PATIENT

Zoey Harrenstine

SPECIES

Canine

BREED

Jack Russell Terrier

SEX

FS

AGE

10 years

WEIGHT

18 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

South Reno Veterinary Hospital

REFERRING VET

Dr. Schmitt

INVOICE

10845

DATE

12/2/2025

PRESENTING CLINICAL SIGNS

Owner reports no vomiting diarrhea coughing sneezing. Eating and drinking normal. Mobility and activity normal. Extremely active. Hunts birds. Recommend Senior wellness with dental prophylaxis.

Abnormal PE/Chem/CBC/UA Results: RADS attached for supplemental use Asymmetrical hepatomegaly. on rads. Bile Acids WNL- MS: 10/16/2025 at 11:13a: Chemistry screen: Moderate increased alkaline phosphatase 871- increased PSL 221 CBC: No significant finding Heartworm test antigen: No Antigen Detected Fecal: All undetected Urinalysis: Increased pH likely causing falsely increase protein. A: Hyper-alkaline phosphatemia concern for primary hepatic disease DDX: Idiopathic, inflammation, infection, toxin, neoplasia versus metabolic.

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 (3.9 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 cortical cyst noted measuring 0.3 cm. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.5 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 normal in size measuring 0.48 cm at the cranial pole and 0.6 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 normal in size measuring 0.63 cm at the cranial pole and 0.5 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 and shape, and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There are two subtle hypoechoic nodules in the parenchyma. One measures 0.56 cm, and the other measures 0.33 cm.

Liver

The liver is subjectively normal in size, rounded, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The

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visible portions of the vasculature and biliary tract appear normal. No focal mass lesion is observed. The right side of the liver appears more rounded/swollen in contour. There are occasional poorly defined hypoechoic nodules in the parenchyma. Examples on the right side measure 0.48 cm, and 69 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. 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 (0.38 cm), jejunum (0.25 cm) and ileum have a uniform diameter with minimal fluid distension. There is mild mucosal speckling visualized associated with the duodenum. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. 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 prominent, mottled and hyperechoic in the right limb. There is no evidence of nodules or cystic lesions. There is some reactive mesentery in the region. Changes are most consistent with mild chronic pancreatitis.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no significant lymphadenopathy visualized. A portal lymph node is prominent measuring 0.6 cm. 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.

Other

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

ULTRASONOGRAPHIC FINDINGS

- Two small hypoechoic nodules in the spleen. There are several, non-cavitated, hypoechoic splenic nodules visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis

- Pancreatic changes most consistent with mild chronic pancreatitis and pancreatic remodeling in the right limb.

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- Heterogenous rounded liver with occasional 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. 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.

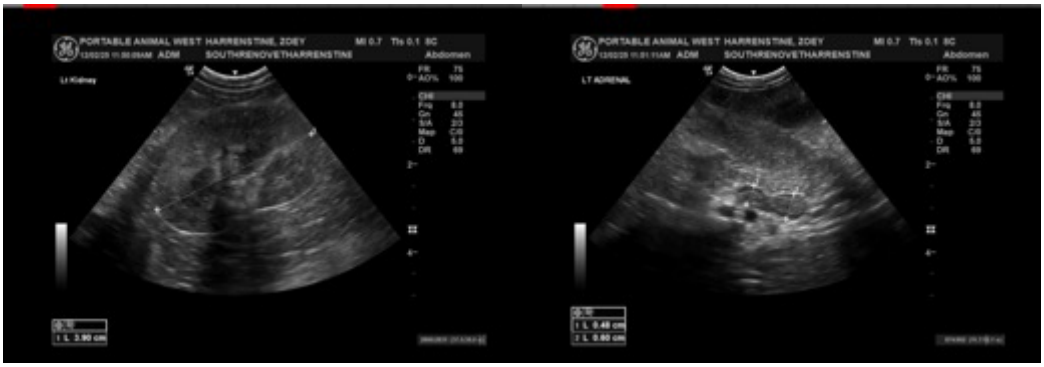
- Mildly thickened small intestine with mild mucosal speckling. Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc. in the mucosal crypts. The significance of this is uncertain in the absence of underlying gastrointestinal symptoms.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No significant focal lesions are visualized associated with the liver to explain the elevation in ALP reported. Findings could very well be consistent with a vacuolar hepatopathy. Although, other hepatopathies are possible. You could consider a liver function test and a fine needle aspirate of the liver to further investigate. Both adrenals appear normal in size making Cushing's disease less likely but not impossible. If classic symptoms are present, you could consider adrenal function testing.

There are two small hypoechoic nodules in the spleen. Options moving forward would include a fine needle aspirate or continued monitoring with ultrasound.

There are changes in the right limb of the pancreas most consistent with chronic active pancreatitis. Correlate with a PLI level and consider a low-fat diet. In the absence of symptoms, continued monitoring could be considered.



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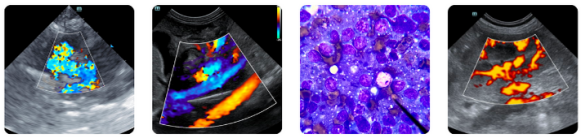

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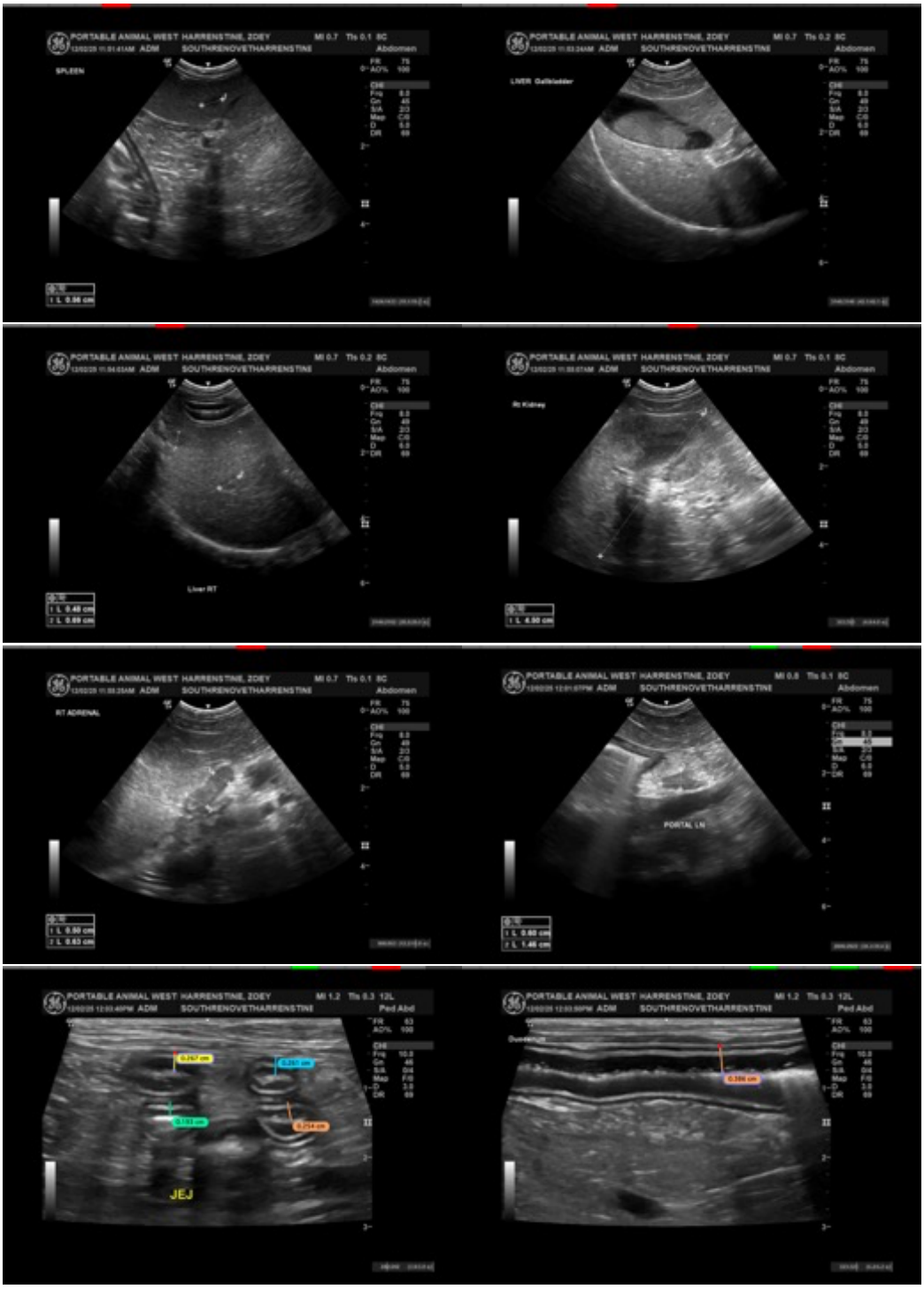

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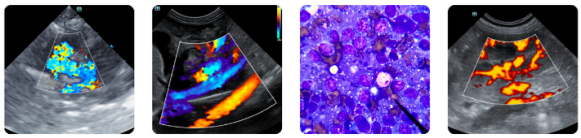

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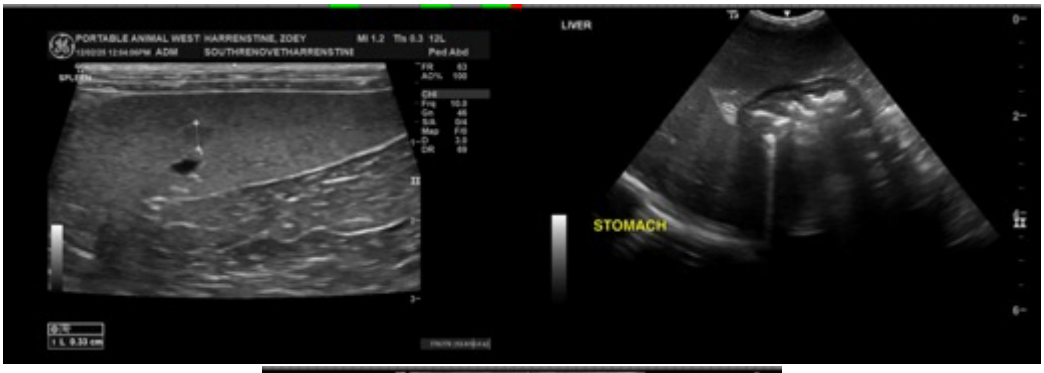

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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