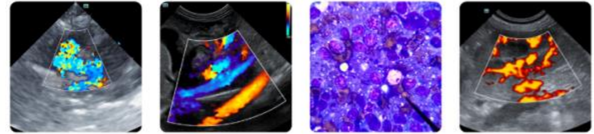


PATIENT
Shelby Ambler

SPECIES
Canine

BREED
Chow Chow Mix

SEX
Female Spayed

AGE
6 years 9 mos

WEIGHT
48 lbs

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

IMAGING PERFORMED BY
Kelly Romero

HOSPITAL NAME
Countryside AH

REFERRING VET
Kristin White

INVOICE
22662

DATE
3-8-26

PRESENTING CLINICAL SIGNS

History: Current vomiting and lethargy. One month ago, vomited about 5 times over the course of 2 days, but resolved. Currently dribbling discolored urine. No reported PU/PD.

Abnormal PE/Chem/CBC/UA Results: CBC-WNL Chem: ALT 773 U/L (H), ALKP 389 U/L (H), GGT 31 U/L (H), Tbilirubin 0.5 mg/dl (H), otherwise WNL UA - SpG 1.005, inactive sediment

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System
In the visualized portion of the urinary bladder, it appears mildly- to moderately-distended. The visible walls are normal in thickness. Luminal contents are anechoic. No obvious cystic calculi are seen.

The left kidney is normal in size (5.78 cm in length) with a normal shape, architecture and 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 hydroureter.

The right kidney is normal in size (5.86 cm in length) with a normal shape, architecture and 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 hydroureter.

Adrenal Glands
The left adrenal gland is overall normal in size (0.48 cm at cranial pole) (0.54 cm at caudal pole) with a slightly irregular shape. A 0.83 x 0.64 cm hyperechoic, slightly expansile nodule is observed approximately mid-gland. The remaining glandular echogenicity and detail are normal. Surrounding vasculature appears normal.

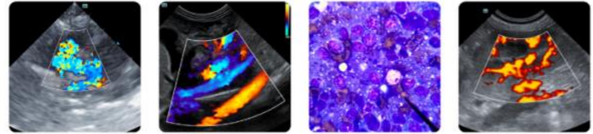
The right adrenal gland is normal in size (0.94 cm at cranial pole) (0.54 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen
In the visualized portion of the spleen, it appears subjectively normal in size (1.71 cm in width at the level of the hilus) with normal peripheral contours. The parenchyma is homogenous. No focal lesions are observed. Splenic vasculature appears normal with no obvious evidence of thrombosis.

Liver
The liver is subjectively normal in size with normal peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. There is an increase in portal markings. Intrahepatic biliary mineralization is visualized in some regions. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small- to moderate amount of mobile echogenic debris is observed within the lumen. The distal common bile duct is visible and appears dilated (up to 0.51 cm). Luminal contents are empty. The duodenal papilla is thickened (up to 0.56 cm).

Gastrointestinal
The gastric lumen is mildly fluid-distended. 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



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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.

Pancreas
The left 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
The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The increase in hepatic portal markings is suggestive of an inflammatory process (i.e., cholangiohepatitis, chronic hepatitis). Other considerations include Leptospirosis, hepatotoxicity, or less likely, infiltrative neoplasia). Intrahepatic biliary mineralization is present.
- Gallbladder debris, non-mucocele. There is no obvious evidence of a distal common bile duct obstruction.

Secondary Findings

- Minor bilateral age-related renal changes
- The left adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.
- Mild gastric fluid retention
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Leptospirosis testing (i.e., blood and urine PCR, serology) is recommended, particularly if clinical suspicion for disease is high.
- Cytologic evaluation of the liver should be considered in this patient if clotting status is appropriate. A fine needle aspirate using a 25-gauge needle is recommended. If cytologic evaluation is inconclusive, consider a surgical liver biopsy with aerobic and anaerobic bile cultures and acquisition of additional hepatic tissue samples for copper quantitation. If hepatic tissue sampling is not pursued at this time, consider empirical treatment for cholangiohepatitis with amoxicillin-clavulanic acid, Denamarin, +/- a Ursodiol. If liver values improve with therapy, a 4–6-week course of treatment is recommended.

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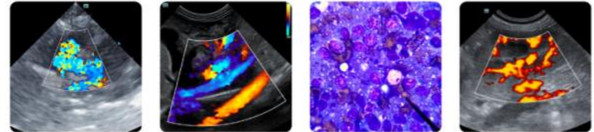

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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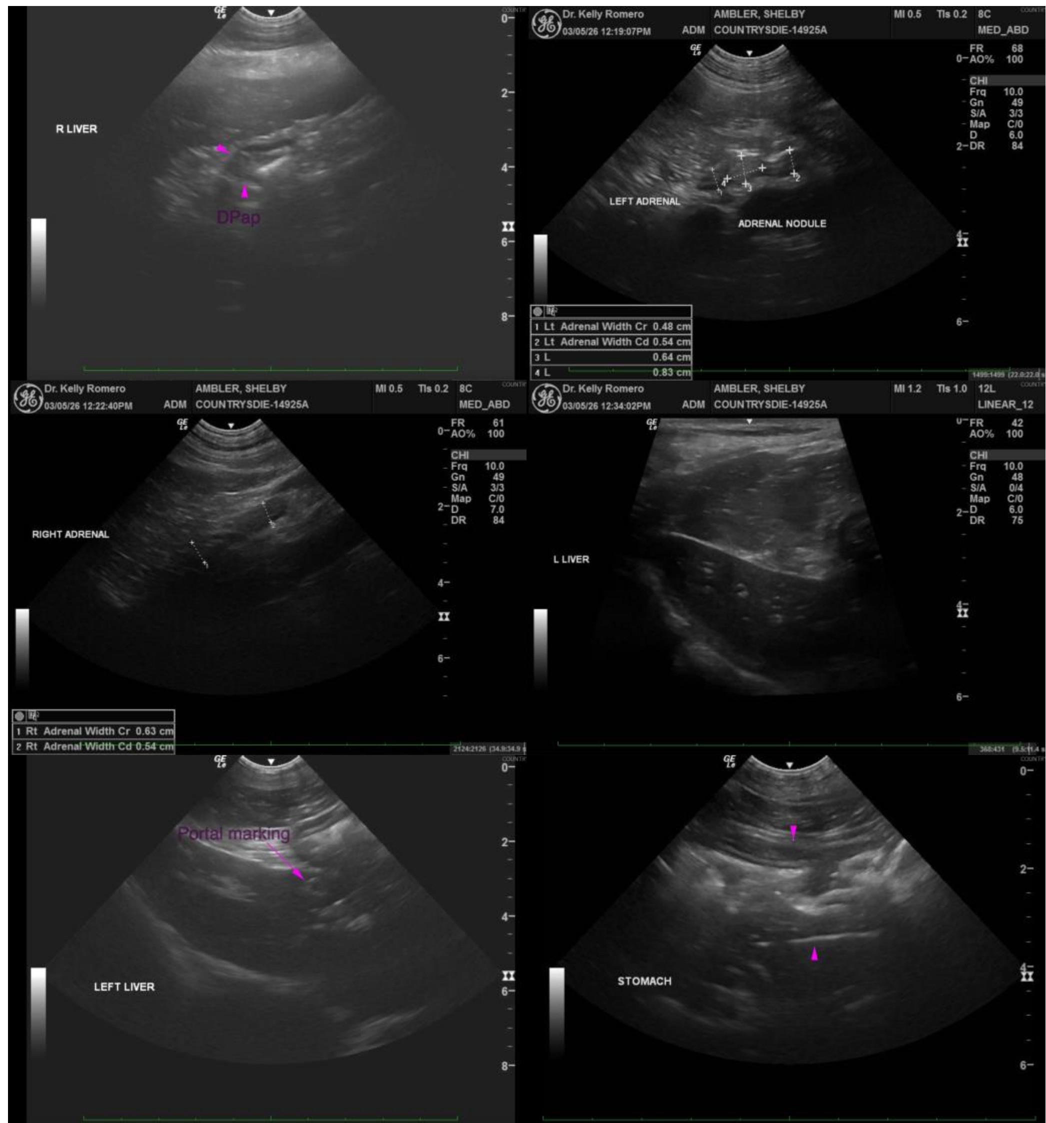
- Regarding the left adrenal nodule, consider the following:

1. Baseline blood pressure measurement
2. +/- three-view thoracic radiographs to assess for metastatic disease in the chest
3. Further testing for a functional tumor (once the patient's hepatopathy is resolved)
4. Recheck ultrasound in 2-3 months to assess for growth of the lesion



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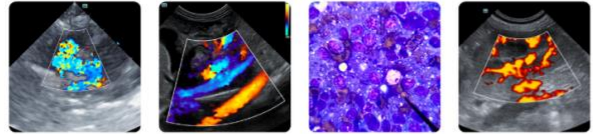

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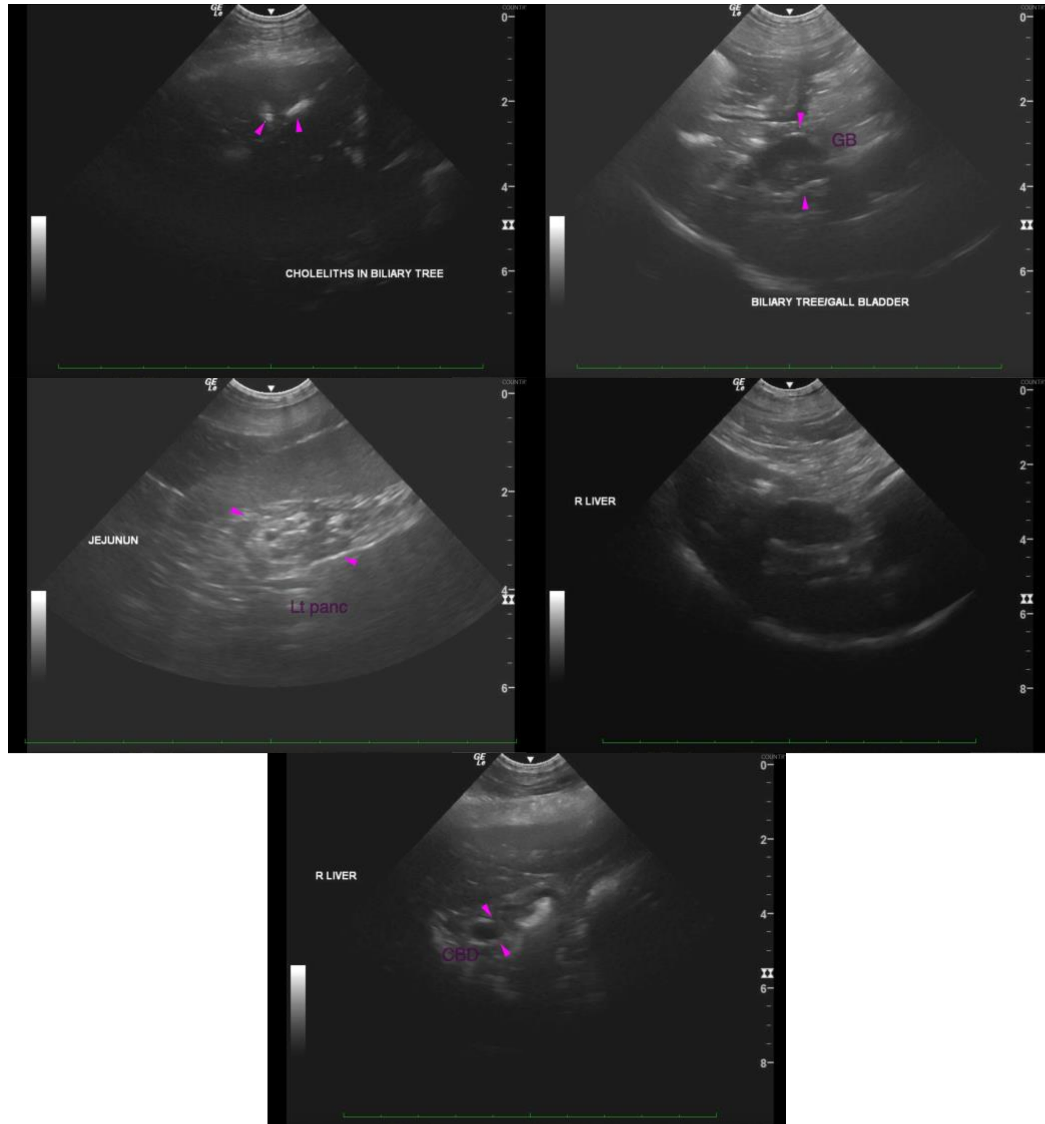

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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