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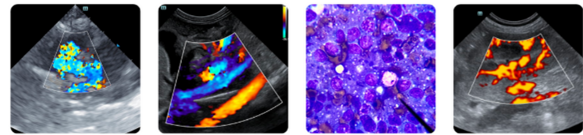


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Leo Sullivan

SPECIES
Canine

BREED
Beagle/Harrier X

SEX
Male Neutered

AGE
14 yrs

WEIGHT
27.6 lbs

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY
Sara Hansen

HOSPITAL NAME
VCA Westmoreland AH

REFERRING VET
Dr. Sullivan

INVOICE
12773

DATE
11/5/25

PRESENTING CLINICAL SIGNS

History: Presented with nausea and vomiting on Monday morning (11/3/25). Cerenia controlled nausea and vomiting but another dose was given Tuesday morning. P still lethargic, not drinking much, becoming more dehydrated and hiding behaviors started. P sitting and trembling, more than normal. BW and radiographs performed 11/4/25. P is on GI low-fat food. Increased pica (digging up dirt to eat, eating feces out of poop bucket on porch) which is new behavior for P. P still eating. Administered SQ fluids yesterday, 11/4/25. History of 2 hemilaminectomies, cognitive dysfunction and number dermal masses/warts/skin tags ABNORMAL Lab work Values Elevated AST 994, ALT 6141, ALP 3314, GGT 135, T. Bilirubin 2.0, BUN 37, Phosphorus 6.2, Cholesterol 432, Triglycerides 524, Precision PSL 279UA: Bilirubin with bilirubin crystals CBC:WNL

Medications Galliprant 30 mg PO SID, Gabapentin 100 mg PRN, Cerenia 30 mg PO SID since Monday 11/3/25

Radiographic – Moderate nonobstructive gastric and mild multisegmented small intestinal luminal soft tissue may represent residual ingesta in conjunction with functional ileus and delayed gastric emptying from gastroenteritis or may represent foreign material. If not already performed, consider repeating fasted radiographs to monitor for complete transit of this luminal content. No obstructive pattern, peritoneal fluid, masses or organomegaly is demonstrated– Normal thorax without evidence of cardiovascular disease, pneumonia or thoracic neoplasia. – Mild bilateral shoulder

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

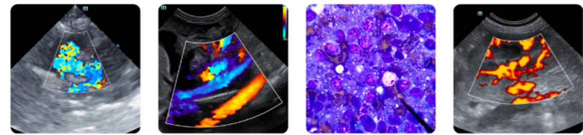
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The residual prostate was free of pathology.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.9 cm in length. The right kidney measured 6.5 cm in length.

Adrenal Glands

A well-defined, hyperechoic nodule was present in the cranial left adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 0.81 cm x 0.70 cm. Generalized left adrenomegaly with maintained symmetrical contour and non-mineralized parenchyma measuring 3.1 cm length x 1.2 cm width at the caudal pole. The right adrenal gland was enlarged in size with mild capsule asymmetry and intact capsule integrity and mild heterogeneous, non-mineralized parenchyma measuring 2.6 cm length x 0.90 cm width at the caudal pole.



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Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. 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. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver exhibited generalized hepatomegaly with symmetrical contour and maintained mild, non-homogeneous, hyperechoic hepatic parenchyma echogenicity compared to the spleen. No mass or nodules visualized. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with normal walls and without inflammation or edema. Non-dependent, mild to variably congealed yet non-organized debris. The common bile duct was not visualized.

Gastrointestinal

The visible gastric walls exhibited intact wall layering without mural pathology or hypertrophy. The stomach contained variably echogenic to focally shadowing ingesta without evidence of obstruction to pyloric outflow. Pylorus wall measured 0.49 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. Duodenum wall measured 0.51 cm and jejunum wall measured 0.48 cm.

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

Pancreas

The pancreas base and right pancreatic limb was normal in size with mild, non-homogeneous, hyperechoic parenchyma compared to adjacent omentum.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy exhibiting mild parenchyma hyperechogenicity – vacuolar/cholestatic hepatopathy, inflammatory disease, hyperplasia, fibrosis or other hepatopathy with neoplasia thought less likely yet not excluded
- Early immature gallbladder mucocele
- Structurally unremarkable gastrointestinal tract with gastric ingesta
- Possible mild right limb chronic/chronic active pancreatitis
- Mild chronic renal changes
- Bilateral adrenomegaly with left adrenal nodule – hyperplasia, adenoma, emerging left or bilateral adrenal tumors thought less likely

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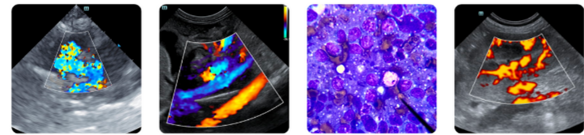

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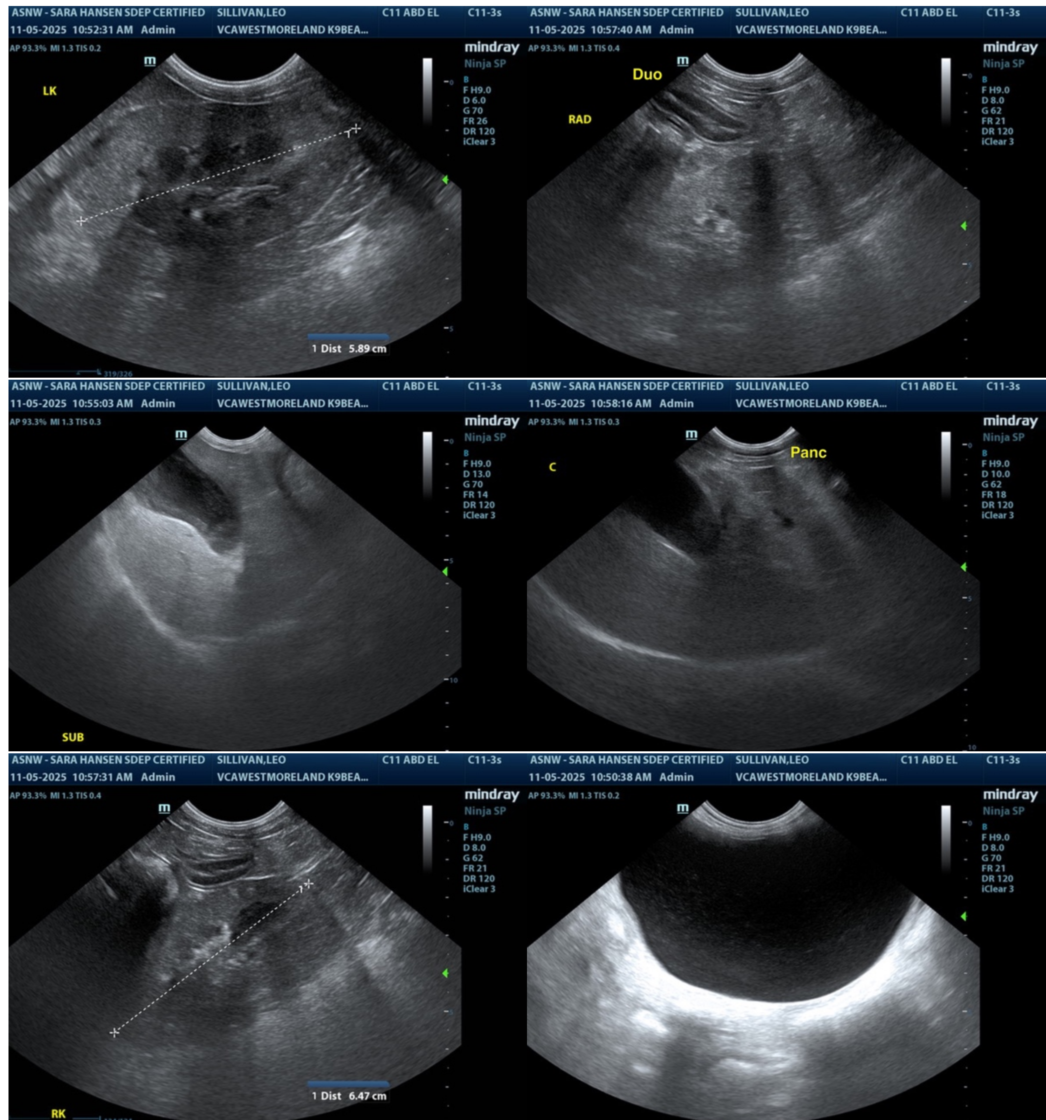
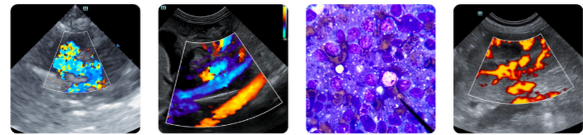
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of mechanical gastrointestinal obstruction, i.e. mural pathology, tumor or foreign body. Spec cPL or ideally GI panel to include PLI/TLI/Cobalamin/Folate to correlate with pancreas to assess for non-structural intestinal disease is recommended. Assuming normal clotting status, hepatic FNA cytology warranted for further clarification. Although, current clinical signs not overtly suggestive of adrenal disease. Adrenal screening or workup could be considered if clinical signs are not reported or arise. Monitoring systemic BP for evidence of hypertension as well as monitoring of the left adrenal nodule for evidence of progression is recommended. Hepato-gastrointetsinal support which may include dietary trial, as needed gastro protectants and sonographic reassessment if progressive gastrointestinal signs or evidence of cholestasis is recommended.





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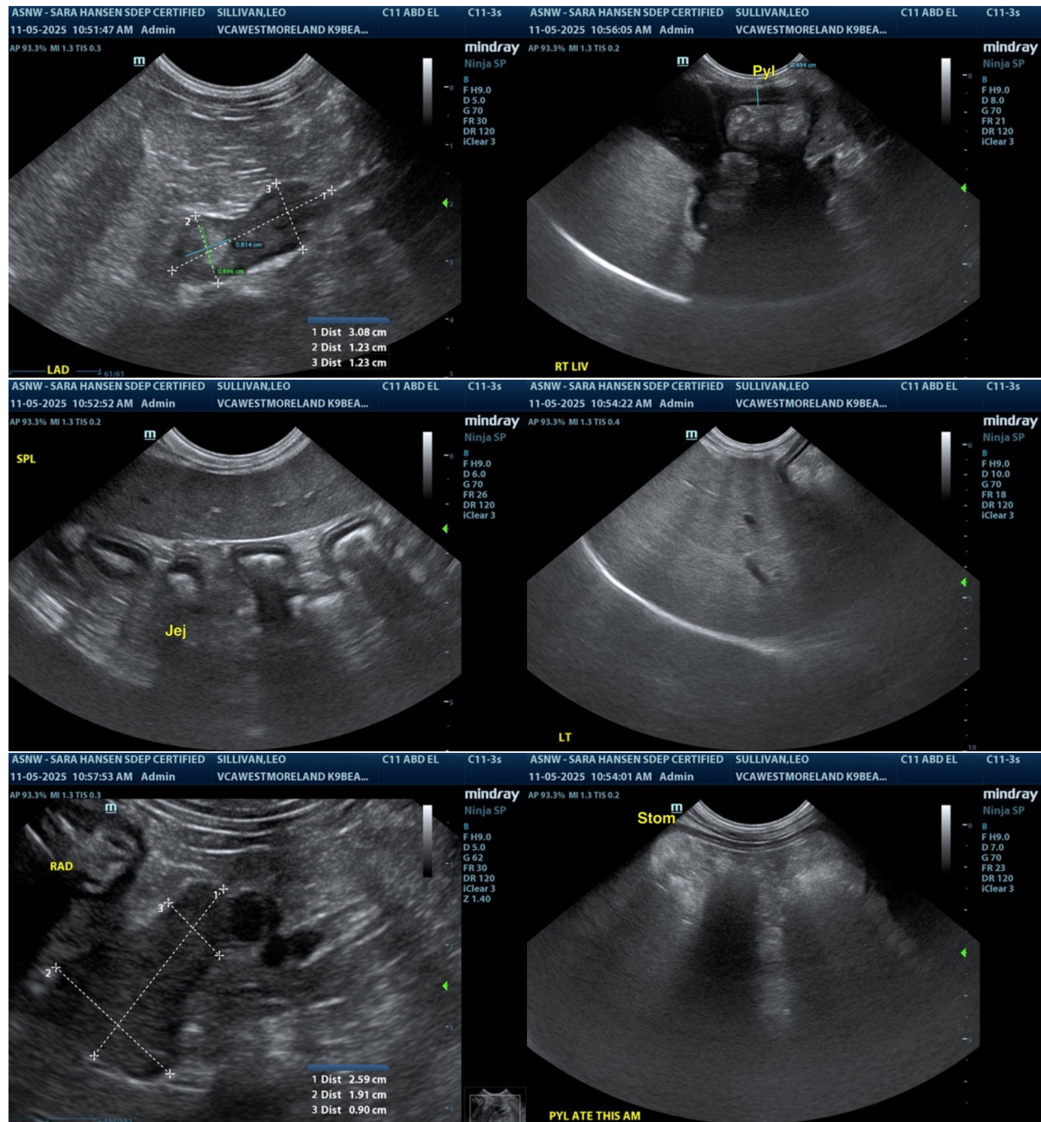

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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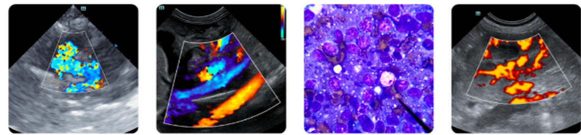

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