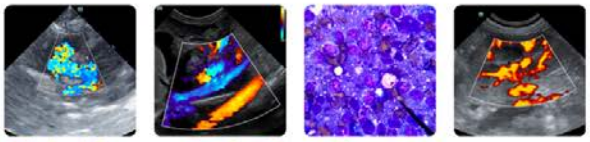


PATIENT

Gracie Meyer

SPECIES

Canine

BREED

Australian Shepherd x

SEX

Spayed Female

AGE

14 Years

WEIGHT

43 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Bailes

HOSPITAL NAME

All Creatures Great & Small Veterinary Clinic

REFERRING VET

Dr. Beth Marszewski

INVOICE

74525

DATE

4/16/26

PRESENTING CLINICAL SIGNS

Hx of chronic progressive liver value elevations as well as chronic intermittent vomiting - vomiting with increased frequency more recently. More recently has started drinking more water and urinating more often. Hx of food allergies - on strict hydrolyzed diet. Was scheduled for dental cleaning but owner elected to postpone in light of most recent labwork results and until further diagnostics can be performed. LDDST was rec'd but declined @ this time.

Abnormal PE/Chem/CBC/UA Results: Thin BCS, dental dz, otherwise NSF on PE Most recent BW: CBC: UR Chem: TP (7.7), Glob (4.1), ALT (262), AP (1050)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. The Bladder wall appears mildly thickened and irregular, measuring 0.66 cm in the apical view. The region of the trigone and ureteral papillae appear free of any mass lesions or calculi. The urethra is poorly visualized due to lack of urine distention.

The left kidney has a normal shape and size (5.74 cm) with numerous small non-obstructive nephroliths. 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.81 cm) with occasional shadowing non-obstructive nephroliths. 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.49 cm at the cranial pole and 0.56 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.

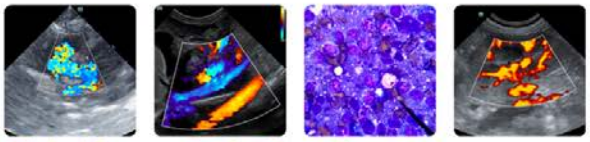
The right adrenal gland is normal in size measuring 0.65 at the cranial pole and 0.49 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (2.72 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 and rounded. 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 variably sized hypoechoic nodules noted throughout the parenchyma. Examples measure 0.99 cm and 1.03 cm.



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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 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. Duodenum wall measures 0.42 cm. Jejunum wall measures 0.35 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 right limb of the pancreas is prominent and mottled 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

- Mildly thickened, irregular urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Age related changes and non-obstructive mineralizations visualized associated with both kidneys.
- Pancreatic changes most consistent with chronic pancreatic remodeling.
- Large, heterogeneous 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.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

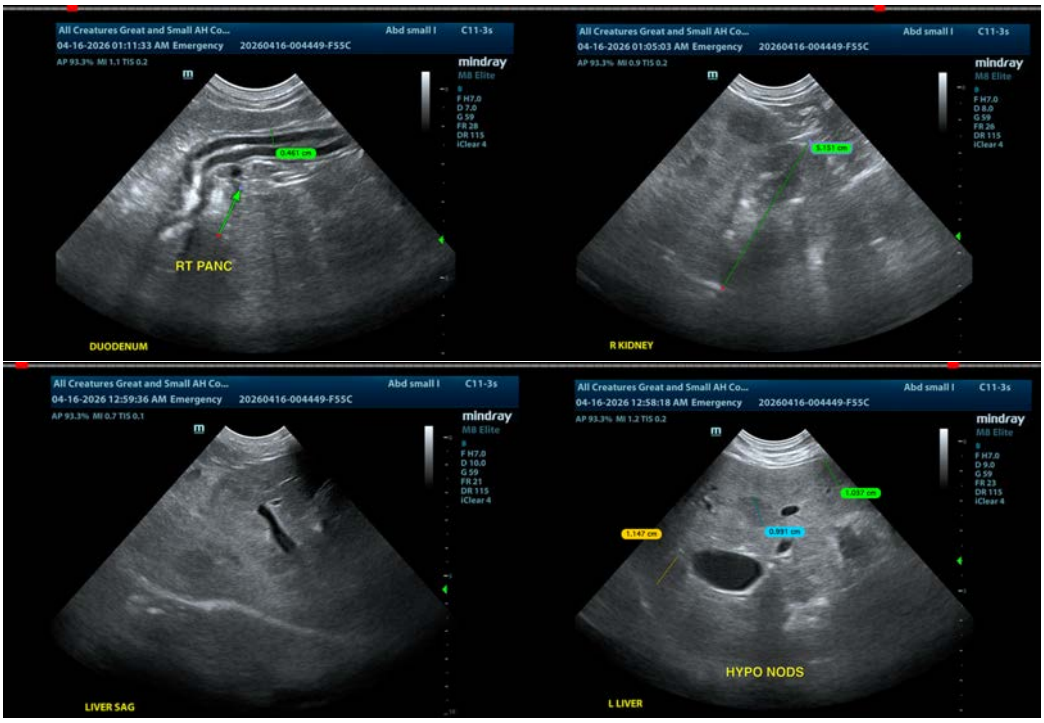
The liver appears large with too numerous to count hypoechoic nodules. These generally have an appearance most consistent with benign regenerative nodules or similar, although neoplastic nodules cannot be definitively ruled out. Further evaluation could involve a fine needle aspirate (provided coagulation parameters are normal) and a liver function test.

No focal lesions are visualized associated with the GI tract to explain the vomiting reported. Unfortunately, there are many causes for vomiting that cannot be definitively diagnosed by ultrasound alone. You could consider the following for further evaluation/treatment:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

If vomiting is persistent and underlying liver disease is unlikely to be the source (normal liver function), ultimately biopsies of the GI tract may be warranted. Additionally, you could consider repeat imaging in the future, looking for progression of today's lesions or the development of new lesions.

Recommend urinalysis and culture to further evaluate the appearance of the urinary bladder and the PU/PD reported.



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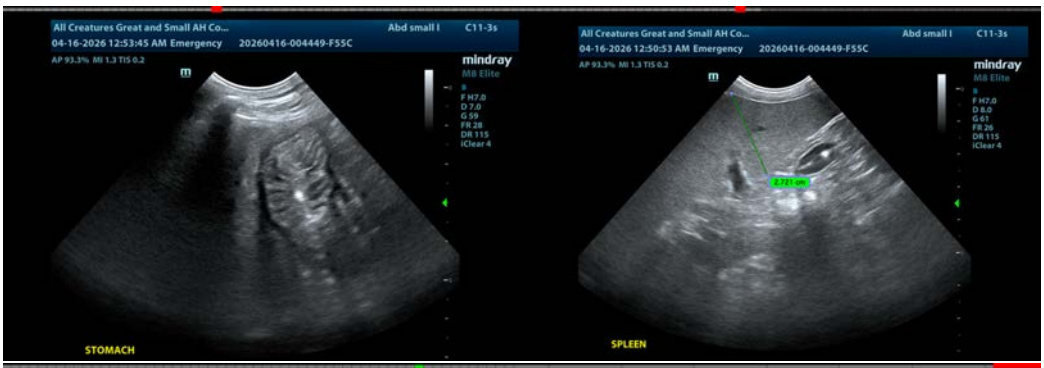

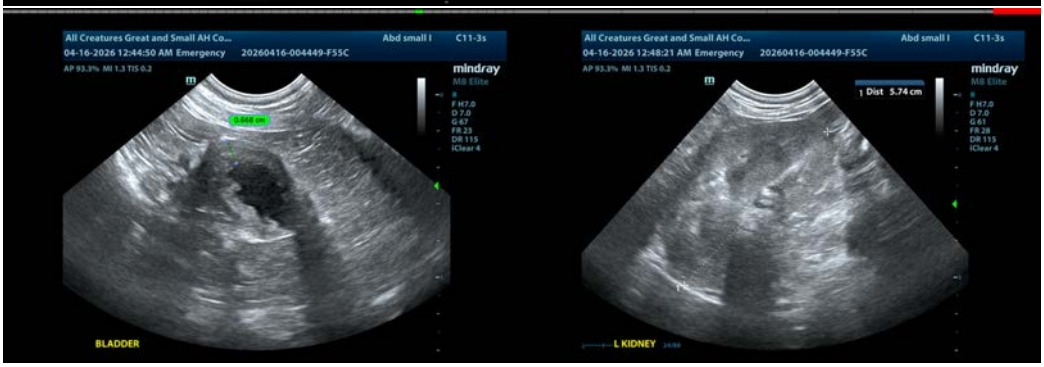

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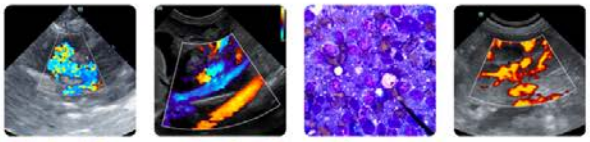

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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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