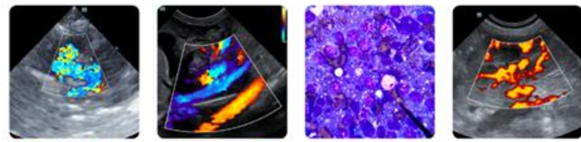


PATIENT
TOBY BOUCOURT

SPECIES
Canine

BREED
Havanese

SEX
MN

AGE
9yr

WEIGHT
16.7lb

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

IMAGING PERFORMED BY
Dr Rivera

HOSPITAL NAME
DPC Veterinary Hospital

REFERRING VET
Dr Courtney

INVOICE
23089

DATE
12/01/2025

PRESENTING CLINICAL SIGNS

History: Toby is reporting for vomiting occurred either Saturday night or Sunday morning, with vomitus containing all his food. The owner states that Toby has not eaten since Saturday night, except for a treat and his Apoquel medication. No appetite and lethargy noted since the vomiting began.

Abnormal PE/Chem/CBC/UA Results: Previous, recent vomiting: Dietary indiscretion vs FB/obstruction vs infection (parasitic vs bacterial vs viral vs fungal) vs metabolic vs open. Hypo-/Anorexia: Continued from previous vomiting vs pruritis and infection of feet, ears, and chest vs combination vs open. Basophilia: Allergies vs open. Neutrophilia: Infection vs inflammation vs stress vs open. Hyperglobulinemia: Inflammation vs open. Elevated Liver enzymes and TBili: Cholangiohepatitis vs pancreatitis vs GB mucocele vs GB stone/duct obstruction vs Lepto infection (past or no renal changes) vs neoplasia vs toxin vs open. Elevated cPL: Pancreatitis (primary vs secondary) vs open. Hypercholesterolemia: Recent meal vs secondary to pancreas/liver vs open.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

Normal size and margination were 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. Bilateral areas of minor medullary mineral were present. The left kidney measured 4.5 cm in length. The right kidney measured 5.4 cm in length.

The area of the aortic trifurcation was free of pathology.

The residual prostate exhibited mild prominent size, symmetrical contour and heterogeneous to indistinct hyperechoic parenchyma measuring 1.7 cm in diameter.

Adrenal Glands

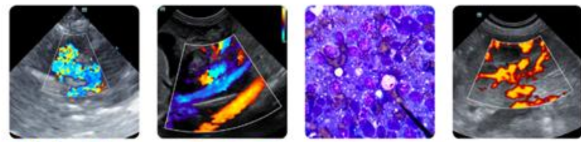
The left adrenal gland was mildly enlarged based on caudal pole width measurement in light of body weight. The left adrenal gland measured 0.64 cm width at the caudal pole. The right adrenal gland was overtly normal in size, position and shape. The right adrenal gland measured 0.45 cm width at the caudal pole.

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/Gallbladder

The liver presented generalized mild to moderately enlarged in size. The hepatic parenchyma revealed diffuse reduced echogenicity compared to the spleen and renal cortical parenchyma with a mild coarse



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echotexture. Mild increased portal vein prominence was evident. The capsule of the liver was normal in margination. Distinct masses or nodules were not evident. The hepatic and portal vasculature were normal in appearance.

The gallbladder was significantly distended in size. The gallbladder lumen was primarily occupied by non-dependent congealed mildly hyperechoic debris. Mild pericholecystic hyperechoic omentum was present consistent with mild pericholecystic inflammation. No obvious visualized pericholecystic or peritoneal effusion.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

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 mechanical/metabolic ileus, obstruction or foreign material.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Gallbladder mucocele with pericholecystic inflammation
- Acute vs acute on chronic hepatopathy
- Sonographically normal gastrointestinal tract / area of pancreas
- Mild left adrenomegaly

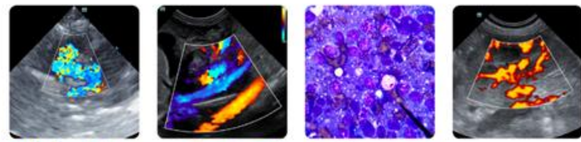
Secondary

- Mildly prominent non-homogenous hyperechoic residual prostate
- Age-related renal changes exhibiting mild medullary mineral

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary cause of the patient's clinical signs is a gallbladder mucocele and concurrent hepatopathy. Potential for concurrent mild to chronic pancreatitis, which may present sonographically unremarkable, is not excluded yet no evidence of significant active pancreatitis or gastrointestinal pathology. Assuming normal clotting status, cholecystectomy with hepatic biopsies is indicated as soon as possible with perioperative gastrointestinal support, broad-spectrum antibiotics, and analgesia.

The residual prostate presentation is nonspecific with potential for patient variant or residual fibrosis if neutered later in life. Possible emerging prostatic pathology, i.e., inflammation or neoplasia cannot be excluded. Correlation with clinical history and with monitoring of urinary signs with potential prostatic



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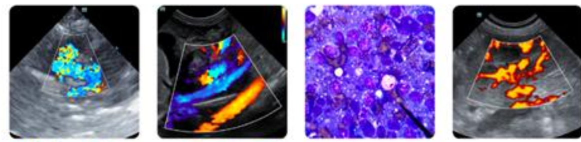
reassessment or sampling if urinary signs arise is recommended.



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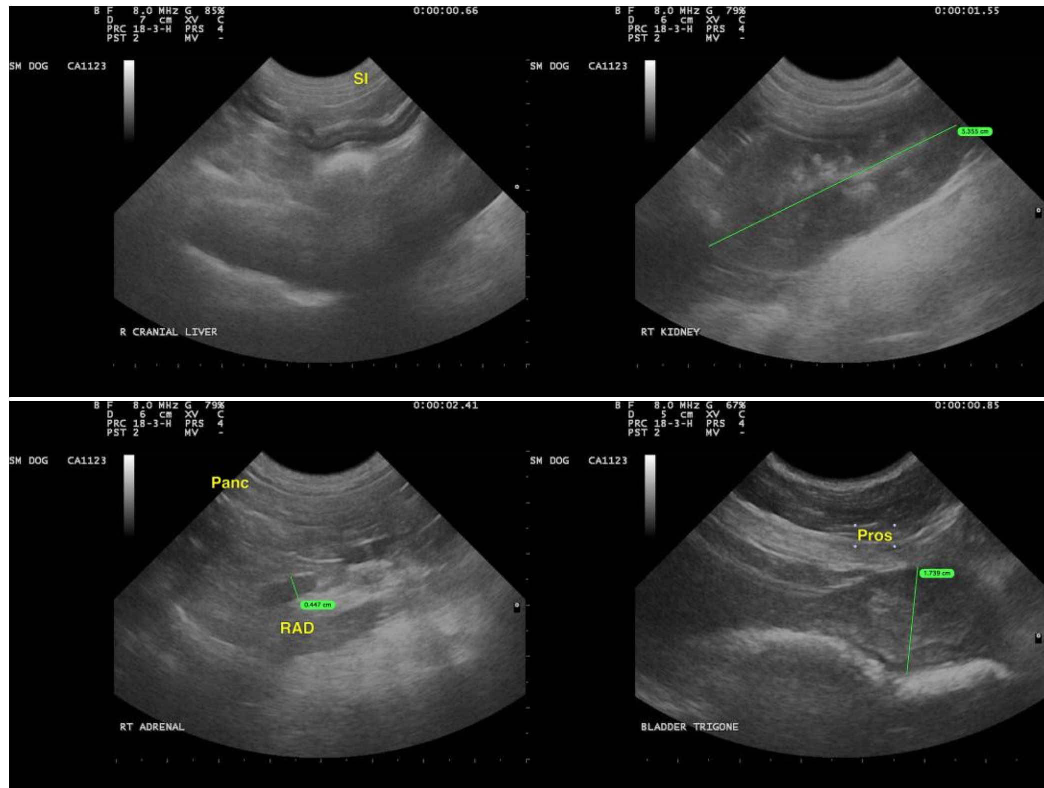

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com