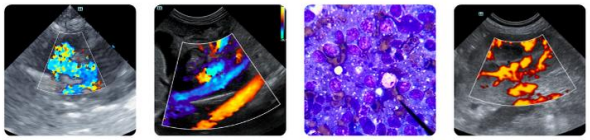


PATIENT

Bella Boo Olivo

SPECIES

Canine

BREED

Maltese/Poodle

SEX

FS

AGE

14Y

WEIGHT

12lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Vincent Tavella

HOSPITAL NAME

Williamsburg Veterinary Clinic

REFERRING VET

Dr. Vincent Tavella

INVOICE

74739

DATE

4-23-26

PRESENTING CLINICAL SIGNS

Patient presented on 4/20/2026 for acute onset Left forelimb ataxia, otitis externa AU, and fever. Treating with meloxicam, doxycycline, and ear medications.
AUS to screen for cause of elevated liver enzymes.
Abnormal PE/Chem/CBC/UA Results: PE: Left forelimb ataxia - wobbly gait. No proprioceptive deficits. Slips on that limb regularly. No pain on orthopedic or neurologic exam. Chem: marked elevation in alkaline phosphatase (ALP 1352) (725 in October 2025) and a mild elevation in ALT (121) (57 in October 2025). There is severe hypertriglyceridemia (1031) and a mild increase in Precision PSL (158) CBC: Thrombocytosis UA: USG 1.042, 2+proteinuria. LDDST from 11/11/2025 Cortisol Sample 1 -7.9, 4 HR Post Cortisol Sample 2 0.4, 8HR Post Sample Cortisol Sample 1.0 (0.0-1.4 mg/dL)

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.

No evidence of pathology in the area of the aortic trifurcation.

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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Pinpoint to focal areas of medullary mineral were present. No evidence of pelvic dilation was present. The left kidney measured 4.1 cm in length. The right kidney measured 4.4 cm in length.

Adrenal Glands

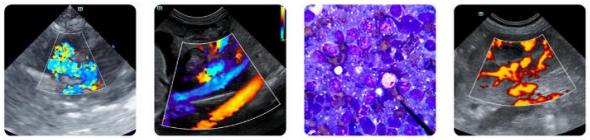
Both adrenal glands presented borderline to mild adrenomegaly. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.51 cm width in the caudal pole. The right adrenal gland measured 0.61 cm width in the caudal pole.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Multifocal perihilar to medial, non-capsule deforming, parenchymal nodules are present. An example of a nodule measured 1.1 cm in diameter. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver/ Gallbladder

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.



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The gallbladder was non distended in size with normal wall. Mild echogenic, nonmineralized, non-dependent biliary sludge is present. The biliary sludge is congealed without organization. No signs of peripheral inflammation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The stomach was nondistended with mild retained fluid and a small amount of nonobstructive hyperechoic shadowing content. The shadowing content measured approximately 1.8 cm in diameter. Solitary visualized gastric polyp measuring approximately 1.8 cm diameter is present in the gastric body lumen. No obstruction to the pyloric outflow.

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.

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

Pancreas

The pancreas was prominent in size and mild asymmetrical capsule contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy – subjectively benign.
- Immature gallbladder mucocele.
- Bilateral chronic renal changes exhibiting pinpoint medullary mineral.
- Borderline/mild bilateral adrenomegaly.
- Hyperechoic splenic nodules – most consistent with benign criteria, i.e., myelolipomas.
- Nonobstructive gastric polyp with mild nonobstructive shadowing gastric content.
- Prominent nonhomogeneous remodeled pancreas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, hepatic FNA cytology warranted for further clarification with occult neoplasia thought less likely. Recheck adrenal workup could be considered if clinical signs consistent with Cushing's syndrome and given previous LDDST results.

Chronic pancreatitis with remodeling is suspected if evidence of cranial abdomen or subxiphoid discomfort on palpation.

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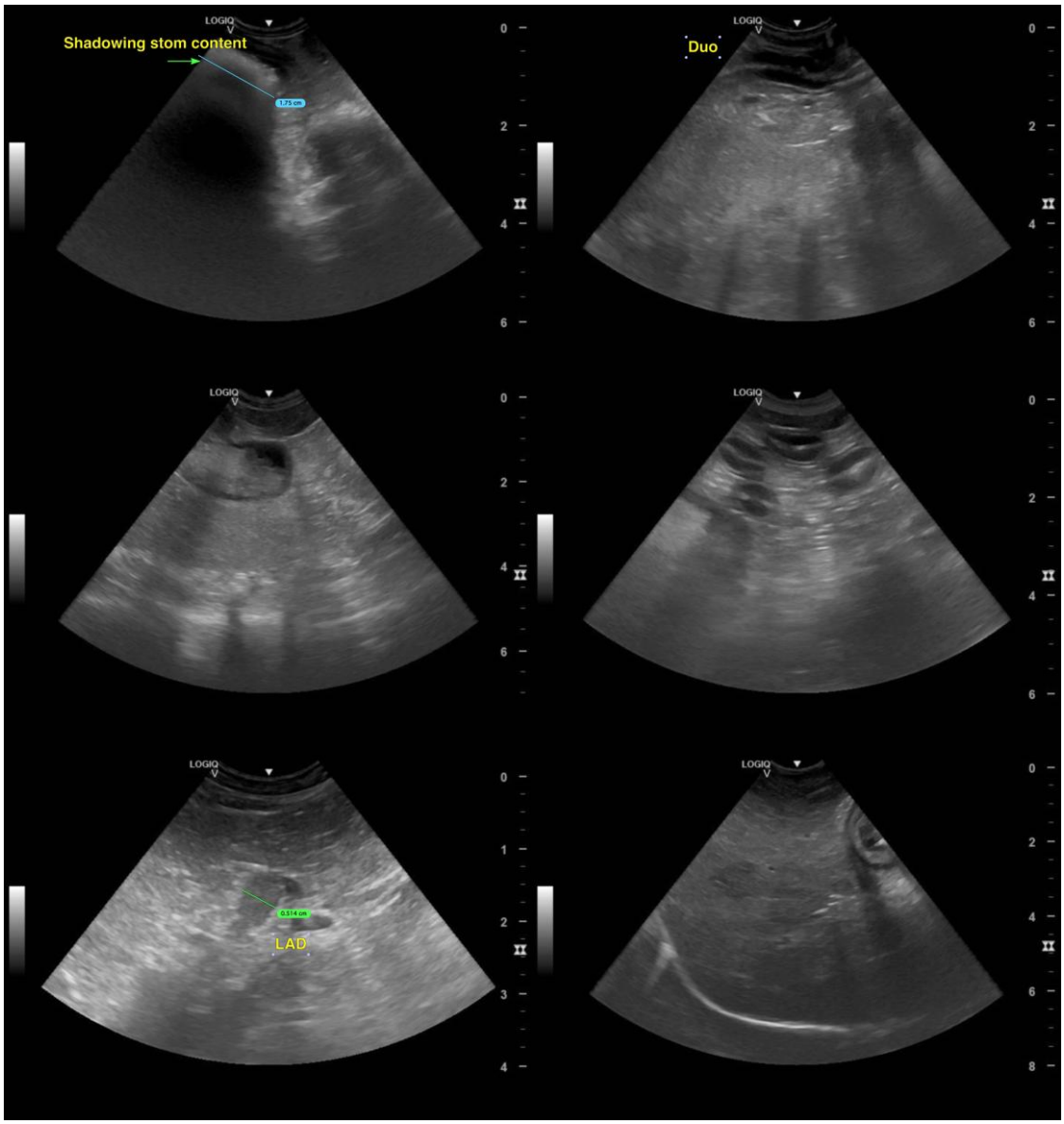
Concern for a small amount of nonobstructive gastric foreign material, i.e. stuffing, fabric, or similar, is warranted without evidence of pyloric obstruction. Correlation with most recent meal ingestion is recommended.

Documented 12-hour fast and sonographic reassessment of the stomach would be ideal. If persistent shadowing content, gastric endoscopy, for further clarification and potential for biopsies given gastric polyp, may be indicated.

Hepatosupportive medications may prove beneficial with sonographic reassessment or monitoring of the gallbladder if progressive cholestasis.



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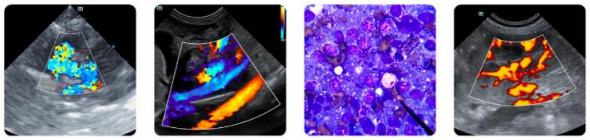

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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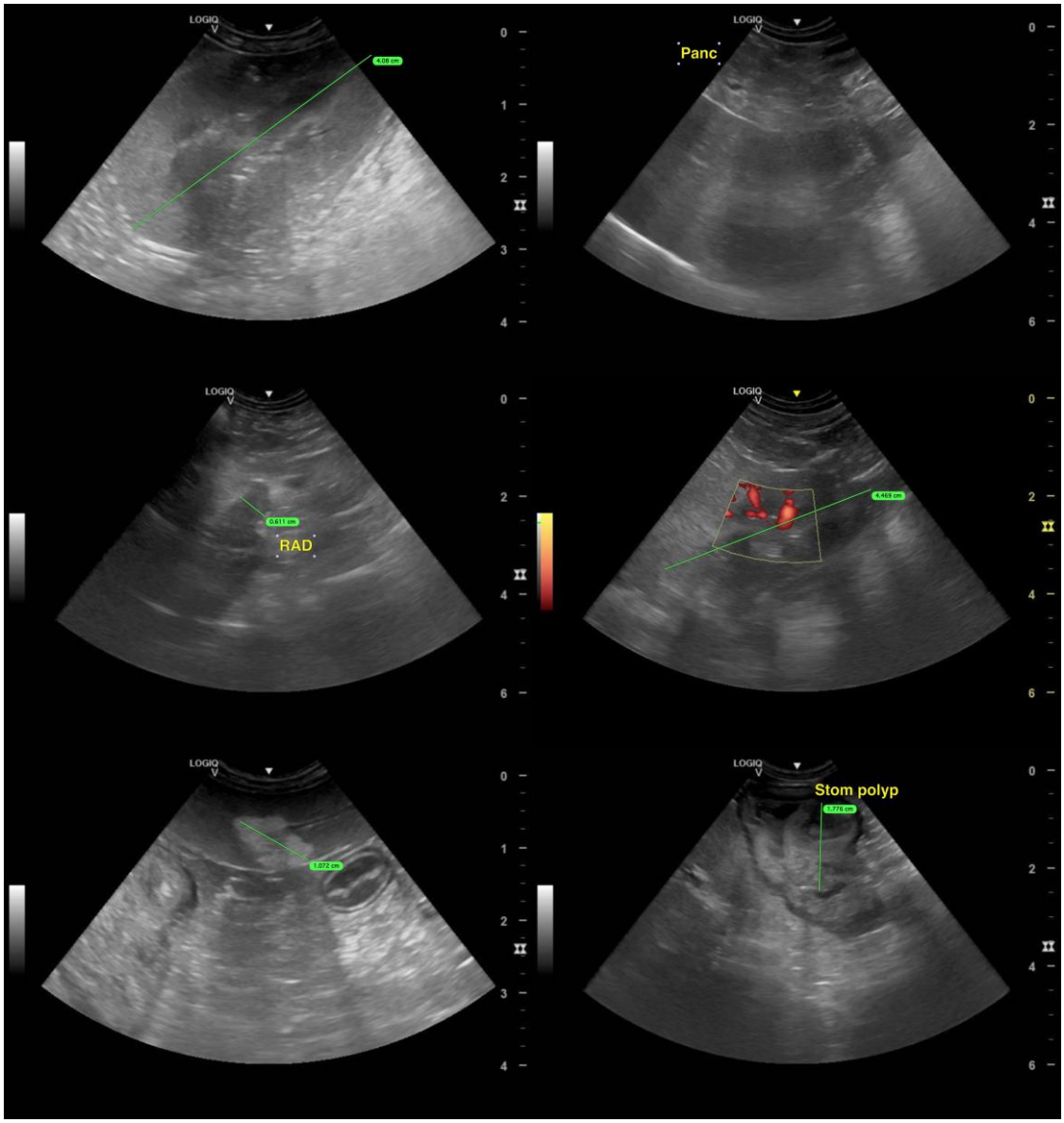

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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