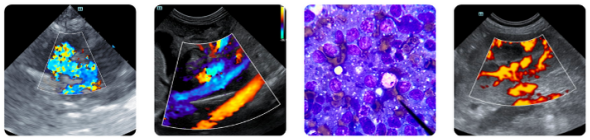


PATIENT

Stella Windmere Sesellee

SPECIES

Canine

BREED

Boxer Mix

SEX

Spayed Female

AGE

13 years 6 months

WEIGHT

20.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Mariusz Chmielinski

HOSPITAL NAME

Apex Veterinary Services Ltd

REFERRING VET

Alpine 24/7 – ER Doctor

INVOICE

11379

DATE

2/26/2026

PRESENTING CLINICAL SIGNS

- Inappetence/lethargy with markedly elevated liver enzymes; equivocal abdominal radiographic finding (possible ventral abdominal mass vs pyloric thickening).
- Presenting Complaint / History: Gradual decreased appetite since January with decreased energy. No vomiting or diarrhea reported.

Abnormal PE/Chem/CBC/UA Results: QAR; HR 116 bpm; CRT <2 sec; T - 38.2 CBC (IDEXX ProCyte): HCT 39.9% (low-normal), RBC/Hgb WNL. Mild lymphocytosis: 5.22 x10^9/L (slightly high); WBC and platelets WNL. Chemistry / SDMA (IDEXX Catalyst/SDMA): ALT 1767 U/L (markedly elevated; dilution 1:2) ALP 1218 U/L (markedly elevated) GGT 15 U/L Total bilirubin 17 µmol/L Cholesterol 8.09 mmol/L SDMA 17 , creatinine 94 µmol/L , BUN 7.8 mmol/L (WNL) Electrolytes largely WNL (Na 153, K 5.0, Cl 115) TP 76 g/L, albumin 32 g/L, globulin 44 g/L (A:G 0.7) Amylase 907 / lipase 647.

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 (5.82 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 (7.39 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

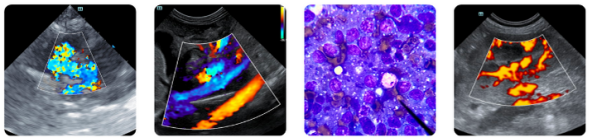
The left adrenal gland is normal in size measuring 0.51 cm at the cranial pole and 0.75 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.58 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 (1.26 cm) 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. No focal parenchymal abnormalities are visualized.

Liver



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The liver is large in size and rounded. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. In the region of the caudate lobe of the liver, there is a poorly defined, hyperechoic “mass effect” measuring 5.8 cm x 5.61 cm. A prominent rounded liver lobe could be an alternate differential.

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. Along with hypoechoic debris, there is hyperechoic shadowing debris most consistent with mineralized debris/small choleliths. The common bile duct is visualized at the level of the duodenal papillae measuring 0.27 cm.

Gastrointestinal

The stomach has moderate gas. 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. Gas interferes with evaluation of some regions of the stomach.

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 (0.63 cm in wall thickness) and the jejunum measured as normal (0.32 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 prominent and mottled in both limbs. There are occasional mottled, cystic regions visualized within the pancreas, particularly in the left limb. There is mild subjective reactive mesentery in the region.

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, mottled, cystic pancreas. Findings are most consistent with chronic pancreatic remodeling and chronic pancreatitis.
- Large, rounded, heterogenous liver with an ill-defined hyperechoic mass effect in the region of the caudate lobe. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy. If the mass lesion observed is a true mass, this could represent a primary hepatic mass lesion such as an adenoma, carcinoma, other.

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- Moderate/large gallbladder debris with mineralized debris/choleliths. 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 labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.

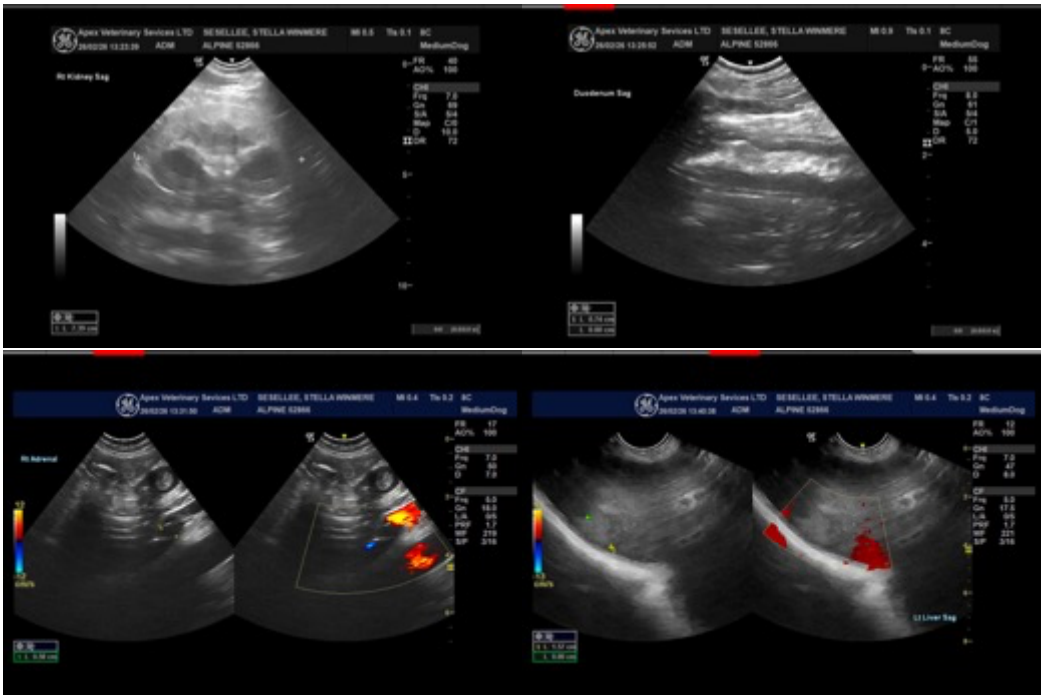
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is large, heterogenous and rounded. In the region of the caudate lobe there's a very poorly defined, hyperechoic rounded area concerning for a possible mass effect. Recommend a fine needle aspirate of the liver in this region and possibly in a more "normal" region as well. Based on the appearance of the liver, I am concerned that biopsies of the liver may be necessary to obtain a definitive diagnosis (histopathology, culture and copper levels.) Prior to this, cytology is recommended. Additionally, you could consider a contrast CT scan to better evaluate the "mass effect" described. If clinically appropriate, you could consider screening for leptospirosis and/or treating for acute liver injury with a course of ursodiol, denamarin, and antibiotics.

The pancreas appears irregular, mottled and cystic with some mildly reactive surrounding mesentery. These changes are most consistent with chronic active pancreatitis. Correlate with PLI level and consider empirical treatment for pancreatitis. Pancreatic neoplasia seems much less likely but cannot be ruled out. A fine needle aspirate could be considered.

There's a moderate to large amount of debris visualized in the gallbladder as well as some mineralized debris. Recommend starting ursodiol therapy and continued monitoring of the gallbladder and bile duct.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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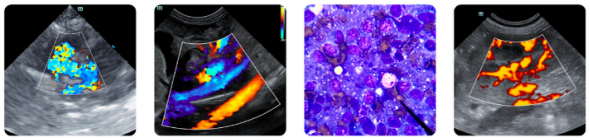

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SonoPath.com info@sonopath.com 1.800.838.4268

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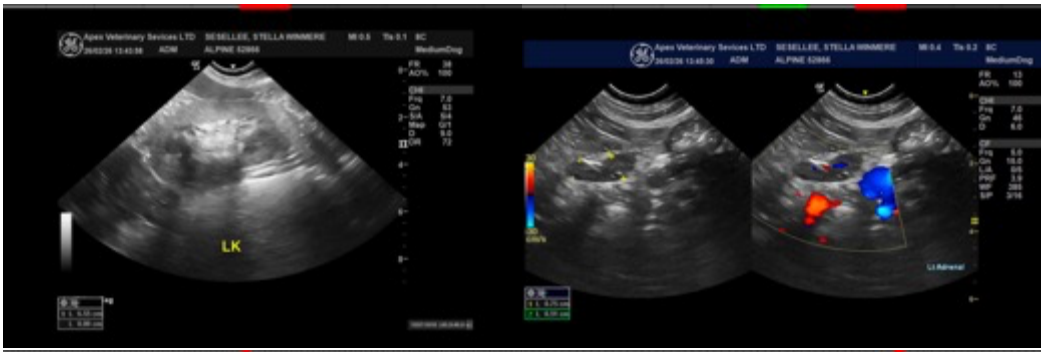

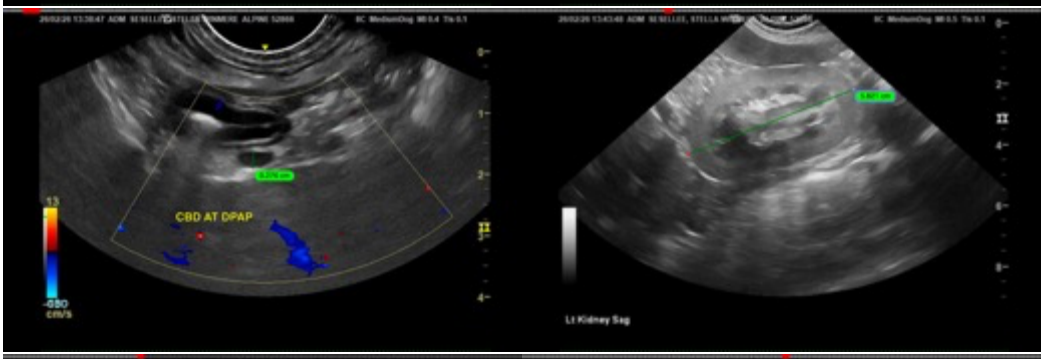

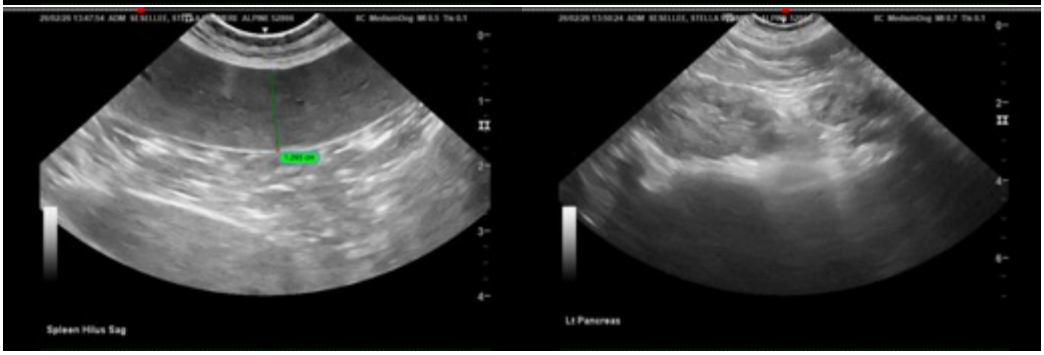

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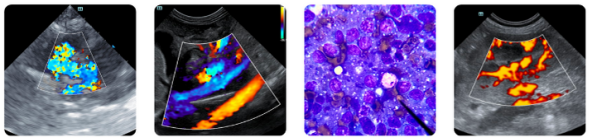

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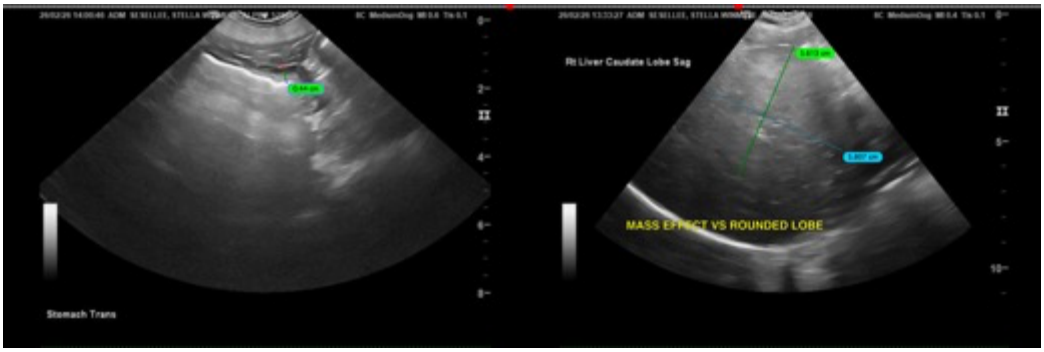

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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