



PATIENT

Bohdi VanHouse

SPECIES

Canine

BREED

Shih Tzu/Terrier Mix

SEX

Neutered Male

AGE

14 Years 1 Month

WEIGHT

19.2

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP

IMAGING PERFORMED BY

Dr. Kellie Pesola

HOSPITAL NAME

Stuga North Veterinary
Care

REFERRING VET

Dr. Kellie Pesola

INVOICE

12045

DATE

11/03/25

PRESENTING CLINICAL SIGNS

Started getting more lethargic / less active about 1 week ago - now not eating well - shaking, taking minimal food with meds - on Denamarin, ursodiol, and vetoryl, normal BM yesterday then softer stool after - no vomiting, unsteady and fell over walking into clinic today

Abnormal PE/Chem/CBC/UA Results: QAR- cataracts OU, no head tilt or nystagmus heart and lungs WNL on auscultation, abdomen painful / uncomfortable on palpation cranially, bladder stones identified on radiograph with decreased detail cranially. See blood work attached - pancreatic enzymes elevated today - Sept lab work Lipase was elevated at >1800 but Amylase was normal at 1041 UA submitted today.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder presented with normal size and tone. Mild prominent ventral, apical and dorsal urinary bladder wall, suggestive of a cystitis pattern. No evidence of overt tumors. Mild to moderate dependent lumen mineral to calculi along with nondependent particulate urine sediment. The urethra was normal in structure and tone to a depth of 3.0 cm.

The area of the residual prostate appeared normal and free of pathology.

The area of the aortic trifurcation was free of pathology.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomodullary distinction was also present. The renal medullary volume was subjectively reduced. Mild areas of medullary mineral were visualized. The left kidney measured 5.1 cm in length. The right kidney measured 5.5 cm in length.

Adrenal Glands

Suspect indistinct mixed echogenic left adrenal mass visualized from the right abdomen measuring approximately 3.5 cm x 2.8 cm.

The right adrenal gland was mildly enlarged in size. Homogenous parenchyma and symmetrical contour was present without suspicion for overt neoplasia. The right adrenal gland measured 0.85 width in the caudal pole.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

Liver



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The liver presented with generalized hepatomegaly with normal to mildly reduced hepatic parenchyma exhibiting mild coarse echotexture and normal vascular volume. No visualized hepatic mass or nodules.

The gallbladder was distended in size with nonthickened nonedematous gallbladder wall. There was biliary sludge that appeared to be non-mobile and organized. A stellate pattern to the organized biliary sludge was present. Nonthickened nonedematous gallbladder wall.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The stomach was nondistended containing mild retained anechoic fluid.

The small intestine presented generalized intact wall layering and normal wall layer ratio. Subjective mild hypoechoic mucosa with mild nonobstructive duodenal ileus without obstructive pattern to the level of the colon.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

Diffuse enlargement of the left and right pancreas with ill-defined, hypoechoic to heterogeneous parenchyma and asymmetrical contour was present. The surrounding omental fat around the enlarged to hypoechoic pancreas was echogenic indicative of reactive change, adhesions, focal peritonitis, or saponification. Peripancreatic to generalized hyperechoic omentum and mild volume of peritoneal effusion was visualized.

Free Abdomen

No overt visualized significant omental lymphadenopathy was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Pancreatitis.
- Hepatopathy.
- Gallbladder mucocele.
- Gastroduodenitis to generalized gastroenteritis pattern.
- Suspect left adrenal mass with concurrent mild right adrenomegaly.
- Generalized peritonitis.

Secondary Findings

- Chronic renal changes.
- Urinary bladder mineral/calculi.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Multiple comorbidities are present. The primary clinical player at this stage (given patient's clinical signs) is active pancreatitis and peritonitis. Potential for pancreatic to multicentric neoplasia involving the liver and left adrenal mass is strongly suggestive of adrenal neoplastic criteria, is possible. Likewise, the concurrent gallbladder mucocele, as a contributing factor to the clinical signs and hepatopathy/cholestasis, is suspected. Initial hospitalization with supportive care for active



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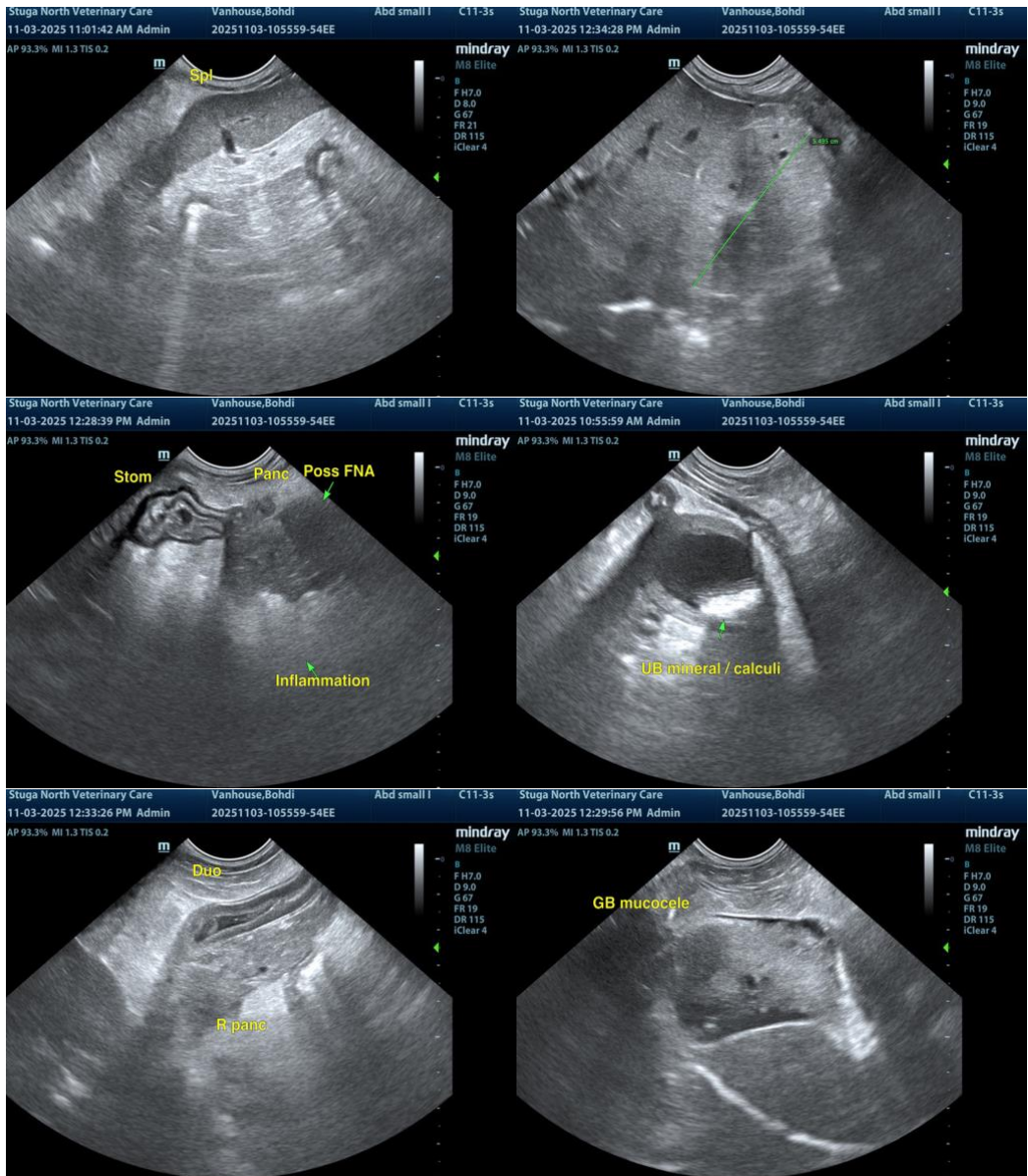
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pancreatitis with close clinical monitoring would be reasonable. Assuming normal clotting status and using a 25-gauge needle, screening hepatopancreatic FNA cytology as well as effusion analysis to assess for evidence of inflammation or sepsis may be considered. If pancreatitis resolves and assuming no pathology on three view chest radiographs, consideration for cholecystectomy and potential left adrenalectomy could be considered. An extremely guarded prognosis is indicated.





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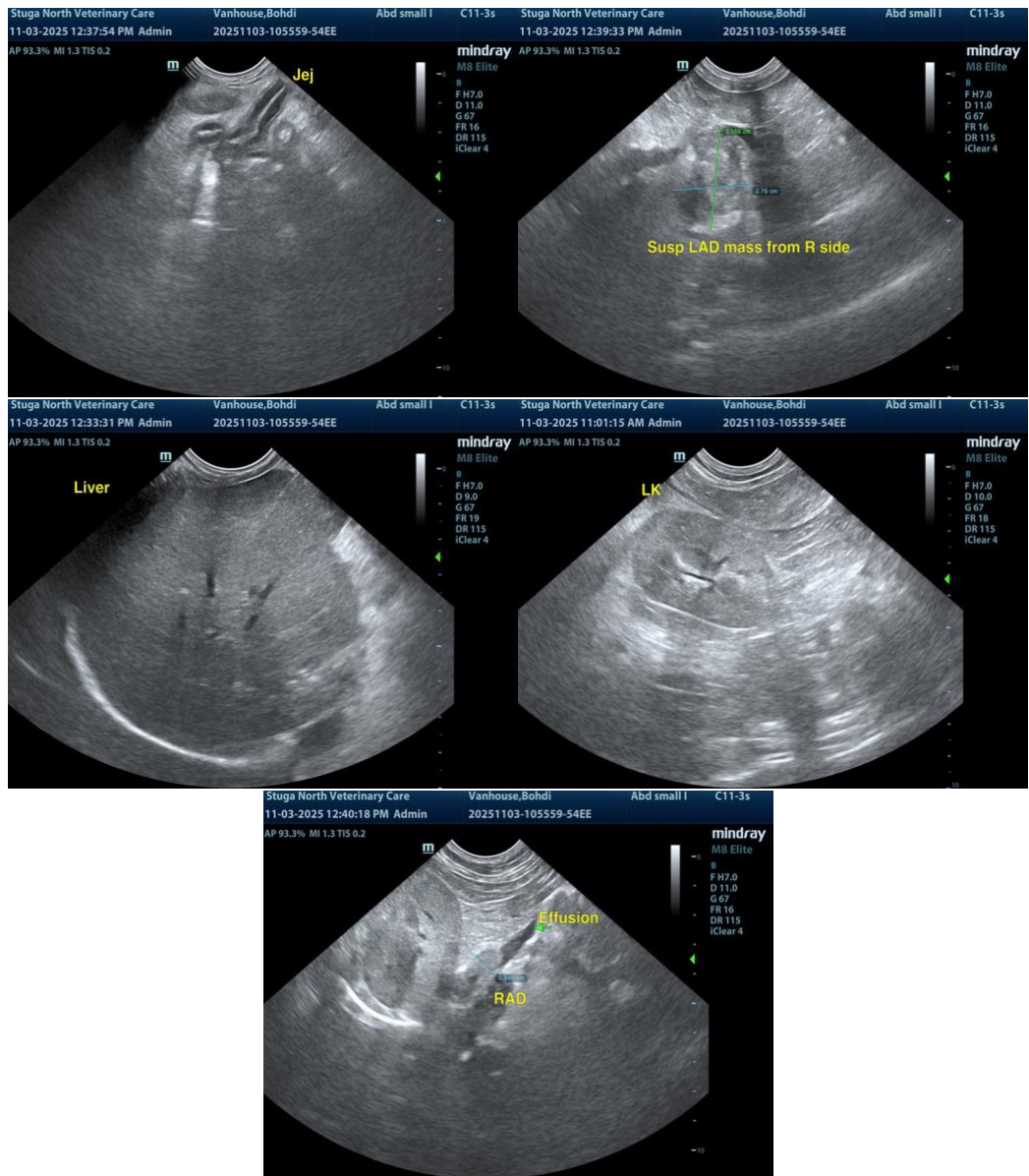
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com