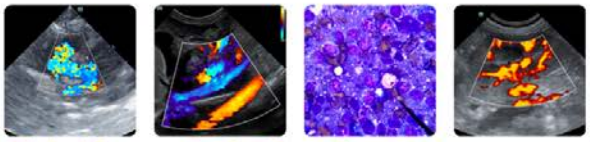




**PATIENT**

Willow Abar

**SPECIES**

Canine

**BREED**

Bichon Frise x Shih Tzu

**SEX**

Spayed Female

**AGE**

12 Years

**WEIGHT**

8.3 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Gira

**HOSPITAL NAME**

Prairie Winds Animal Clinic

**REFERRING VET**

Dr. Bhardwaj

**INVOICE**

74313

**DATE**

4/8/26

## PRESENTING CLINICAL SIGNS

Blood work was done as a dental consultation, Dr. recommended further testing on kidneys and liver and pancreas due to abnormalities. Patient is asymptomatic.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended with anechoic urine. The Bladder wall is diffusely severely thickened and irregular, measuring 0.74 cm in the apical region. The region of the trigone, ureteral papillae and proximal urethra are free of any mass lesions or calculi. Findings are suggestive of diffuse severe cystitis, although an underlying neoplastic process cannot be ruled out.

The left kidney has a normal shape and size (4.14 cm) with pyelectasia at 0.25 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.37 cm) with pyelectasia at 0.39 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is large, measuring 0.50 cm at the cranial pole and 0.72 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 large, measuring 0.71 cm at the cranial pole and 0.84 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.

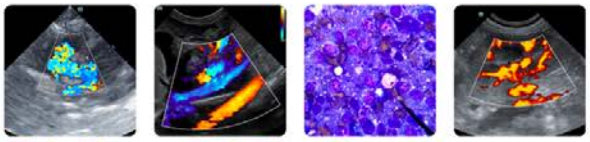
### *Spleen*

The spleen is subjectively normal in size (1.09 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 in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. There is a hyperechoic nodule in the left side of the liver measuring 2.0 cm x 1.85 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.





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### *Gastrointestinal*

The stomach contains mild fluid/shadowing ingesta. Gastric wall measures up to 0.77 cm. Some sections of gastric wall appear to have an irregular, thickened mucosal layering. Wall layering generally appears intact.

The visualized areas of duodenum, jejunum 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. Duodenum wall measures 0.43 cm. Jejunum wall measures 0.28 cm. Visualized peristalsis appears appropriate. There is mild mucosal speckling visualized associated with the duodenum.

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 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. There is no evidence of a significant lymphadenopathy. There are occasional prominent mesenteric lymph nodes. A jejunal lymph node is visualized measuring 0.58 cm. The omentum is generally normal in echogenicity.

### ULTRASONOGRAPHIC FINDINGS

- Thickened, irregular bladder wall – Findings are most consistent with severe cystitis. An underlying neoplastic process is less likely.
- Decreased corticomedullary distinction in both kidneys with bilateral pyelectasia – Pyelectasia of the kidneys could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Bilateral adrenomegaly – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.
- Pancreatic changes most consistent with chronic pancreatic remodeling.
- Large, hyperechoic liver with a large, hyperechoic nodule – The diffuse hepatic changes are non-specific and can be seen with vacuolar hepatopathy, reactive change, nodular hyperplasia or, less likely, inflammatory/immune-mediated disease, infiltrative neoplasia, or other hepatopathy. The hyperechoic lesion has an appearance most consistent with an early adenoma, although other differentials are possible.
- 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.

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- Areas of thickened, irregular gastric wall with intact wall layering – Findings are suggestive of gastritis, mucosal hyperplasia, etc. An underlying neoplastic process cannot be definitively ruled out.
- Mildly thickened small intestine with mucosal speckling – Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

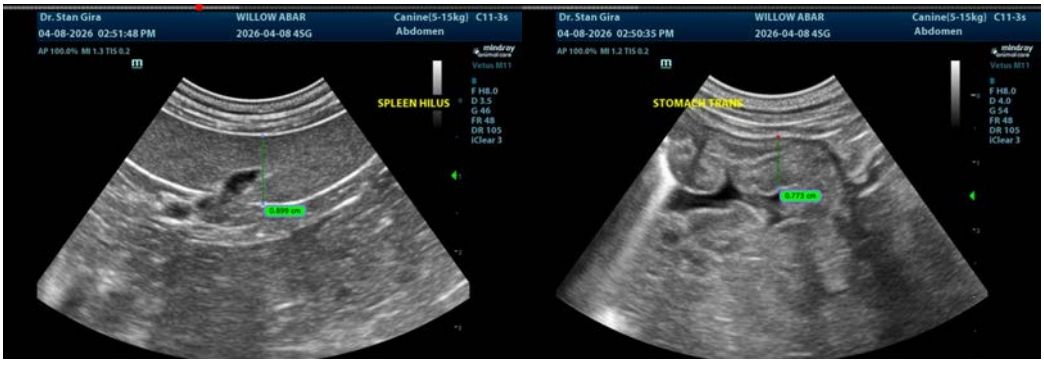
The liver is large and hyperechoic with a hyperechoic nodule on the left side. Findings are most consistent with a vacuolar hepatopathy, although other hepatopathies are possible. The hyperechoic lesion has a somewhat benign appearance, but continued monitoring is warranted.

Additionally, both adrenals are large. The hepatic changes in light of the adrenal enlargement could increase concern for pituitary dependent hyperadrenocorticism. If this fits, consider adrenal function testing.

Both kidneys have changes consistent with chronic renal disease and pyelectasia. Additionally, the urinary bladder is severely thickened and irregular. Strongly recommend a urine culture once off antibiotics for at least 5-7 days, as there is concern for severe cystitis and possible pyelonephritis. If a urine culture is negative, consider traumatic catheterization to obtain biopsies of the bladder wall for histopathology and culture.

The stomach is somewhat prominent with some areas of gastric wall appearing to have a prominent irregular mucosal layer and generalized thickening. This could be mucosal hypertrophy/hyperplasia. In the absence of underlying gastrointestinal symptoms, the significance is uncertain. Further evaluation would likely involve upper GI endoscopy. This could also be reassessed in 4-6 weeks along with the urinary bladder to determine if these changes are persistent.

The duodenum appears somewhat prominent with some mild mucosal speckling. In the absence of underlying gastrointestinal symptoms, recommend continued monitoring.



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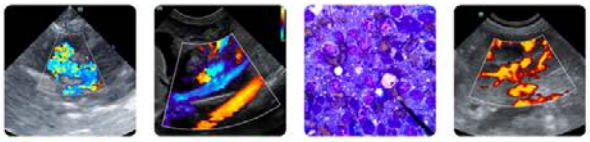

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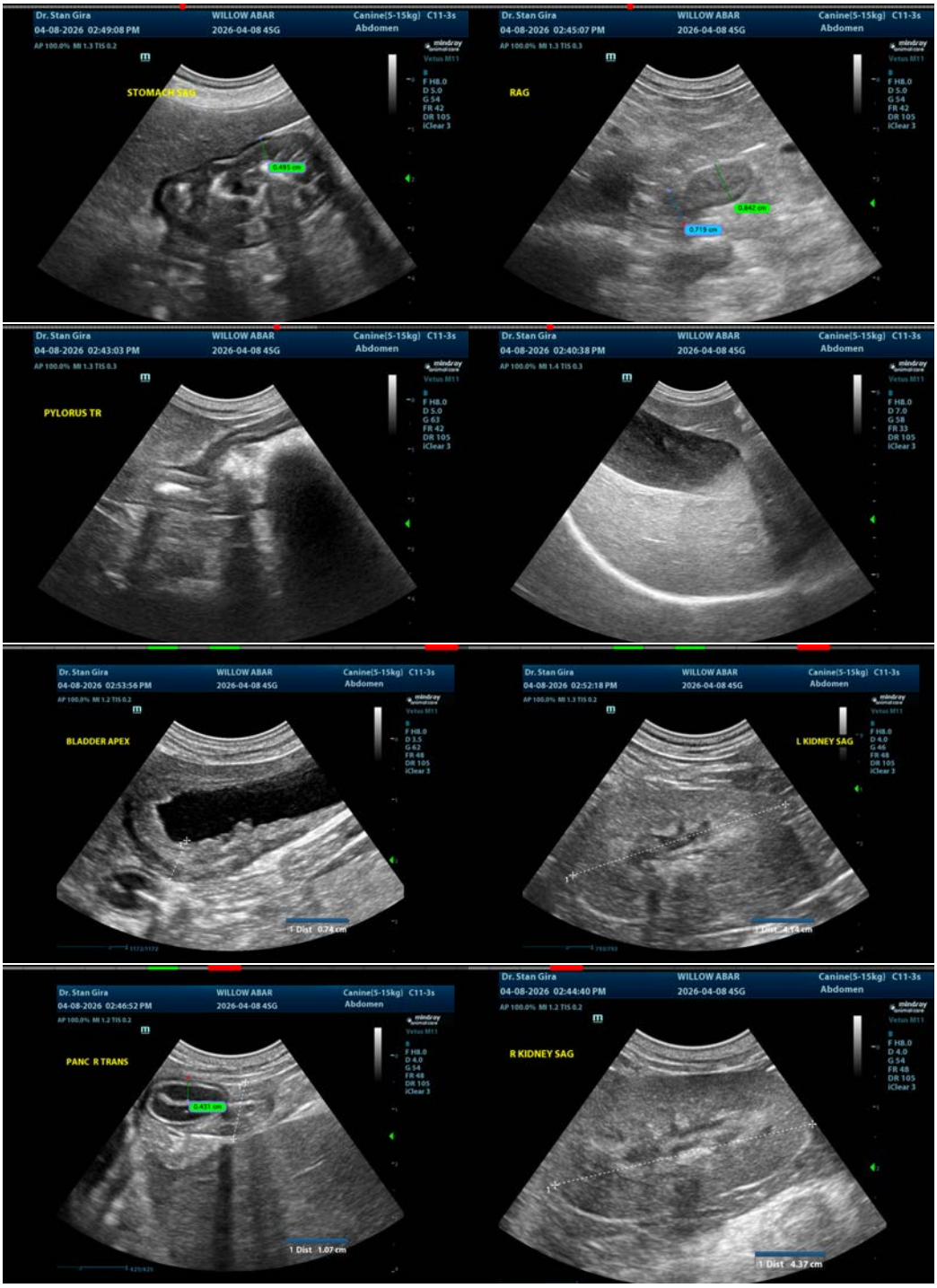

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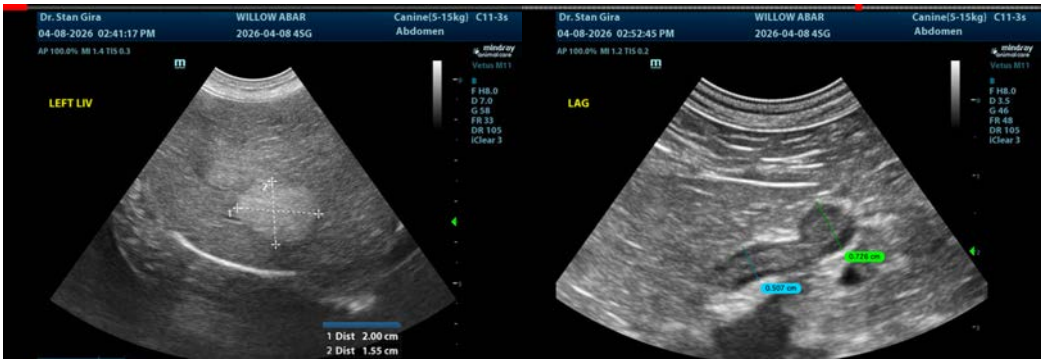


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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