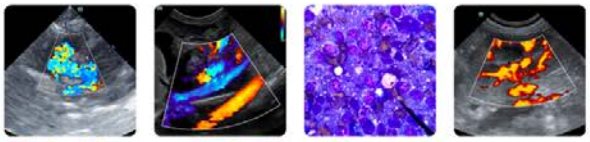


PATIENT

Scarlet Myers

SPECIES

Canine

BREED

Goldendoodle

SEX

Spayed Female

AGE

11 Years

WEIGHT

38.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Megan Cassels-Conway, DVM

HOSPITAL NAME

Central Broward Animal Hospital

REFERRING VET

Megan Cassels-Conway, DVM

INVOICE

75003

DATE

5/6/26

PRESENTING CLINICAL SIGNS

Presented 4/9/26 for seizures 1 the night prior and 1 the morning of presentation, first occurrence. Liver enzymes elevated. Brief US at the time showed hyperechoic nodule in right liver and moderate gallbladder debris. Started on clavamox, metronidazole, ursodiol for 2 weeks and 1 month denamarin. Keppra was initiated and began tapering after 1 week due to owners concern of making P sedate and liver enzymes improved. 10 days off clavamox, metronidazole and ursodiol, P had a seizure. Resumed keppra. Came in the next day for exam. Liver enzymes increased again. Mild chronic ALP elevation. P had been started on carprofen in February for OA of hips. Carprofen discontinued 4/9/26 after initial liver enzyme elevation. Sedated with 0.2mg/kg butorphanol for ultrasound. Bile acids pending.

Abnormal PE/Chem/CBC/UA Results: 5/5/26 (seizure the night prior, off meds 10 days, still on denamarin) NSAID: ALT 365, ALP 459, AST 59 4/23/26 (completed 2 week course abx and ursodiol) NSAID: ALT 185, ALP 319 4/17/26 NSAID: ALT 172, ALP 411 (prev 4/9 ALT 909, ALP 633) PCV:50% TP:7.9 Blood and urine Lepto PCR: Neg 4/9/26 CBC stat WNL Chem 17 lytes: Glob 4.7, ALT 909, ALP 633, Chol 447 PCV 40% TP 8.6 UA: 1.023, 1+ protein Accuplex: NEG 3/6/26 (2 weeks on carprofen) CBC: WNL CHEM: ALP 241, ALT 108 10/24/25 CBC: WNL CHEM: ALP 267, Chol 389 T4: WNL U/A: 1.025, 1+ protein

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.

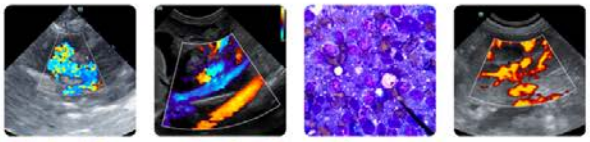
The left kidney has a normal shape and size (4.97 cm). Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.41 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 large measuring 0.91 cm at the cranial pole and 0.91 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is slightly irregular in appearance in that there is the suggestion of a hyperechoic nodule in the cranial and caudal poles, most consistent with prominent medulla. Continued monitoring is warranted.

The right adrenal gland is normal in size measuring 0.80 cm at the cranial pole and 0.57 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.



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Spleen

The spleen is subjectively normal in size (1.6 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 normal/borderline large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is a hyperechoic nodule visualized in the cranial right aspect of the liver measuring 1.45 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.

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 0.37 cm. Jejunum wall measures 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 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.

ULTRASONOGRAPHIC FINDINGS

- Plump left adrenal with a prominent cortex – The significance of this is uncertain. This could be consistent with mild hyperplasia. Recommend continued monitoring.
- Age related changes visualized associated with both kidneys.
- Mildly heterogeneous liver with a hyperechoic nodule – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic

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hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The hyperechoic nodule has an appearance most consistent with a benign lesion. An early neoplastic lesion cannot be ruled out.

- 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.

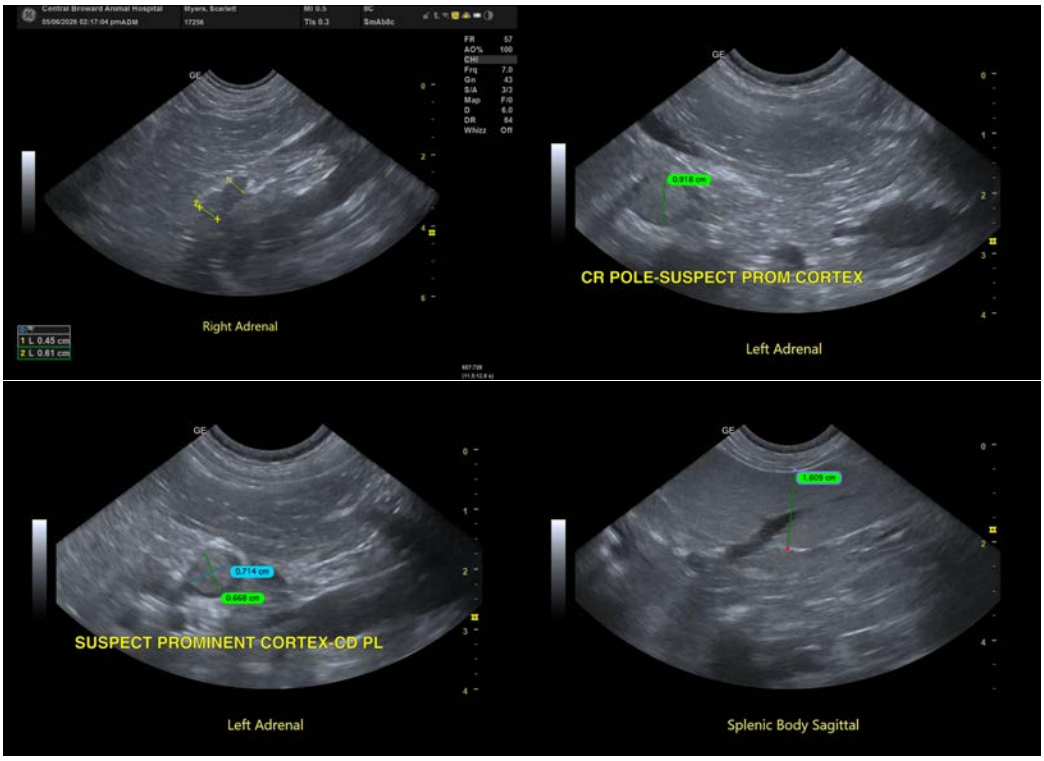
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver changes noted are relatively mild and non-specific. The focal hyperechoic nodule has a somewhat benign appearance, and the location would make a fine needle aspirate challenging. Consider continued monitoring (recheck in 2-3 months).

The left adrenal is plump. The medullary region appears somewhat prominent and hyperechoic, most consistent with mild hyperplasia, although an early neoplastic process cannot be ruled out. The right adrenal appears relatively normal. Recommend reevaluation of the adrenal along with the liver nodule.

The liver changes are non-specific. If further evaluation is desired, recommend pre- and post-prandial bile acids (I suspect this is currently pending), and a fine needle aspirate of the general liver parenchyma (provided coagulation parameters are normal).

Additionally consider reevaluation of liver values not post-seizure, as this can cause temporary rises in liver enzymes due to excessive muscle activity, etc. Ultimately, if liver values are persistently elevated with abnormal bile acids, biopsies of the liver may be warranted with samples for histopathology, culture and copper levels.



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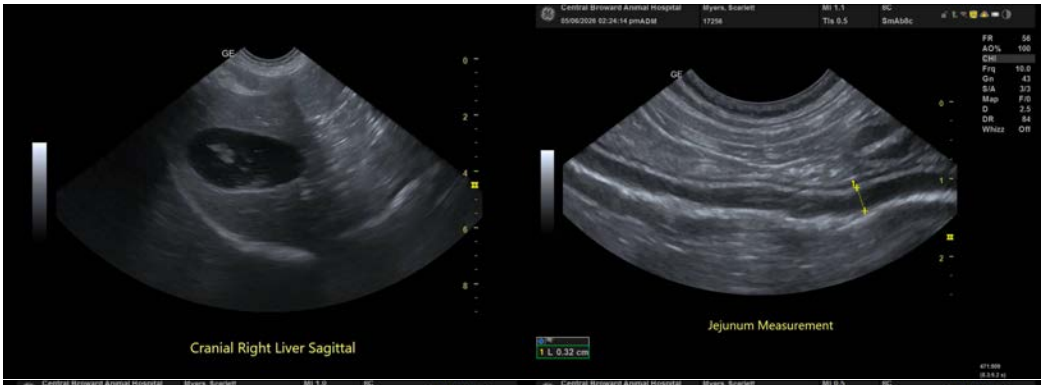

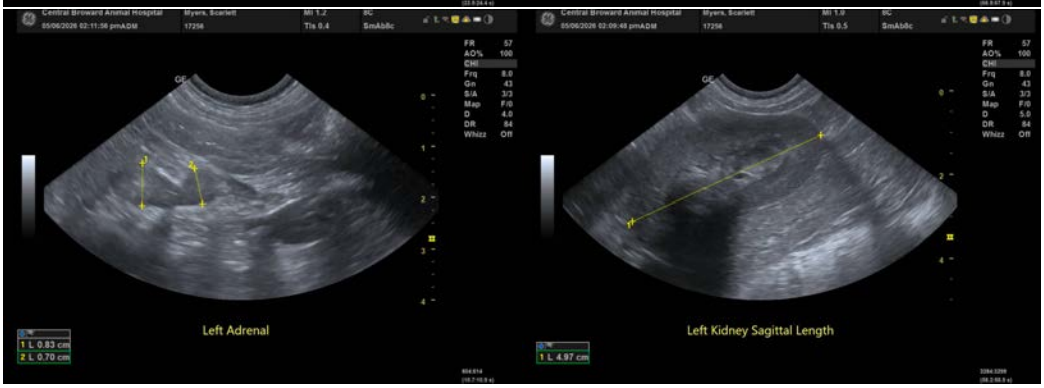

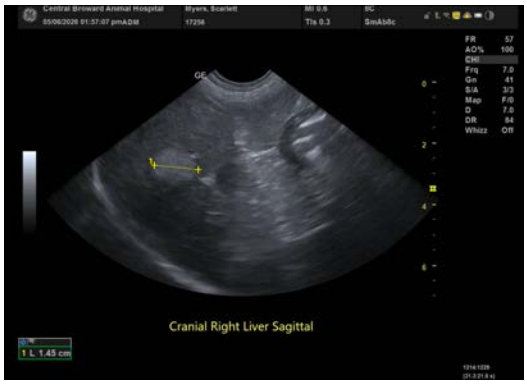

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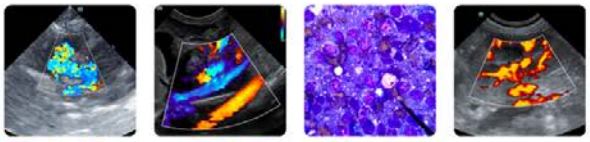

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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