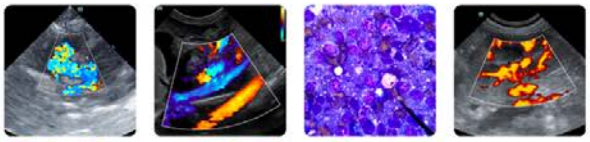




**PATIENT**

Otis Carrick

**SPECIES**

Canine

**BREED**

Labradoodle

**SEX**

Neutered Male

**AGE**

14 Years

**WEIGHT**

23.6 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Sara Barthelemy

**HOSPITAL NAME**

Southwood Veterinary Hospital

**REFERRING VET**

Dr. Harris

**INVOICE**

75010

**DATE**

5/6/26

## PRESENTING CLINICAL SIGNS

Previous AUS in March to assess marked liver enzyme elevations - this has drastically improved and clinically doing much better. New finding is irregularly irregular rhythm characterized by periodic VPC

Abnormal PE/Chem/CBC/UA Results: ALT 238 (previous 837) ALP 334 (previous 538) Creatinine 298 and SDMA 22 Mills elevated platelets 442

## 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 visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (4.39 cm) with pyelectasia and 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.

The right kidney has a normal shape and size (6.4 cm) with pyelectasia at 0.23 cm and mild 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.

### *Adrenal Glands*

The left adrenal gland is large but normal in shape, measuring 0.71 cm at the cranial pole and 0.79 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is slightly abnormal in that it is large and there is a small anechoic structure in the caudal pole measuring 0.31 cm, possibly consistent with a cystic lesion or similar. No evidence of vascular invasion visualized. A partially occlusive thrombus is visualized in the aorta at the level of the kidney.

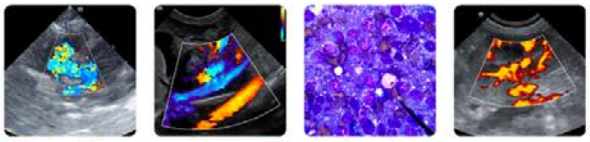
The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

### *Spleen*

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a mixed echogenicity, poorly defined lesion in the parenchyma measuring 0.63 cm, possibly consistent with myelolipoma.

### *Liver*

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.





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The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

### *Gastrointestinal*

The stomach contains moderate shadowing ingesta and fluid. 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 0.32 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 area of 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. There is a large thrombus in the distal aorta at the level of the trifurcation. This subjectively appears somewhat flattened and remodeled/contracted and appears partially occlusive (1/3 to ½ of lumen diameter), allowing adequate blood flow to the distal extremities. The omentum is of normal uniform echogenicity.

## ULTRASONOGRAPHIC FINDINGS

- Large left adrenal gland (suspect bilateral adrenomegaly based on previous exam), with a small hypoechoic nodule in the caudal pole – Findings could be concerning for pituitary dependent hyperadrenocorticism/bilateral hyperplasia or anatomic variation. The small hypoechoic nodule is of uncertain significance. Recommend continued monitoring.
- Age related changes and mild pyelectasia associated with both kidneys – Pyelectasia of the kidneys could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Subtle mixed echogenicity nodule in the spleen – This is small and poorly defined, possibly consistent with a myelolipoma. Recommend continued monitoring with ultrasound.
- Heterogeneous liver – 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.

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- Large gallbladder debris – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.

- Moderate shadowing ingesta visualized within the gastric lumen – Correlate with feeding history. If the patient was adequately fasted this could represent delayed gastric emptying (barring unseen outflow tract obstruction).

- Suspect remodeling/contracting extensive aortic thrombus – This is visualized at the level of the left kidney and distally at the level of the trifurcation.

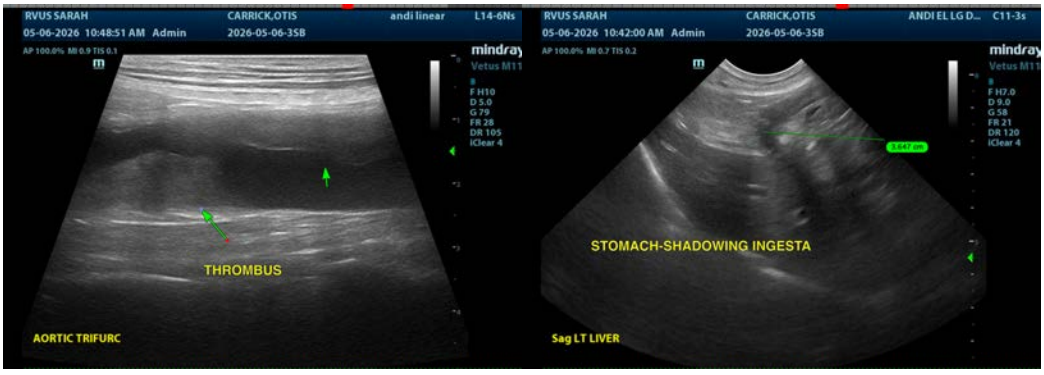
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The thrombus within the distal aorta is visualized on today's exam. It appears to occlude maximally at ½ the lumen diameter, but typically at 1/3 or less, allowing adequate blood flow to the caudal extremities. Subjectively, the clot appears somewhat rounded and contracted, potentially remodeling.

With a combination of adrenomegaly and liver changes, there could be the possibility of Cushing's disease. If symptoms consistent with Cushing's disease are present, consider adrenal function testing.

The gallbladder still has a large amount of echogenic debris with a prominent but not overtly thickened wall. Recommend lifelong continuation of Ursodiol and potential treatment for cholecystitis if liver values increase again.

The previous infection +/- Cushing's disease could be responsible for the hypercoagulable state causing the thrombus. If not already done, recommend a urine protein to creatinine ratio, looking for significant proteinuria, as this can often be a contributing factor. Recommend full cardiac ultrasound to further evaluate for underlying heart disease.



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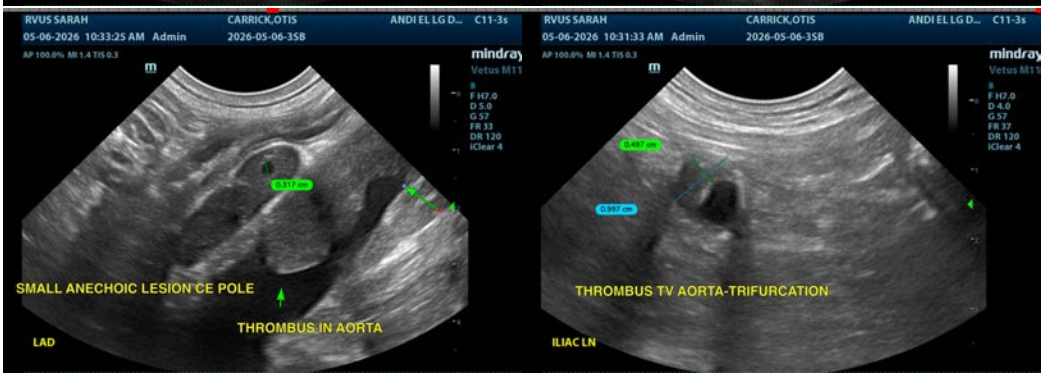



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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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