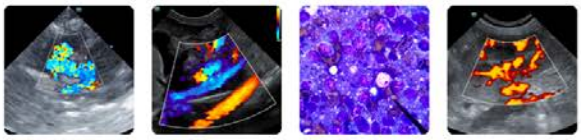


DATE

5/7/26

PATIENT

Oliver Griggs

SPECIES

Canine

BREED

Multi Poo

SEX

Neutered Male

AGE

10/14/11

WEIGHT

12.2 lbs

INTERPRETED BY

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

HOSPITAL NAME

Docside Veterinary Medical Center

REFERRING VET

Dr. Tierney

INVOICE

75032

PRESENTING CLINICAL SIGNS

Patient History: Due for annual, needs to scheduled AUS/Echo for yearly recommended check.

Current Medications: None listed.
Labwork Results: Labwork attached, reported as: CBC* WNL *Chemistry* ALT 175 (was 142), ALP 735 (was 438), Calcium 12.6 (was 8.9)., Cholesterol 538 (was 440), Triglycerides 294, very mildly elevated (was 201) PSL mildly elevated at 170 (was 115). T4 2.1 WNL *Urinalysis* USG 1.019, pH 7.0, protein negative, sediment benign. DT: 03-11-26 at 8:37a: CBC WNL. CHM shows elevated and mildly increasing ALT (175 was 142) and ALP (735 was 438) as well as mildly incr chol (538)
Date of Previous IntraPet Ultrasound: 5/9/25. See attached.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

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 prostate is normal in size (1.08 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (3.45 cm). Overall echogenicity is slightly hyperechoic with mildly 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 (3.63 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.58 cm at the cranial pole and 0.58 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 0.52 cm at the cranial pole and 0.54 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 (1.01 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 is a small complex cystic lesion visualized in the mid cranial region of the liver measuring approximately 2.0 cm x 1.57 cm. Additionally, there are numerous small hyperechoic nodules in the mid region of the liver. Examples measure 0.61 cm and 1.29 cm. There is a larger poorly defined, subtle hypoechoic mass effect visualized in the left caudal aspect of the liver measuring 1.98 cm x 3.04 cm.

The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris and there is organization and stranding of this debris into a mucocele. There is some somewhat poorly defined mineralized material visualized within the lumen possibly consistent with a cholelith, measuring approximately 1.01 cm in diameter. There is minimal surrounding inflammation and no obvious free fluid observed. The bile duct is normal/not visible. Findings are consistent with a mucocele. Consider close monitoring and initial medical management.

Gastrointestinal
The stomach contains minimal luminal contents. It measures at a normal thickness of 0.38 cm 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 0.45 cm. Jejunum wall measures 0.27 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 appears somewhat thickened distally with intact but reduced detail of wall layering, measuring at 0.33 cm.

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. No significant lymphadenopathy noted. The omentum is of normal echogenicity.

PRIMARY FINDINGS

- Large, heterogeneous, rounded liver with a small complex cystic lesion in the mid cranial region, occasional small hyperechoic nodules, and a largely poorly defined hypoechoic mass effect on the left side – These lesions have a somewhat benign appearance, particularly the hyperechoic nodules and the cystic lesion. The larger lesion could represent a large regenerative nodule, an adenoma, early carcinoma, other. Generalized enlargement could be consistent with vacuolar hepatopathy or other hepatopathy.

- Mature gallbladder mucocele.

- Thickened descending colon wall – Findings could be consistent with mild focal colitis. An early neoplastic process cannot be ruled out.

SECONDARY FINDINGS

- Age related changes visualized associated with both kidneys.

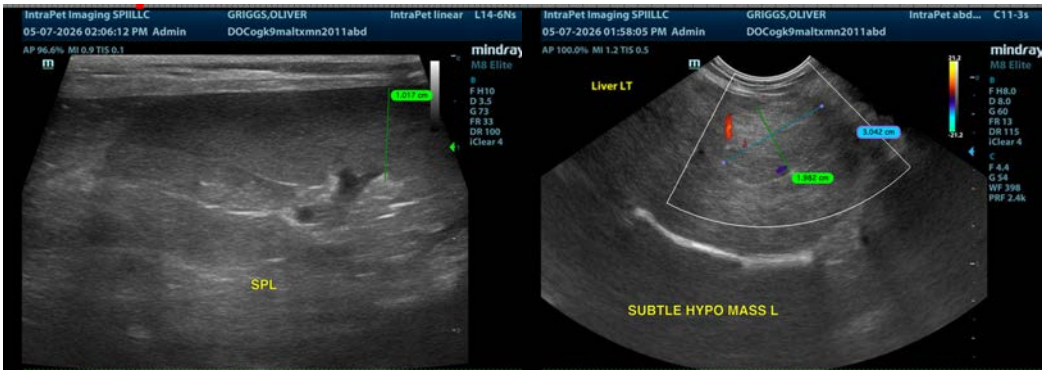
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

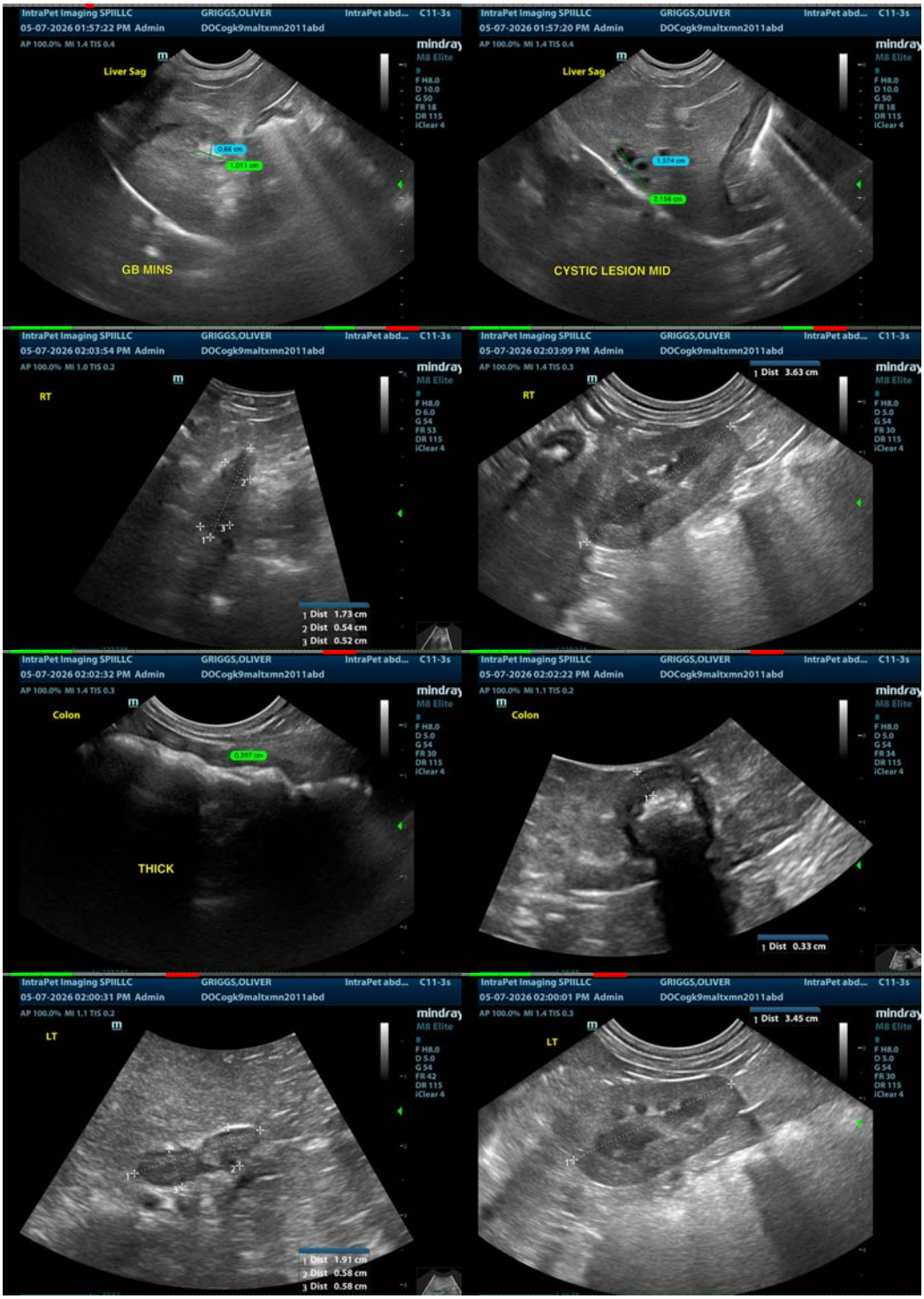
The gallbladder has mildly progressed into a mature mucocele. Significant inflammation in this region is not evident. Surgical removal would typically be recommended. Considering the patient's age, an option of close monitoring could be considered with the intention of prompt evaluation if symptoms occur.

There are some small lesions visualized associated with the liver. This includes a small slightly cystic area that likely represents a cystadenoma, possibly a cystadenocarcinoma. This would be too deep to sample. Recommend continued monitoring. Additionally, there are some hyperechoic nodules that have a somewhat benign appearance. There is a larger, subtle hypoechoic lesion in the left caudal aspect of the liver that has a somewhat benign appearance but could represent an early adenoma, carcinoma, other. Options would include continued monitoring or a fine needle aspirate. The liver itself appears large and rounded, most consistent with a vacuolar hepatopathy. If further evaluation is considered, recommend pre- and post-prandial bile acids and a fine needle aspirate of both the mass lesion and the general hepatic tissue.

The distal colon wall is prominent and slightly thickened. The significance of this is uncertain in the absence of diarrhea, hematochezia, straining, etc. Consider probiotic therapy and continued monitoring/possible reevaluation in 2-3 months, sooner if symptoms occur. Further evaluation would likely involve a colonoscopy.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).

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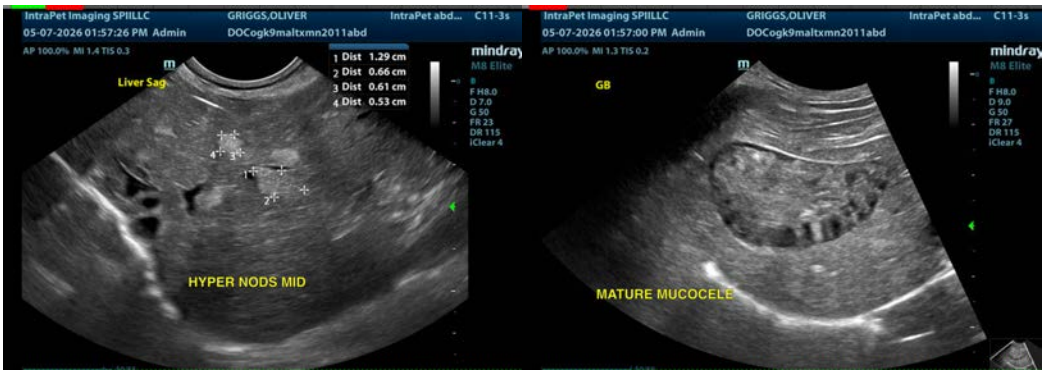

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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