

PATIENT

Chuck Estrellado

SPECIES

Canine

BREED

Jack Russell Mix

SEX

Male, neutered

AGE

12 Yrs.

WEIGHT

17.6 lbs.

INTERPRETED BY

Andrea Nicastro, DVM,
Diplomate ACVIM
(Small Animal Internal
Medicine)

**IMAGING
PERFORMED BY**

Dr. Jo Goodman

HOSPITAL NAME

Evandale Blue-Ash Pet
Hospital

REFERRING VET

Dr. Jo Goodman

INVOICE

12820

DATE

PRESENTING CLINICAL SIGNS

History: Presented Oct 2021 for a dental procedure and ALT was elevated compared to his annual bloodwork from Feb 2021. Convenia injection was given during dental procedure. Recheck ALT on 10/25/21 and it has continued to creep up. Started on denamarin. Rechecked ALT on 11/15/21 and value had decreased slightly. Advised owner to continue on the denamarin. Rechecked value on 1/3/22 after patient presented for possible seizure or stroke and soft stool. Started on metronidazole and proviable. Value was slightly elevated from visit on 11/15/21. Owner has not noted any increase in thirst or urination. Patient pants excessively while in the hospital d/t stress.

Abnormal PE/Chem/CBC/UA Results: 2/26/21: ALT - 112 10/8/21: ALT - 184 10/25/21: ALT - 209 11/15/21: ALT - 199 1/3/22: ALT - 201

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.74 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (4.88 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis.

The right kidney is normal size (4.56 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

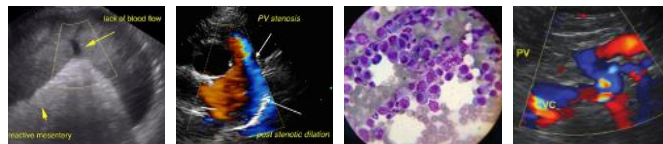
Adrenal Glands

The caudal pole of the left adrenal gland is visualized and is normal size (0.38 cm in width) with a normal shape, glandular echogenicity and detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (0.69 cm at cranial pole) (0.67 cm at caudal pole) (1.62 cm in length) with a normal shape and smooth peripheral contours. The parenchyma is slightly heterogeneous in appearance with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.24 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.



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The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance with a few ill-defined hyperechoic nodules. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

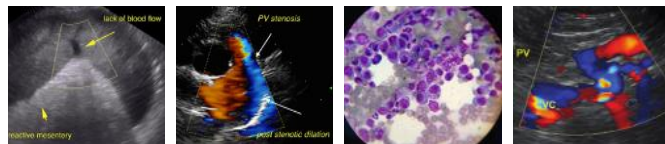
Primary Findings:

- Non-specific diffuse hepatopathy. Differentials include inflammatory/immune mediated disease (i.e., chronic active hepatitis), hepatotoxicosis (i.e., copper), reactive hepatopathy, infiltrative neoplasia (less likely) +/- concurrent benign age-related pathology (i.e., regenerative nodular hyperplasia).

Secondary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mild right adrenomegaly.
- Bilateral non-specific age-related renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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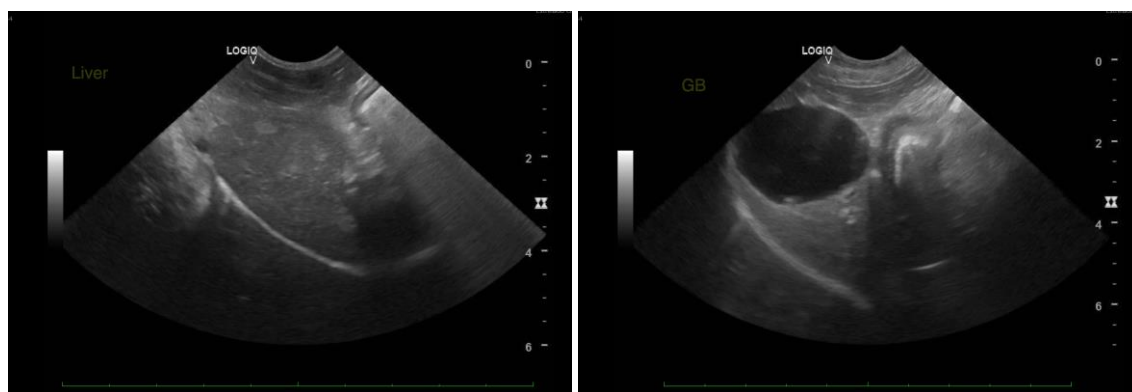
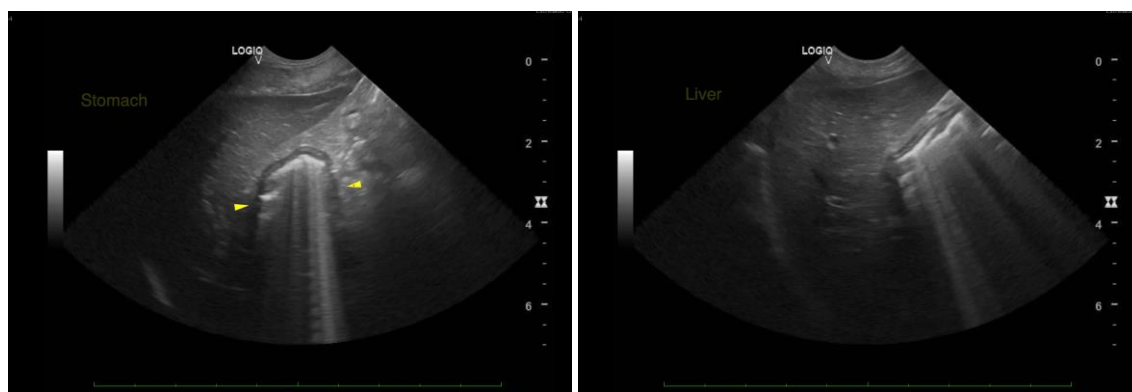
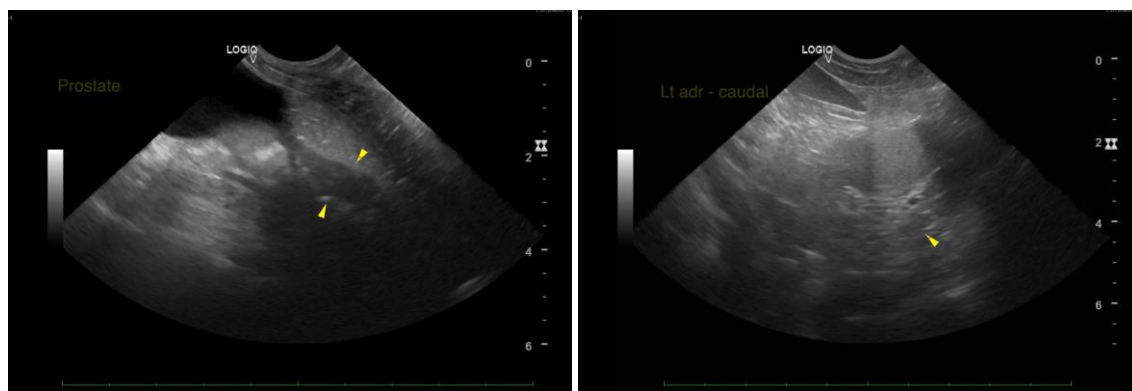
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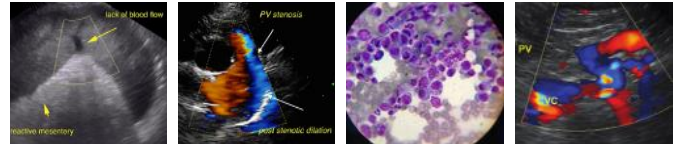
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- If an aggressive approach is desired, consider hepatic tissue sampling (i.e., fine needle aspirate or surgical biopsy) along with pre- and post-prandial serum bile acids to assess hepatic function. If surgery is pursued, aerobic and anaerobic bile cultures as well as acquisition of additional hepatic tissue samples for potential copper quantitation should also be obtained.
- If a more conservative approach is desired, serial monitoring (i.e., every 2-3 months) of the patient's liver values is recommended. If values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling should be considered.
- Given the recent seizure like episode, a baseline blood pressure measurement, three-view thoracic radiographs and a neurologic consultation are recommended.





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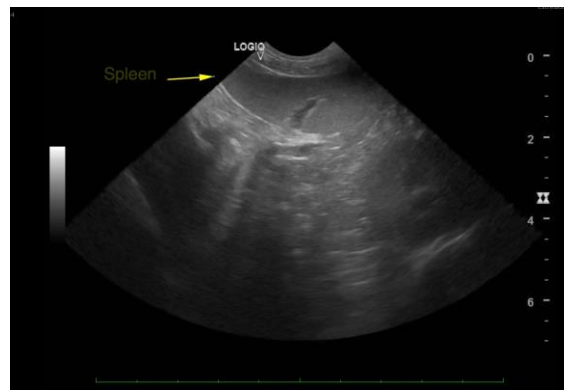
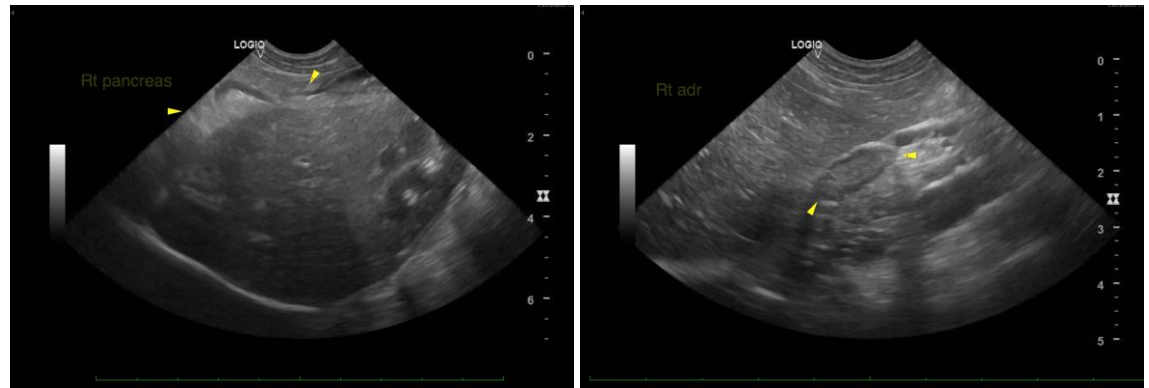
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate ACVIM (Small Animal Internal Medicine)

Andrea.nicastro@sonopath.com

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