

DATE PRESENTING CLINICAL SIGNS

4/21/26

Patient History: Dementia has gotten worse lately. Seems lost a lot. ED normally, no VD. Urinary accidents in the house but could be behavioral. A few months ago she had episodes of urethral irritation but seemed to resolve. BP= WNL

PATIENT

Maxine Rose

Current Medications: Body Sore- 1 capsule BID, Ursodiol 125mg BID- has been on it since since 07/28/23 but increased on 1/24/24, Myos Muscle Supplement, Adequan- 0.44ml SQ q2 weeks, B12- 0.3ml SQ q2 weeks- 2 months, Tacrolimus and EDTA ophthalmic drops- 2 years, Denamarin Advanced Sm/Med Dog-1/2 tab SID. Vetriscience Hepaticlear Pro- 1/2 chew SID, Glycoflexx Plus- 1 chew daily, Fish Oil

SPECIES

Canine

Labwork Results: Labwork attached, reported as: 4/17/26: UPC- 1.5, CYSTATIN B- 364. 4/13/26: SDMA- 16, ALP- 1423, HGB-14.2, CYSTATIN B- 327, UPC- 2.5. 11/6/25: ALP-1292, HGB-14.2. 7/9/25: UPC- 0.4, CYSTATIN

BREED

Scottish Terrier

Date of Previous IntraPet Ultrasound: Yes. See attached.

Sedation: Gaba PO.

Stat Report: Not requested.

SEX

Imaging Performed by: Stephanie Warga RDCS, RVT.

Spayed Female

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

AGE

Urinary System

10/25/10

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.

WEIGHT

19.8 lbs

The left kidney has a normal shape and size (4.65 cm) with mild pyelectasia and occasional small cortical mineralizations. Overall echogenicity is slightly hyperechoic with mildly reduced 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 infarcts or hydroureter. Renal vasculature is normal.

INTERPRETED BY

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

The right kidney has a normal shape and size (4.65 cm) with occasional small cortical mineralizations. Overall echogenicity is slightly hyperechoic with mildly reduced 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.

HOSPITAL NAME

Fallston Veterinary
Clinic

Adrenal Glands

The left adrenal gland is normal in size measuring 0.56 cm at the cranial pole and 0.53 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.

REFERRING VET

Dr. Harvey

The right adrenal gland is normal in size measuring 0.90 cm at the cranial pole and 0.48 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.

INVOICE

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Spleen

The spleen is normal in size and shape. The blood flow through the hilus and splenic parenchyma appears normal. There is a somewhat poorly defined hyperechoic/mixed echogenicity nodule visualized in the mid body of the spleen measuring 2.15 cm x 1.36 cm (previous measurement on 5/6/25 was 2.16 cm – the lesion appears stable).

Liver

The liver is large in size and irregular in shape. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The vasculature appears normal. There are too numerous to count small hyperechoic pinpoint mineralizations in the parenchyma, most consistent with biliary mineralizations. Additionally, there are occasional ill-defined hypo- and hyperechoic nodules.

The gall bladder is large with a large amount of mucoid debris forming a stellate pattern, most consistent with mature mucocele. The wall appears mildly thickened, measuring up to 0.35 cm with the appearance of some mild surrounding inflammation. The bile duct appears normal/not clearly visualized.

Gastrointestinal

The stomach contains minimal luminal contents. The gastric wall appears slightly prominent and thickened (0.94 cm) with intact wall. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity.

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 0.34 cm. Jejunum wall measures 0.29 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. The descending colon wall is slightly prominent, measuring at 0.24 cm with intact wall layering.

Pancreas

The pancreas is mildly mottled. 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.

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.

PRIMARY FINDINGS

- Mixed echogenicity hyperechoic nodule in the spleen – This could represent a benign or neoplastic lesion. This appears stable from the previous exam, suggestive of a non-aggressive lesion.
- Large, irregular, heterogeneous liver with too numerous to count pinpoint mineralizations and occasional ill-defined hyper- and hypoechoic nodules – Findings are most consistent with a vacuolar hepatopathy and regenerative nodules. Mild chronic cholangitis cannot be ruled out. An early neoplastic process cannot be definitively ruled out.
- Gallbladder mucocele with a prominent/thickened gallbladder wall and some mild surrounding inflammation – The gallbladder mucocele appears to have progressed somewhat since the last evaluation with some concern for concurrent cholecystitis.

SECONDARY FINDINGS

- Age related changes visualized associated with both kidneys as well as mild pyelectasia of the left kidney.
- Pancreatic changes most consistent with mild pancreatic remodeling.
- Prominent gastric wall with intact wall layering – The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.
- Prominent colon wall with intact wall layering – The significance of this is uncertain. This could be consistent with mild colitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

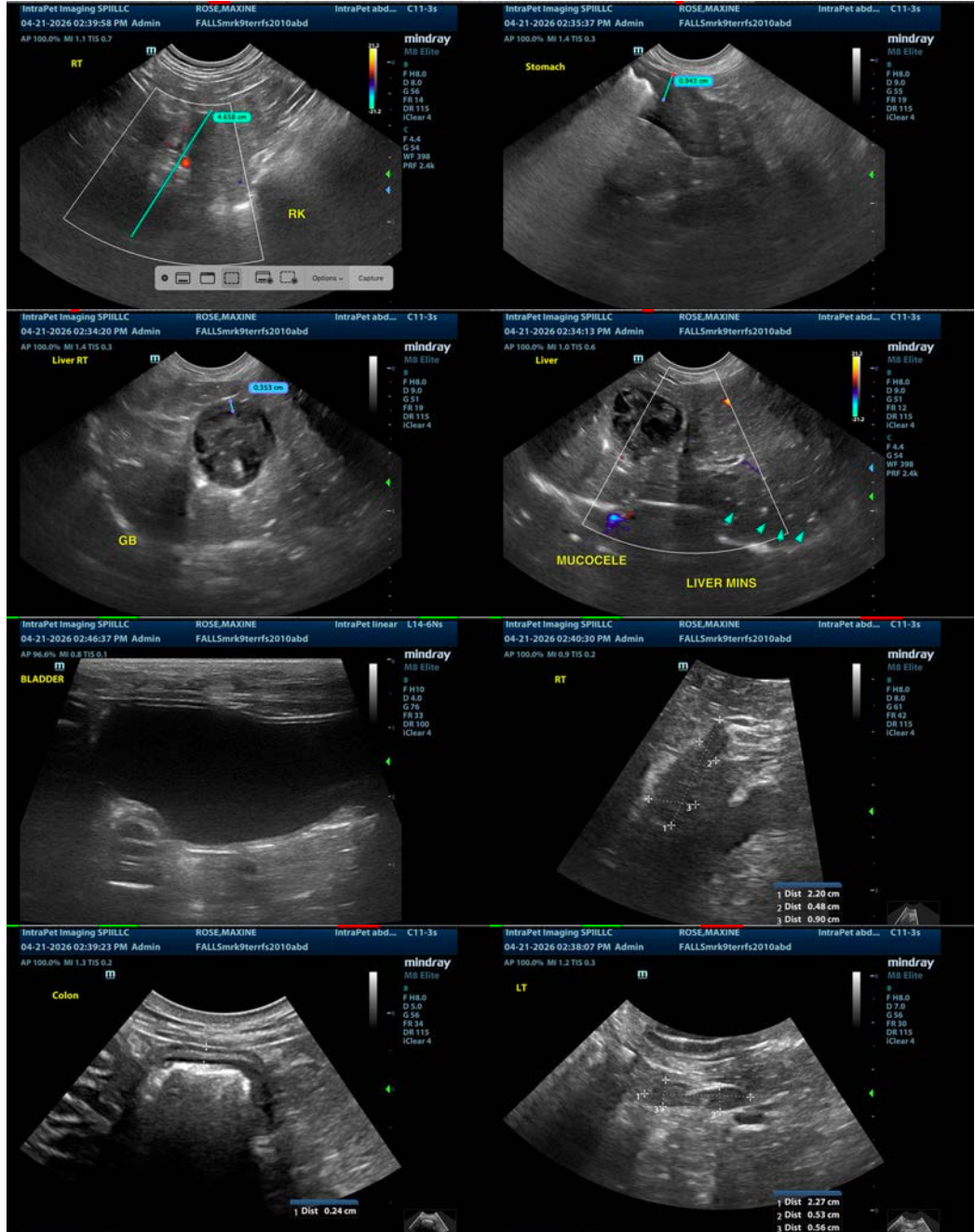
Many of the changes observed appear relatively stable on today's exam. This would include the renal changes and the splenic lesion.

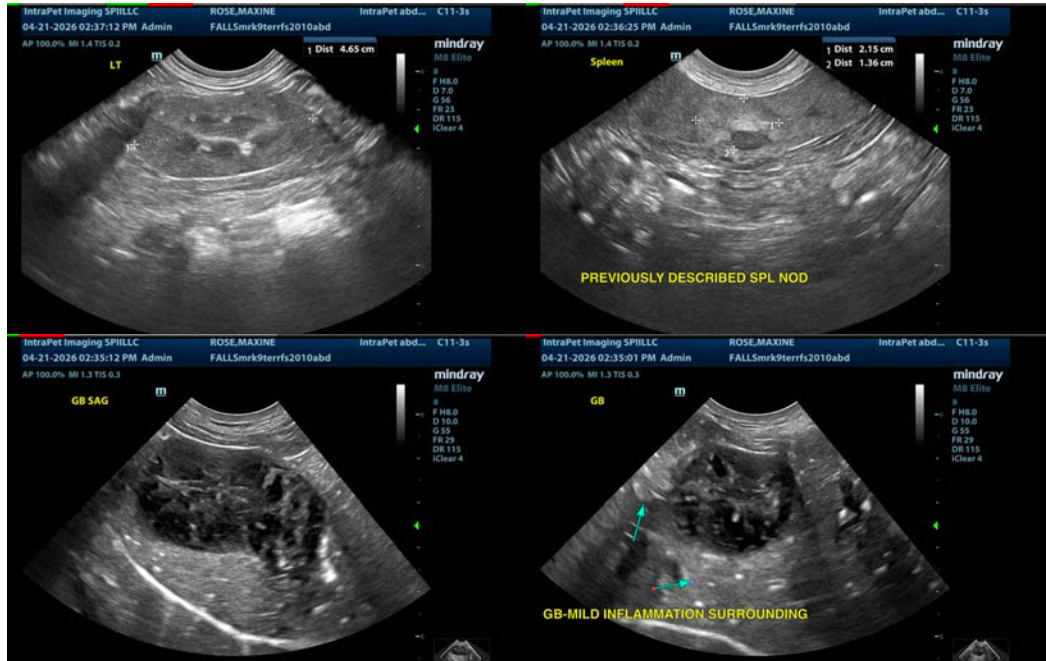
Subjectively, the gallbladder mucocele appears slightly more defined as a mucocele, and the gallbladder wall is more prominent with some mild surrounding reactive mesentery. This is mild and subjective, but there could be concern for concurrent cholecystitis. Typically, I would recommended surgery at this point out of an abundance of caution. Alternately, if the patient is clinically doing well, you could consider close continued monitoring or a course of antibiotics (in conjunction with probiotics) and continued monitoring of liver values and potential reevaluation of the gallbladder post therapy (typically 2-6 weeks depending on the patient).

The liver changes appear slightly more prominent on today's exam, but no definitive new focal lesions are concerning. Continued monitoring is warranted. If there is concern for cholangiohepatitis, you could consider a fine needle aspirate of the liver.

The colon and stomach wall appeared slightly prominent on today's exam. I suspect this is not clinically significant, but continued monitoring for any symptoms to suggest that these changes are more significant is recommended.







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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