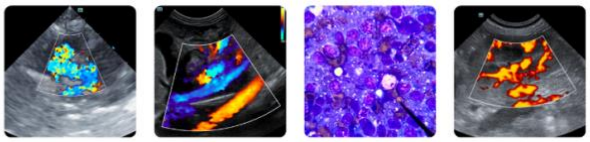


PATIENT

Max Daugherty

SPECIES

Canine

BREED

Labrador Retr Mix

SEX

Neutered Male

AGE

10

WEIGHT

47 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores VEC

REFERRING VET

Lisa Miller

INVOICE

22793

DATE

4-6-26

PRESENTING CLINICAL SIGNS

History: Max has a long-standing history of chronic gastritis since he was 5 years old. During his initial trials he was on hydrolyzed diets and novel proteins. None of which seemed to work. He was eventually placed on a homecooked diet and prednisone. Max is currently receiving Pred 10mg every other day and has been on this dose for 3.5 years now. This year Max has started with increased drinking and urination. His urine has also altered color to a dark orange to brown. In early January he had relatively normal lab work. On 3/21/2026 Max was taken to Rossmoyne for a brief history of vomiting and diarrhea. Owners at that time thought he possibly has an obstruction since he could not even keep water down. During this time they also noticed he became super lethargic and his appetite depleted off. A workup was performed and he was discharged with supportive care. Rads showed concerns for some potential free fluid or peritonitis in the cranial abdomen. Max rebounded after a few days and then had 3-4 good days of appetite and energy back to 100% normal. However, more recently he has fallen off again and is anorexic and lethargic. Labwork and visit at RDVM on 4/3/2026 showed severely elevated liver enzymes. Most currently the owners report the following: appetite 0-25% of normal- he will decline high value treats and is currently only intaking crackers, toast and some turkey lunchmeat. Concern for acute liver insult- neoplasia vs toxin vs other; gallbladder disease

Abnormal PE/Chem/CBC/UA Results: PE: jaundice MM, sclera, pinna; mild pain 2/4 with abdominal palpation; reactive with cranial abdomen rDVM 1/26: All values were normal except ALP 432 H rDVM 4/2: ALT 2883 H, ALP 15,097 H, AST 325 H, GGT 188 H, T Bili14.3 H, triglycerides 441 H T4: checked twice (1/26 and 4/26) normal spec PSL check twice (1/26 and 4/26) normal rads RAHUCC 3/21 report: free fluid cranial abdomen; liver and spleen both noted as normal shape and size

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 visible portion of the proximal urethra are normal.

The region of the prostate is not visualized due to its pelvic location.

The left kidney is normal in size (7.48 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.

The right kidney is normal in size (6.97 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.

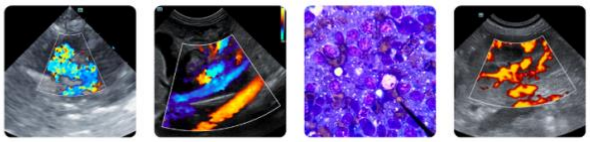
Adrenal Glands

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

The right adrenal gland is normal in size (1.51 cm at cranial pole) (0.81 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 normal in size (2.13 cm in width at the level of the hilus) with a normal capsular



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contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder is distended. The wall is normal in thickness. A small amount of echogenic debris is suspended within the lumen. The visible cystic and common/bile duct is dilated (up to 2.1 cm).

Gastrointestinal

The gastric 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 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 is prominent-in-size, with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat, and slightly heterogenous in appearance. The pancreatic duct is not overtly dilated. Surrounding mesentery is hyperechoic.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gallbladder and cystic/common bile duct distention. Intraluminal or extraluminal obstruction is suspected (although not visualized in the available images).
- The pancreatic changes in the left limb are suggestive of mild pancreatitis with adjacent peritonitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider additional abdominal imaging (i.e., abdominal CT scan) to further evaluate for a bile duct obstruction. Alternatively, consider referral to a board-certified surgeon for an abdominal exploratory and assessment of bile duct patency. Hepatic biopsies, aerobic and anaerobic bile cultures, and samples of liver for copper quantitation should also be obtained at the time of surgery.

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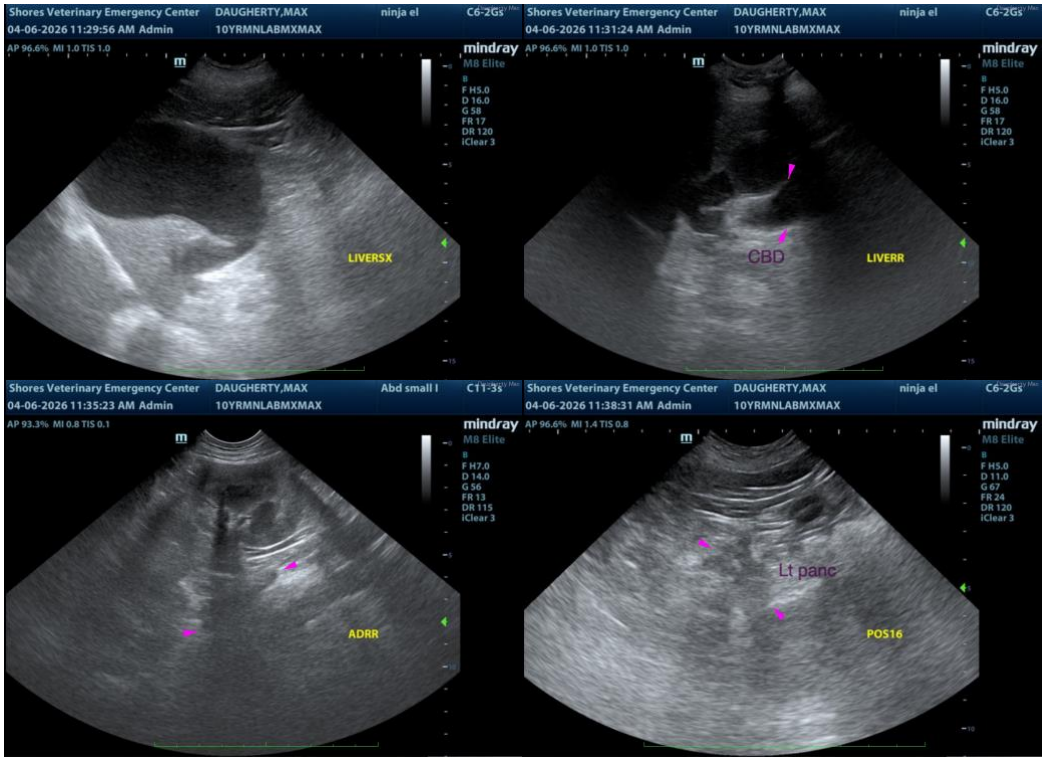

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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