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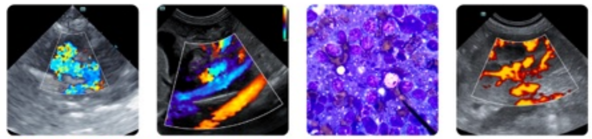


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

**PATIENT**

Daisy Mae Amengual/Beligianis

**SPECIES**

Canine

**BREED**

Coonhound

**SEX**

Spayed female

**AGE**

17 years

**WEIGHT**

34.6 kgs

**INTERPRETED BY**

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

**IMAGING PERFORMED BY**

Cassandra VanNieuwal, DVM

**HOSPITAL NAME**

Animal Emergency Hospital Vousia

**REFERRING VET**

Cassandra VanNieuwal, DVM

**INVOICE**

68867

**DATE**

11/20/25

## PRESENTING CLINICAL SIGNS

History: Patient presented for evaluation after Owner states that rDVM has requested an ultrasound. Daisy May has had a history of pancreatitis, bloat twice, possible Cushing's, arthritis, and elevated liver values. The liver values have continuously gone up over the past year. rDVM also told them there is masses on the bladder after getting xrays and bloodwork two days ago. Patient was originally brought into rDVM due to vomiting and then decreased appetite. Appetite and behavior are back to normal after cerenia and Labrella shot.
Abnormal PE/Chem/CBC/UA Results: ALT (SGPT) 1716 H 12 118 IU/L ALK PHOS 6230 H 5 131 IU/L GGT 124 H 1 12 IU/L T. BILIRUBIN 0.7 H 0.1 0.3 mg/dL AMYLASE 1223 H 290 1125 IU/L PrecisionPSL 739 H 24 140 U/L

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is small with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

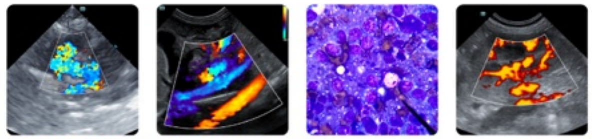
Normal renal size (left measured 7.0 cm, right measured 7.2 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident.

### *Adrenal Glands*

The adrenal glands are bilaterally enlarged (right > left) with a slightly rounded shape and a hypoechogenic appearance, but maintained normal position and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.7 cm in width. The right adrenal gland measured 0.92 cm and 0.76 cm in width.

### *Spleen*

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 2.0 cm in width.





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### *Liver*

Normal size with a diffuse, increased echogenic and coarse appearance, prominent portal markings, and regular curvilinear capsule. No nodules or masses evident. Normal appearance of the hepatic and portal vasculature.

### *Gallbladder*

The gallbladder is full containing hypoechoic and hyperechogenic adhered and non-adhered sediment. The adhered sediment organized an early stellate pattern. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

### *Gastrointestinal*

Normal appearance of the stomach, duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen. A small amount of ingesta is present in the stomach.

### *Pancreas*

Normal size with a mottled echogenic appearance and an irregular capsule. Hyperechogenic appearance of the mesentery and fat surrounding the pancreas.

### *Free Abdomen*

Normal mesenteric lymph nodes.

No ascites evident.

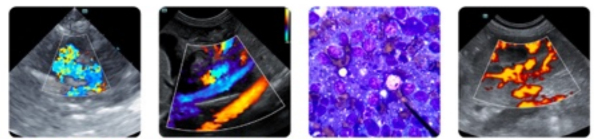
## ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenomegaly.
- Mucocele.
- Hepatopathy.
- Chronic pancreatitis.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the adrenomegaly would be age related change, reactive hyperplasia and possibly emerging pituitary dependent Cushing's disease.

Etiologies for the hepatopathy would be reactive hyperplasia, early nodular hyperplasia, vacuolar, metabolic and chronic hepatopathy with infiltrative neoplasia a less likely differential diagnosis.





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Further assessment would be urinalysis and urine cortisol to creatinine ratio and if abnormal then adrenal function testing (ACTH stimulation/LDDST test) would then be indicated.

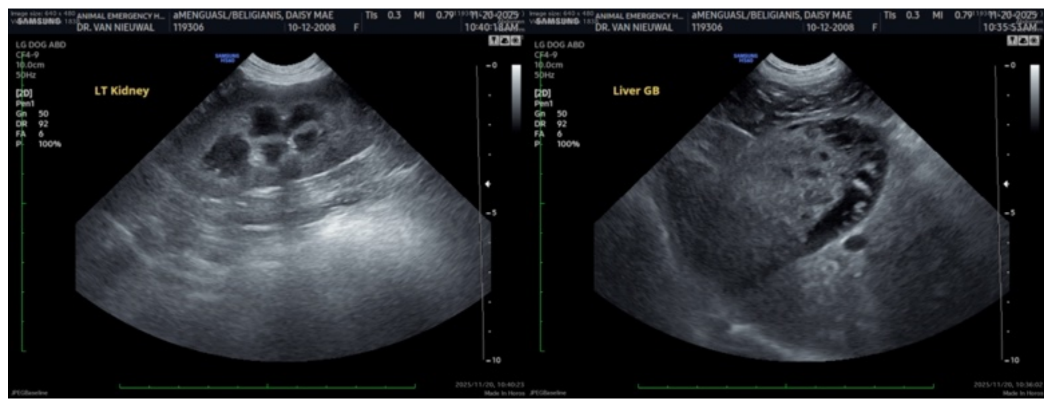
If Cushing's disease has been excluded then further assessment of the hepatopathy would be FNA cytology; however, a tru cut or wedge biopsy may be required for a final etiological diagnosis.

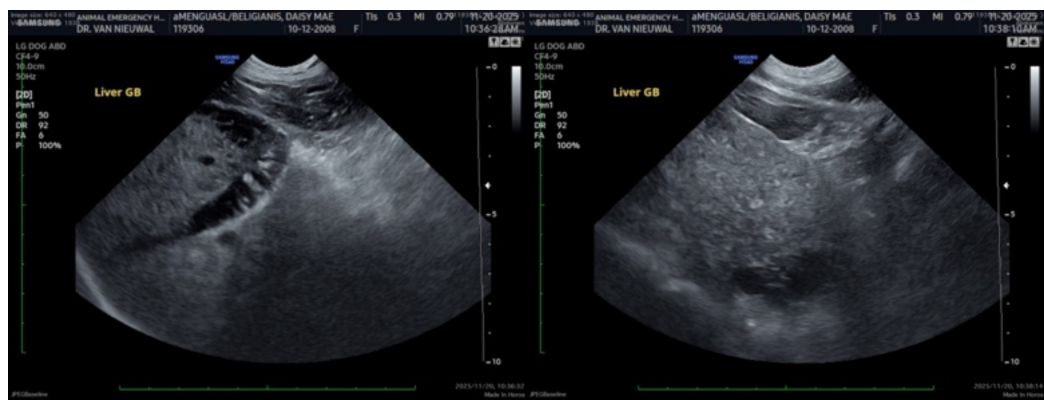
Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management of the chronic pancreatitis would be feeding small frequent meals of a low fat intestinal type diet and the use of antiemetics and analgesics as needed.

Symptomatic management of both the hepatopathy and the mucocele would be the use of Ursodiol with regular monitoring of liver enzyme activity.

A cholecystectomy could be considered for the mucocele.



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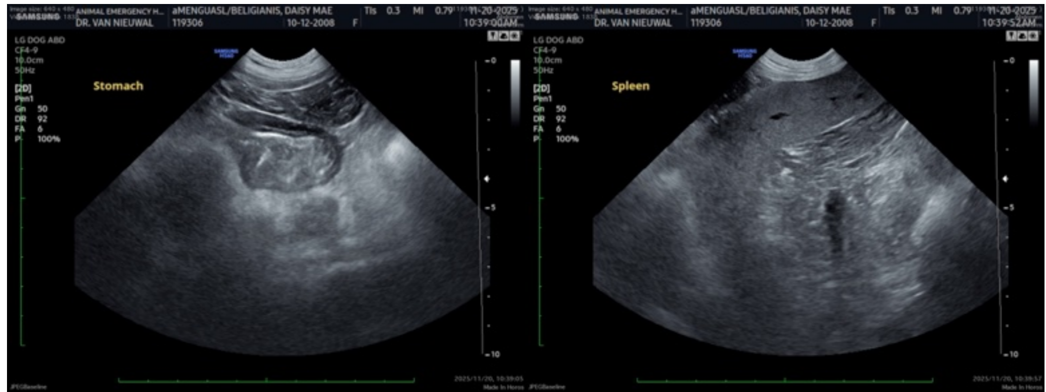


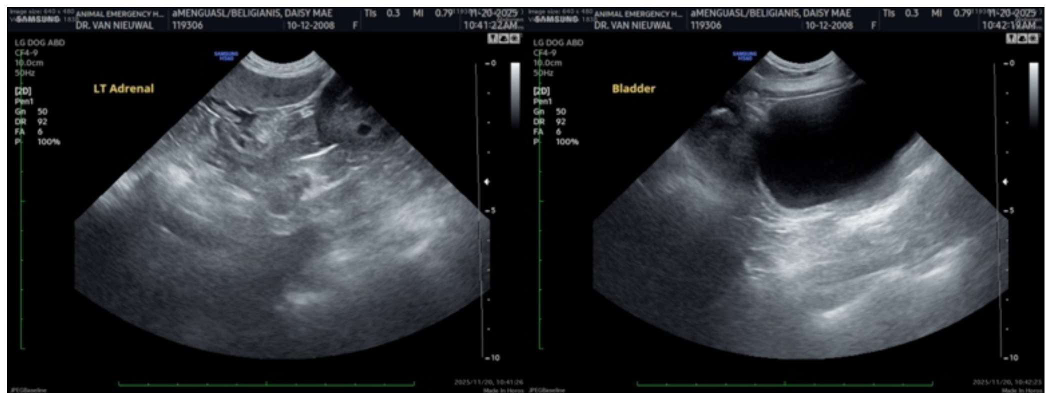


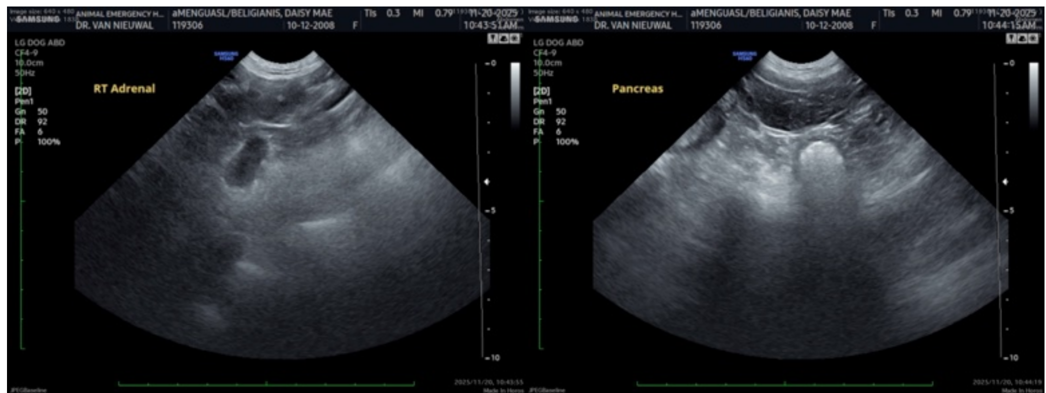

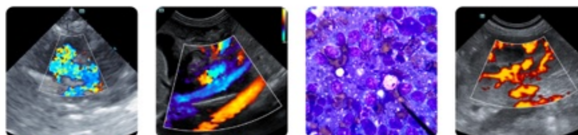



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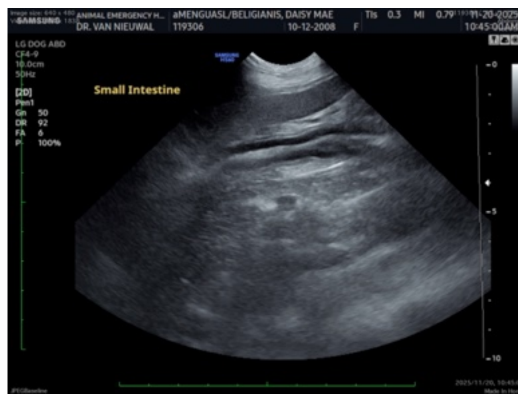


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**Remo Lobetti**, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

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