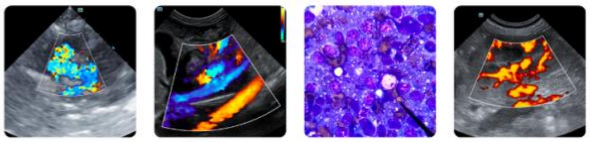


PATIENT

Alli Daub

SPECIES

Canine

BREED

Golden Retriever

SEX

Female Spayed

AGE

8.5

WEIGHT

37 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey AEC

REFERRING VET

Dr. Victoria Orlando

INVOICE

22280

DATE

11-20-25

PRESENTING CLINICAL SIGNS

History: Vomiting and inappetence. Vomiting started a week ago. Vomited at least 6 times overnight. Approximately 6-8% dehydrated with tacky MM. Mild discomfort on abdominal palpation.

Abnormal PE/Chem/CBC/UA Results: Bloodwork: ALT 551, GGT 12, pH 7.465, cPL normal. Lepto: negative Radiographs: The stomach contains a mild amount of gas, some of which shifts into the pyloric antrum as normally expected on the left lateral projection. The small intestines contain mild segmental gas, without evidence of abnormal distention. The colon contains a moderate amount of gas and scant feces. The visible margins of the spleen, kidneys, and urinary bladder are normal. The hepatic silhouette is questionably slightly small, with a cranial shift of the gastric axis on lateral projections.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (6.47 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.27 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.68 cm at cranial pole) (0.78 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.52 cm at cranial pole) (0.54 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

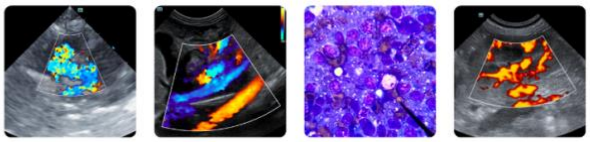
Spleen

The spleen is prominent-in-size (3.08 cm in width at the level of the hilus) with smooth peripheral contours. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is normal to slightly small in size with normal peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal

The lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. 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. There is no evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph Nodes

Two-to-three prominent mesenteric lymph nodes are visualized (one measuring 2.98 x 0.70 cm).

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), Leptospirosis, hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof.

Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Leptospirosis testing (i.e., blood and urine PCR, serology) is recommended.
- Also consider pre- and postprandial serum bile acids.
- Ultimately, laparoscopic or surgical liver biopsies may be necessary to get a definitive diagnosis. If pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be obtained. Clotting times and thoracic radiographs should be performed prior to anesthesia.
- If a conservative approach is desired, consider empirical treatment for bacterial cholangiohepatitis/ Leptospirosis (amoxicillin-clavulanic acid, Denamarin). If no improvement in the liver values is seen within 7-10 days of initiating therapy, antibiotics should be discontinued, and hepatic tissue sampling reconsidered. If liver values improve, continue therapy for at least 4-6 weeks and 1 week beyond normalization of the liver values.

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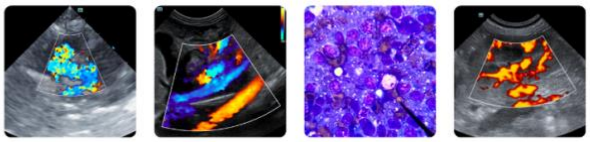

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Educational Teleconsultation Services™

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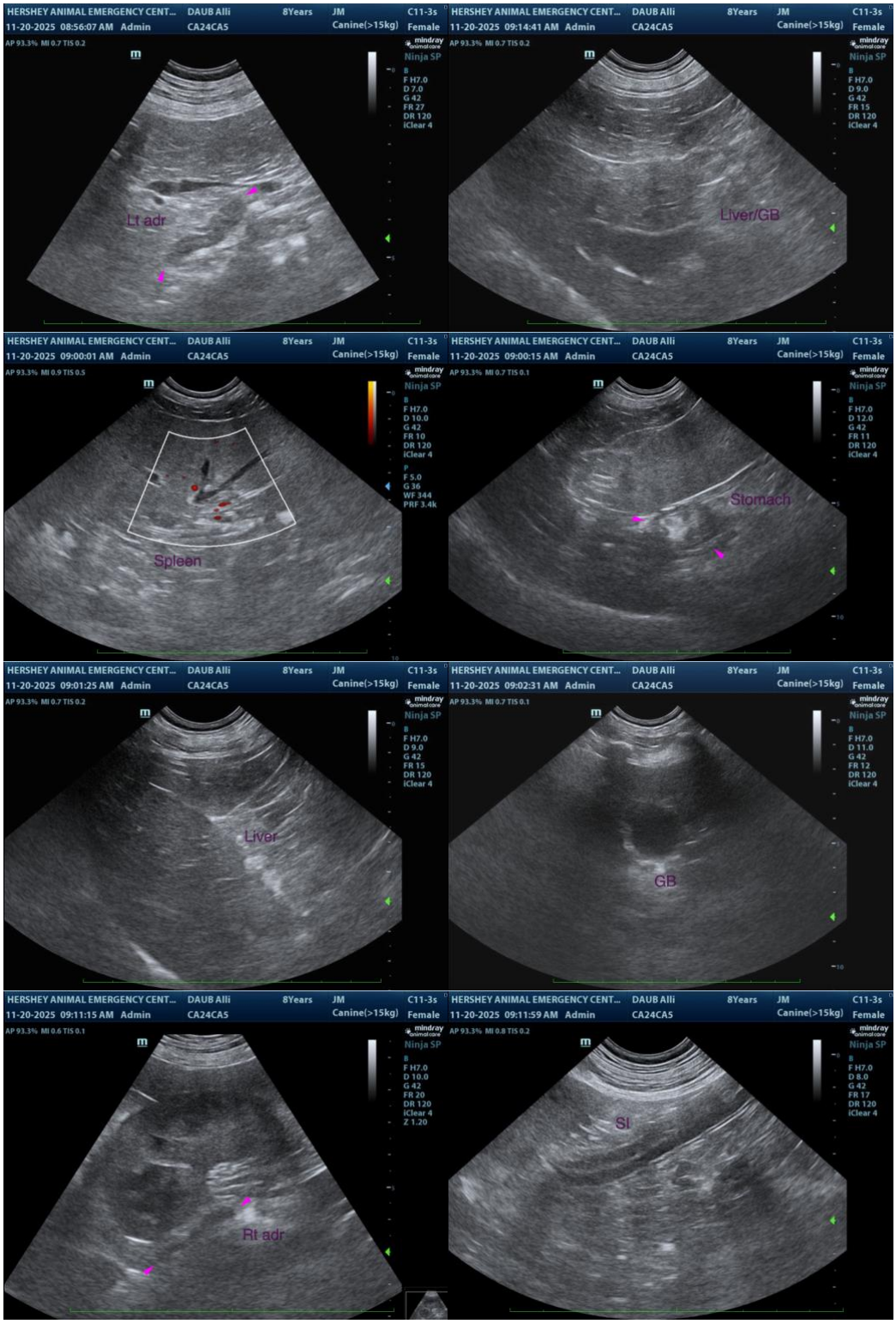

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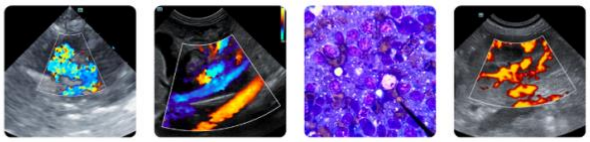

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com