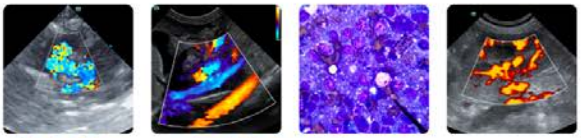




**PATIENT**

Sammy Jerman

**SPECIES**

Canine

**BREED**

Golden Doodle

**SEX**

Spayed Female

**AGE**

9 Years 2 Months

**WEIGHT**

29.5 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Ringwood Animal Hospital

**REFERRING VET**

Dr. Carroll

**INVOICE**

72601

**DATE**

12/16/25

## PRESENTING CLINICAL SIGNS

Elevated liver values. Lethargy, weight loss while eating well. New onset (today) diarrhea. Recent anaplasma positive. Pet is increasingly weak/lethargic. Recheck bloodwork pending. MEDS: Doxycycline for Anaplas completed. Denamarin.

Abnormal PE/Chem/CBC/UA Results: CBC : HCT 40.1, Hemoglobin 14.5, PLT 330 (11/26) WBC 11.4 Chem: ALT 315, ALP 450, GGT 71, Chol 590, Amylase 29.1, Lipase 306, Other: T4 <0.4, Cortisol 7.5

## 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 (6.37 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 no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.01 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 no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is borderline large, measuring 0.70 cm at the cranial pole and 0.88 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.

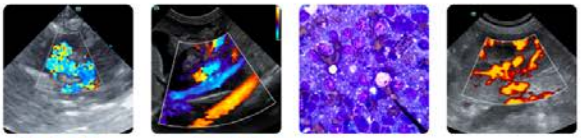
The right adrenal gland is borderline large, measuring 0.93 cm at the cranial pole and 0.80 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

### *Spleen*

The spleen is subjectively normal in size (1.55 cm), echotexture is homogenous, and the splenic capsule is smooth with no 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 normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.





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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. The cystic and common bile ducts are normal/not visible.

### *Gastrointestinal*

The stomach contains mild fluid. 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.

Most of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to mild fluid and gas. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.39 cm. Jejunum wall measures 0.25 cm. Visualized peristalsis appears appropriate. Some sections of small intestine have mild fluid and gas distention, most consistent with an enteritis type pattern.

Sections of colon are dilated with non-formed/liquid fecal material and gas shadowing distally. The descending colon wall appears somewhat prominent, measuring at 0.20 cm with intact wall layering.

### *Pancreas*

The left limb of the pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. 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.

## ULTRASONOGRAPHIC FINDINGS

- Prominent, hypoechoic left limb of the pancreas – Findings are suggestive of mild pancreatic remodeling. Correlate with PLI level.
- Large, heterogeneous liver – 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.
- Moderate gallbladder debris – 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 current issue. Recommend continued monitoring.
- Borderline bilateral adrenomegaly – Findings could be consistent with anatomic variation, early hyperplasia, etc.
- Mildly prominent descending colon wall with fluid distention – Findings are most consistent with diarrhea.

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- Enteritis type pattern visualized associated with the small intestine.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

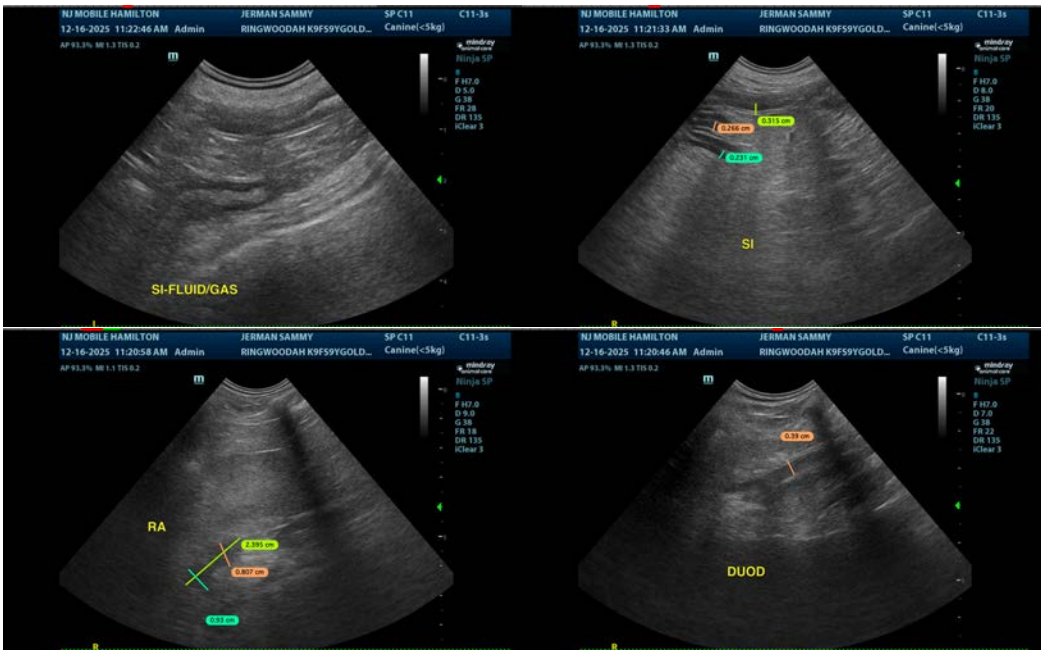
No focal lesions are visualized associated with the liver to explain the elevation in liver enzymes reported. Overall, the liver appears large and somewhat heterogeneous. This is a non-specific finding, possibly consistent with a vacuolar hepatopathy, although other hepatopathies are possible.

There is a moderate amount of gallbladder debris but no evidence of gallbladder wall thickening or surrounding inflammation at this time. Findings are suggestive of a primary hepatopathy. Typically, with a vacuolar hepatopathy you would expect the ALP to be more significantly elevated as compared to the ALT, although this is not always the case. Recommend a liver function test (pre- and post-prandial bile acids) as well as a fine needle aspirate of the liver, looking for neoplastic infiltration, etc. You could consider empirical treatment for acute liver injury (Ursodiol, Denamarin, antibiotics, and supportive care) and screening for Leptospirosis.

If there is no response to treatment, and liver function is abnormal, liver biopsies with samples for histopathology, culture and copper levels would be warranted (provided coagulation parameters are normal).

Some sections of small intestine appear mildly fluid and gas distended. The colon is significantly fluid distended, most consistent with gastroenterocolitis. Recommend empirical treatment. If a primary enteropathy is suspected, and symptoms are persistent, additional evaluation may be warranted.

Both adrenals are borderline large. This could represent anatomic variation, early Cushing's, etc. If Cushing's is present, this could be contributing to some of the symptoms reported (good appetite while not feeling well) but seems unlikely to be responsible for all of the symptoms reported.



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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