# SonoPath

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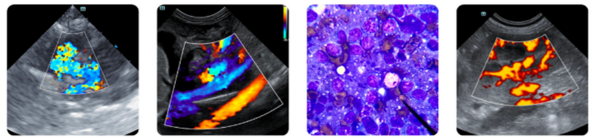


Clinical Sonography & Telecytology

Educational Teleconsultation Services™

**PATIENT**

Junie Yob

**SPECIES**

Canine

**BREED**

Mixed Breed

**SEX**

FS

**AGE**

9 years

**WEIGHT**

30.5

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Abby Gerenser

**HOSPITAL NAME**

Abby Road VH

**REFERRING VET**

Dr. Abby Gerenser

**INVOICE**

11417

**DATE**

3/4/2026

## PRESENTING CLINICAL SIGNS

- Patient has history of persistently elevated ALKP, has had ultrasound about 2 years ago, with gall bladder dilation being only finding
- Has been on Denamarin and Ursodiol since
- ALKP has steadily increased and patient is now proteinuric
- Intermittently has episodes of GI upset with lip smacking and appearing nauseous, responds to famotidine

Abnormal PE/Chem/CBC/UA Results: No significant PE abnormalities Labwork attached (ALKP elevated, proteinuric) Systolic BP ranging from 160-175.

## 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 (6.4 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 (6.35 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 0.53 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.

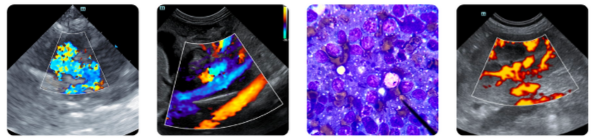
The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

### *Spleen*

The spleen is subjectively normal in size (2.21 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. There's a hyperechoic nodule visualized at the periphery of the spleen, most consistent with a benign myelolipoma measuring 1.16 cm.

### *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. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

### *Gastrointestinal*

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and 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 layering is adequate and there is no impression of reduced peristaltic activity. Shadowing ingesta in the stomach interferes with full evaluation of some areas of the stomach and some areas of the cranial abdomen.

The visualized areas of duodenum (0.43 cm), jejunum (0.34 cm) 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. There's rare mucosal speckling visualized associated with the small intestine. 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 area of the pancreas is normal and isoechoic to surrounding 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.

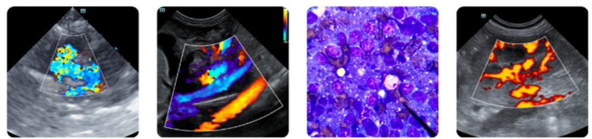
## PRIMARY FINDINGS

- Borderline plump left adrenal. Findings could be consistent with anatomic variation or mild hyperplasia. (The right adrenal is difficult to clearly discern. A nodule is not clearly visualized but cannot be definitively ruled out.)
- Large, heterogenous liver. Findings are most consistent with a vacuolar hepatopathy. Although, other hepatopathies are possible.
- Prominent/mildly thickened small intestine with some areas exhibiting 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.

## SECONDARY FINDINGS

- Age related changes visualized associated with both kidneys.
- Hyperechoic nodule in the spleen, most consistent with a benign myelolipoma. Recommend continued monitoring.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS





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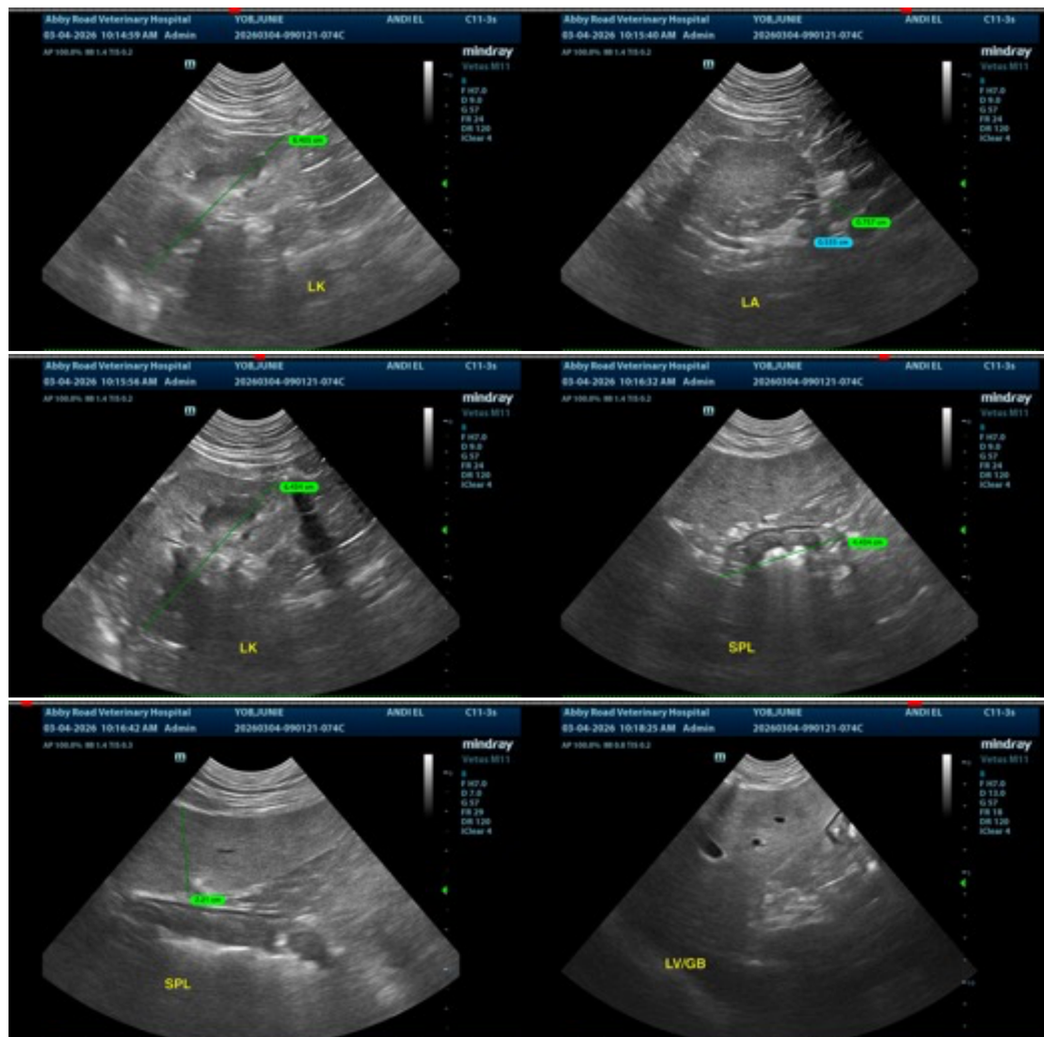
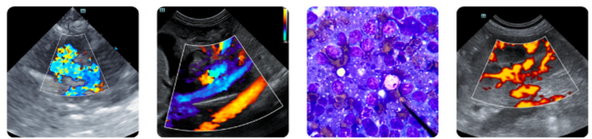
The left adrenal gland appears mildly prominent/plump. Findings could be consistent with mild hyperplasia. If further evaluation for Cushing's is desired, you could consider adrenal function testing.

The liver is large and heterogenous, most consistent with a vacuolar hepatopathy. Although other hepatopathies are possible. This could be associated with Cushing's, a primary vacuolar hepatopathy, etc. If further evaluation is desired, you could consider a liver function test and a fine needle aspirate of the liver (provided coagulation parameters are normal.)

The small intestine appears slightly prominent with some areas exhibiting mild mucosal speckling. In the absence of underlying gastrointestinal symptoms, the significance of this is uncertain.

If the blood pressure is repeatedly elevated as reported, consider medical intervention for hypertension.







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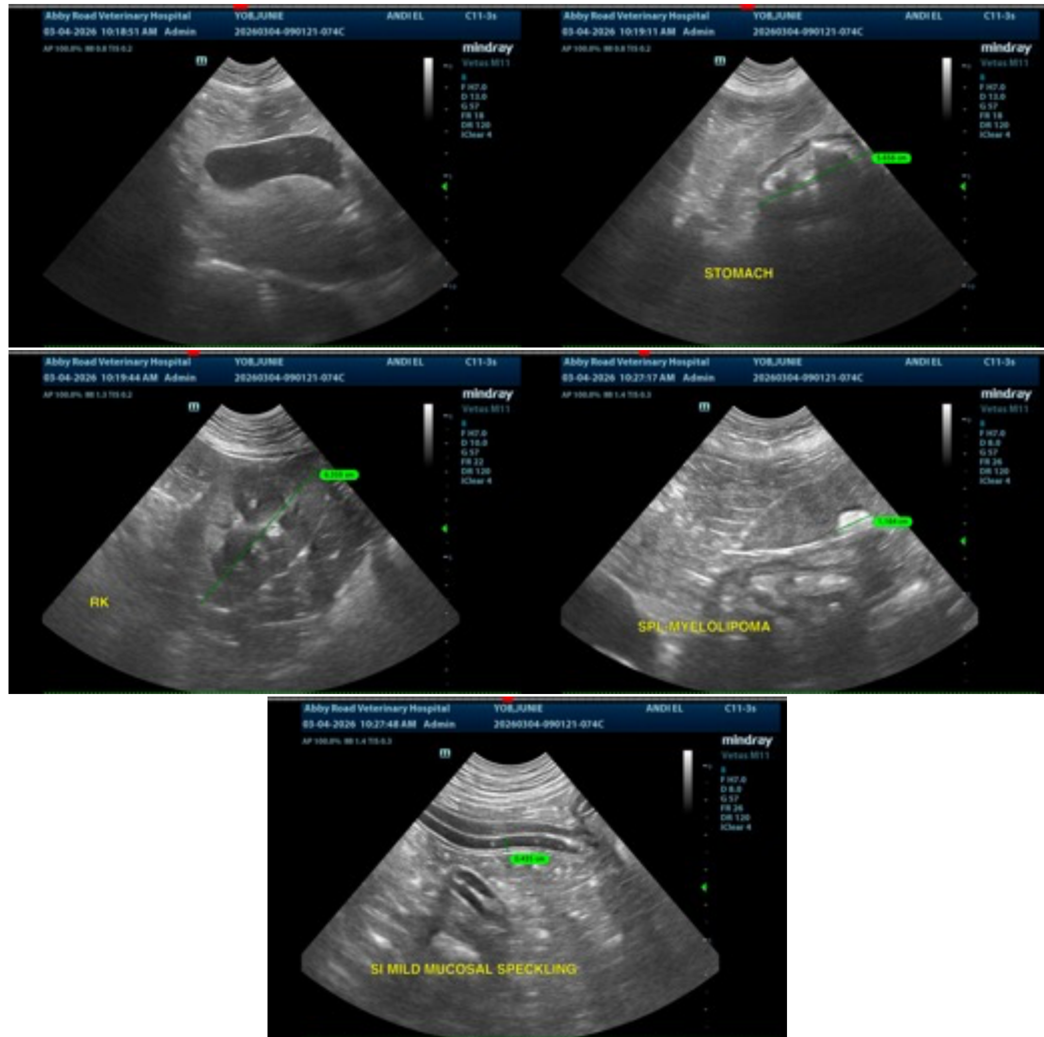


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

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