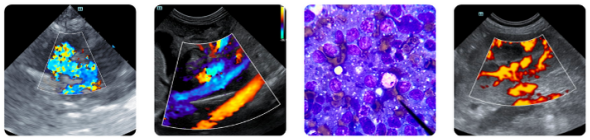

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Walker Parsons

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Intact Male

AGE

10 years

WEIGHT

8.2 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Louise Corbeil

HOSPITAL NAME

Cochrane Animal Clinic

REFERRING VET

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PRESENTING CLINICAL SIGNS

Presented for abdominal ultrasound for increasing liver enzyme elevations while on phenobarbital. General anesthesia planned for small SQ intrascapular mass removal and small eyelid mass removal. Abd ultrasound was recommended for pre anesthetic workup. Bile acids testing also recc'd for liver function assessment. Clinically doing well.

Abnormal PE/Chem/CBC/UA Results: 3/25/26 bloodwork: ALT 286 18 - 121 U/L AST 65 16 - 55 U/L ALP 345 5 - 160 U/L PT/PTT - normal Specific Gravity 1.042 1.030 - 1.098 pH 6.0 6.0 - 7.5 Urine Protein 3+ (3 g/L) - consider checking UPC for significant proteinuria? Phenobarbital 127.3 µmol/L - Therapeutic level: 43 - 172 umol/L (10-40 ug/mL) 3/12/25 last years bloodwork ALT 106 rr 18 - 121 U/L - normal AST 48 rr 16 - 55 U/L - normal ALP 180 rr 5 - 160 U/L - mild increase GGT 19 rr 0 - 13 U/L.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended. The bladder wall is thin and smooth. The luminal contents are anechoic. The bladder neck and proximal urethra appear normal. No uroliths or ultrasonographic evidence of inflammatory or proliferative/neoplastic changes are identified.

The left kidney measures 5.29 cm × 2.47 cm, with a cortical thickness of 0.47 cm in the sagittal plane. The right kidney measures 5.12 cm × 2.95 cm, with a cortical thickness of 0.50 cm in the sagittal plane. Both kidneys are normal in shape and size for a dog of this size (typically 5.0 –7.0 cm). The cortex is isoechoic relative to the liver. The corticomedullary ratio is preserved, and corticomedullary definition is maintained. No pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Prostate

The prostate measures 3.20 cm × 1.78 cm, is diffusely hyperechoic and homogeneous, with multiple small cystic structures measuring approximately 1 mm. These findings are consistent with mild benign prostatic hyperplasia in an intact, middle-aged to older dog.

Adrenal Glands

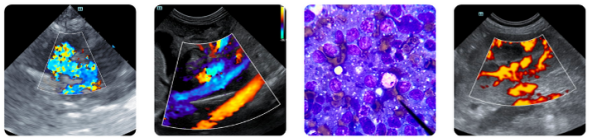
Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.46 cm at the cranial pole and 0.43 cm at the caudal pole. The right adrenal gland measures 0.50 cm at the cranial pole and 0.55 cm at the caudal pole.

Spleen

Splenic thickness is 1.22 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder is adequately distended. The wall is mildly irregular with features consistent with mucosal glandular hyperplasia. A mild to moderate amount of biliary sludge is present. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal

The stomach is empty and folded, with a small amount of fluid and gas. Gastric wall thickness is 2.89 mm with preserved layering (within normal limits).
The pylorus measures 5.44 mm, within normal limits.
Duodenum: 4.53 mm, which is at the upper limit of normal for a dog of this size (typically ≤4.0 mm – 5.0 mm).
Jejunum: 2.48 mm, within normal limits.
Wall layering is preserved throughout. No ultrasonographic evidence of inflammation, ileus, or foreign material is identified.
Colon wall thickness ranges from 0.94 mm –1.24 mm, within normal limits, with formed feces present.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Gallbladder wall changes consistent with mucosal glandular hyperplasia.
- Mild to moderate biliary sludge.
- Prostatic changes consistent with benign prostatic hyperplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This is a largely unremarkable abdominal ultrasound in the context of elevated liver enzymes in a patient receiving phenobarbital. The liver parenchyma appears normal in echogenicity and architecture, with no evidence of focal lesions, nodular disease, or biliary obstruction.
The gallbladder findings (mucosal glandular hyperplasia and biliary sludge) are common and often incidental; while they may be associated with mild biliary stasis,

Importantly, there are no ultrasonographic features to suggest primary hepatobiliary disease, neoplasia, or a diffuse infiltrative process. In this clinical context, these findings are most consistent with phenobarbital-associated hepatopathy, including enzyme induction and possible vacuolar hepatocellular change, which may occur in the absence of overt ultrasonographic abnormalities. Cytologic evaluation of the liver (already performed) will be important to confirm the presence of vacuolar change.

Overall, the ultrasonographic findings do not indicate a contraindication to the planned anesthesia from an abdominal perspective, although continued monitoring of hepatic function is appropriate.

Recommendations

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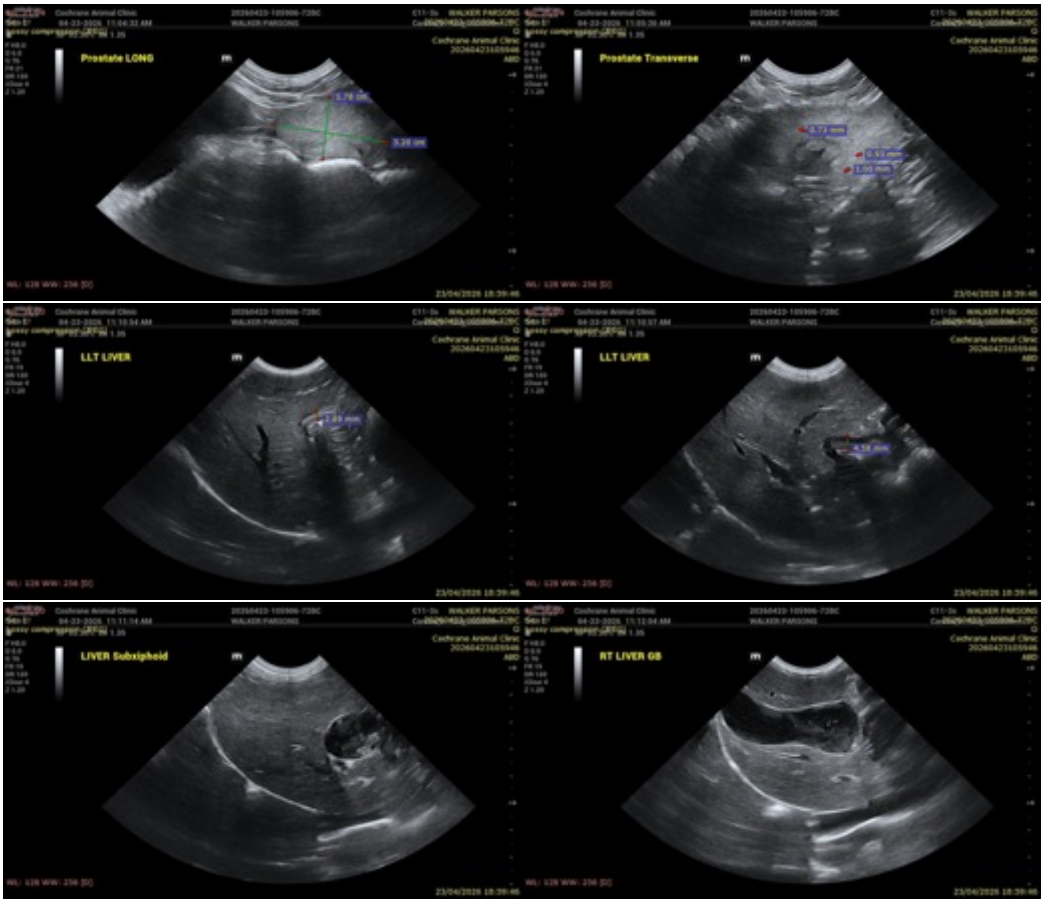
- Correlation with pending liver cytology results.
- Periodic monitoring of liver enzymes is recommended; adjustment of phenobarbital therapy may be considered depending on clinical course and cytologic findings.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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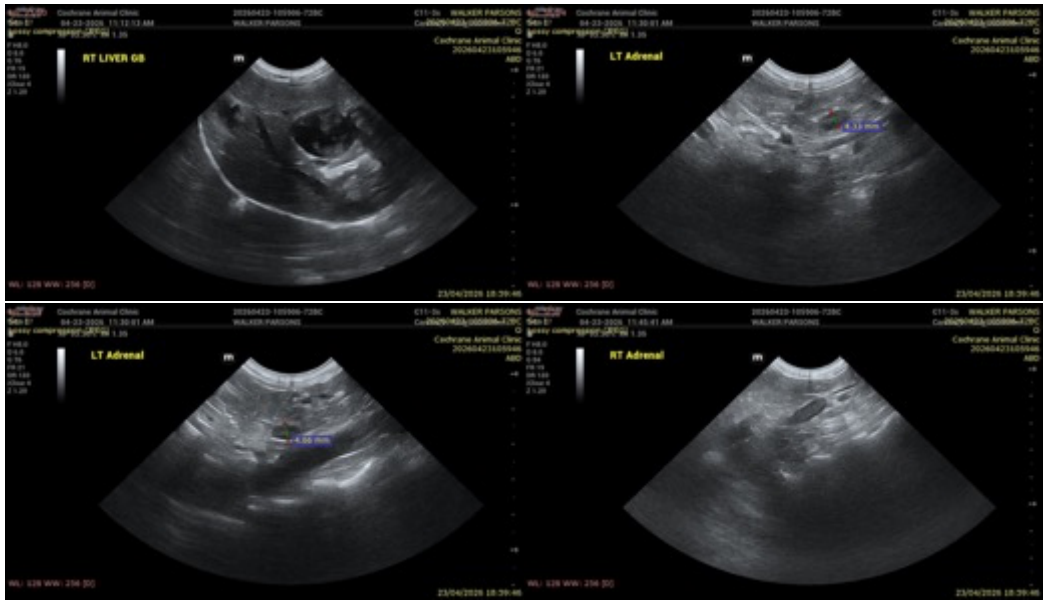

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com