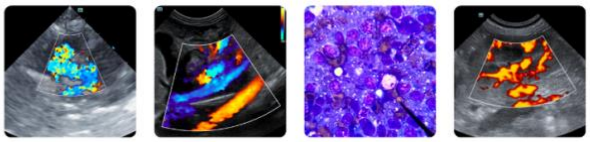


PATIENT

Arista Shanley

SPECIES

Canine

BREED

Sheltie

SEX

Female Spayed

AGE

16

WEIGHT

22 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Julia Bakker, DVM

HOSPITAL NAME

Orange Blossom Vet Imaging

REFERRING VET

Aleia Hollands, DVM

INVOICE

22703

DATE

3-16-26

PRESENTING CLINICAL SIGNS

- Patient presented ADR to the ER with vomiting and diarrhea
- Currently receiving supportive care for pancreatitis, gastroenteritis of unknown origin
- Patient is still vomiting even with Cerenia
- ER SOAP, labwork, and radiograph report to review

Abnormal PE/Chem/CBC/UA Results: BUN 96. Creatinine 2.0. Phosphorus 5.7. Albumin 2.1. ALT 204. ALP 351. GGT 16. CBC unremarkable. T4 0.9. 4dx negative. Bloodwork from December 2025 revealed borderline azotemia, elevated liver enzymes, normal albumin.

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. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone is normal.

The left kidney is normal in size (4.49 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild- to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Mild pyelectasia is present (0.22 cm in the longitudinal plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.69 cm in length) with a slightly irregular shape. The cortex is variably thickened, with mild- to moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is a questionable cortical infarct at the caudal pole. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of the adrenal glands is evaluated. No obvious pathology is observed in this region.

Spleen

The spleen is normal in size (0.77 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Pinpoint hyperechoic foci are observed throughout the organ. A few, small, myelolipomas are also seen. Splenic vasculature is normal.

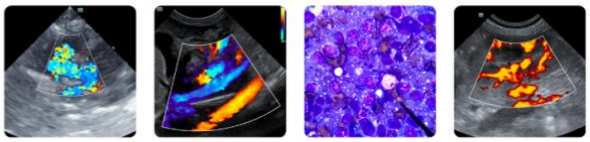
Liver

The liver is subjectively enlarged, with swollen peripheral contours. The parenchyma is hyperechoic-relative to the spleen, and diffusely mottled, with varying-sized hypoechoic nodules throughout the organ. At least one parenchymal cyst is also seen. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is distended. The wall is normal in thickness. A large amount of aggregated, echogenic, suspended sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with ingesta. 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 is normal in thickness 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.



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Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gallbladder changes are consistent with a fully-formed mucocele.
- 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.
- Bilateral nonspecific age-related renal changes with dystrophic mineralization, mild left pyelectasia, and a suspected right cortical infarct.

Secondary Findings

- Minor retained gastric ingesta

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the hepatic changes, consider liver tissue sampling (i.e., aspirates or biopsies) assuming normal clotting status. If biopsies are pursued, consider a cholecystectomy at the time of surgery with submission of the gallbladder for aerobic and anaerobic bile cultures and histopathology. Hepatic copper quantitation should also be performed. If surgery is not pursued at this time, Ursodiol therapy is recommended for the gallbladder mucocele. Serial sonographic monitoring (i.e., every 4-6 weeks) is also recommended to assess for progression, as gallbladder rupture with subsequent bile/septic peritonitis is possible.
- If a conservative approach is desired, consider empirical treatment for bacterial cholangiohepatitis (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.
- Also consider Leptospirosis testing (i.e., blood and urine PCR, serology), particularly if clinical suspicion for disease is high.

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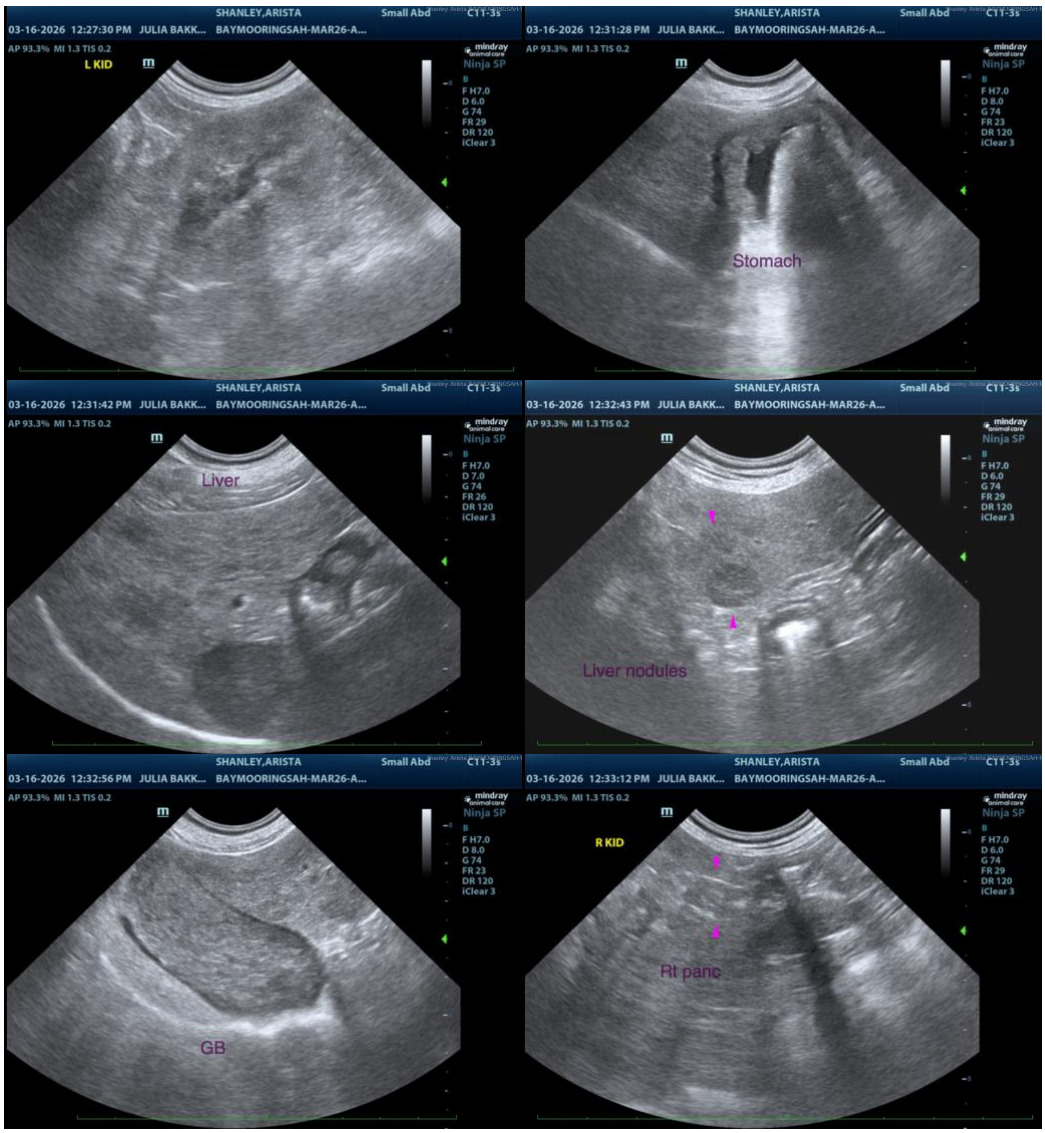
- Regarding the renal changes and azotemia, consider the following:

1. Urinalysis with culture and sensitivity
2. UPC if proteinuria is present in the absence of infection
3. Leptospirosis testing (as stated above)
4. Baseline blood pressure measurement
5. Fluid therapy as needed
6. Serial monitoring of the patient's renal values to assess progression of the azotemia



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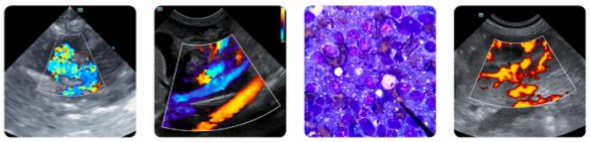

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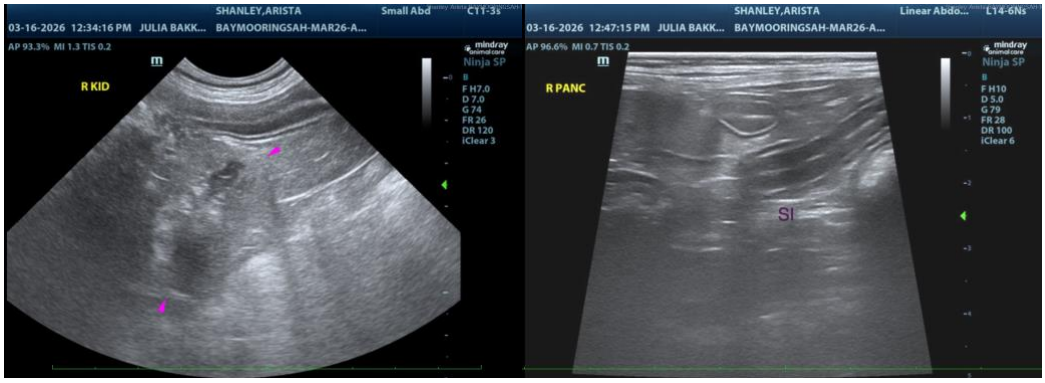

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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