECONDARY FINDINGS

- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with pancreatic remodeling in the right limb.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

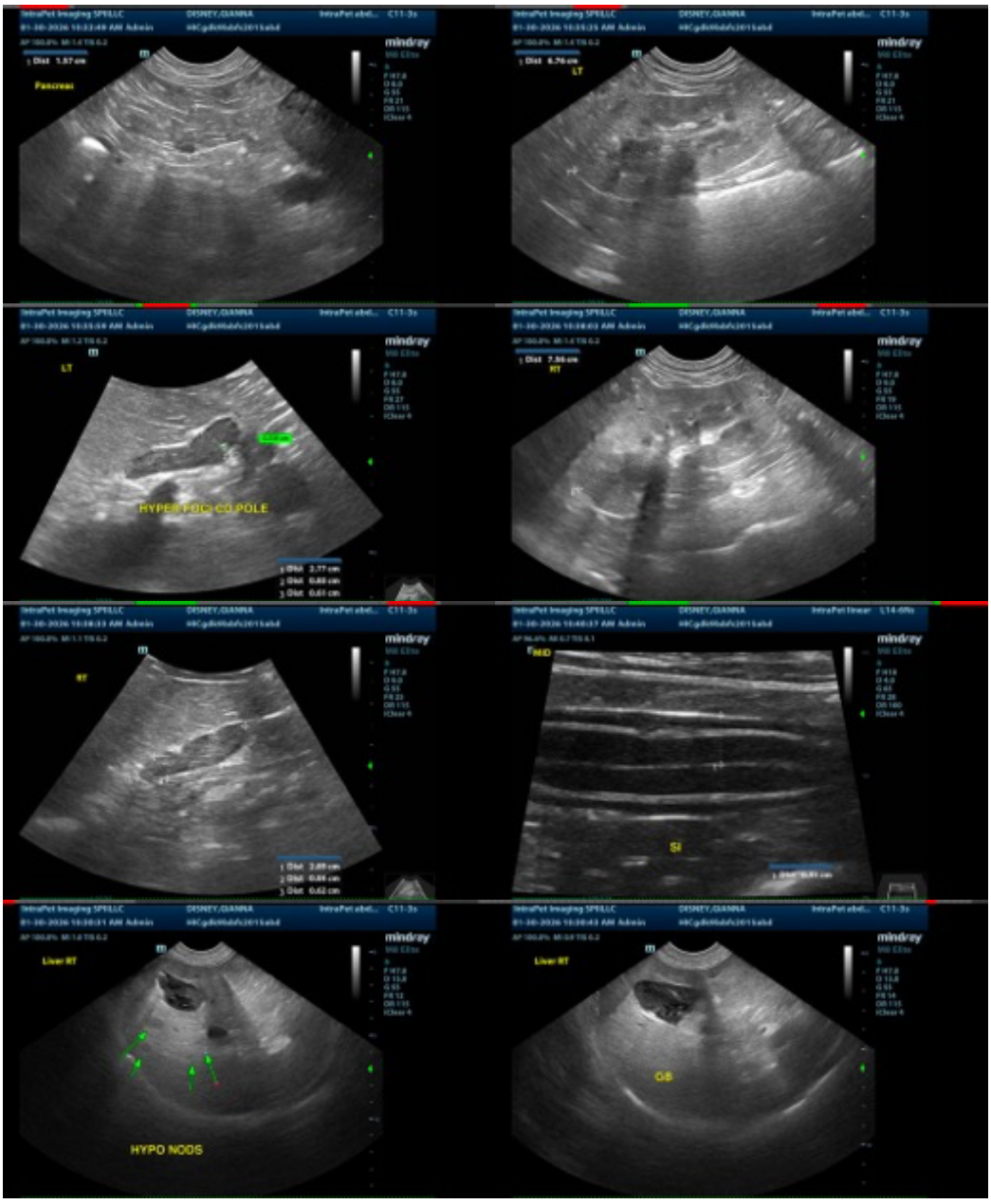
The liver is large, hyperechoic and heterogenous with ill-defined hypoechoic nodules. The general appearance is most consistent with a vacuolar hepatopathy but other hepatopathies are possible. Additionally, the gallbladder has a large amount of debris with no evidence of surrounding inflammation or wall thickening. Recommend pre- and postprandial bile acids as well as a bilirubin level to assess liver function. Consider a fine needle aspirates of the liver (provided coagulation parameters are normal) to look for any evidence of underlying round cell neoplasia or similar.

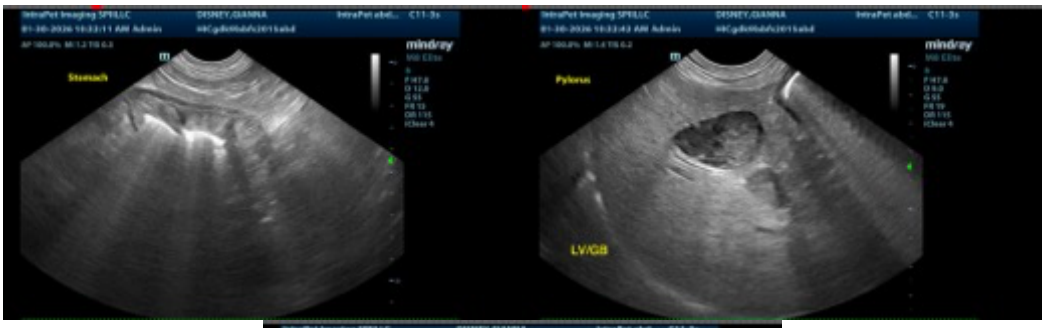
Both adrenals are borderline plump. If there's any concern for Cushing's disease you could consider adrenal function testing.

Based on the changes observed in the gallbladder consider starting chronic ursodiol therapy and continued monitoring of the gallbladder.

If liver function is abnormal, Cushing's disease is unlikely and cytology is not helpful then biopsies of the liver may be warranted with samples for histopathology, culture, and copper levels.

The spleen has normal echogenicity and appearance to the parenchyma but is somewhat prominent. If there are concerns for underlying round cell neoplasia or similar based on additional workup, a fine needle aspirate of the spleen could be considered.


Pancreas
LT
HYPER FOCI CO POLE
RT
SI
Liver RT
HYPO NODS
Liver RT
GB



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