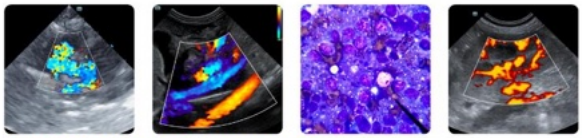

PATIENT

Blaise Cromer

SPECIES

Canine

BREED

Labrador Retriever

SEX

Female, spayed

AGE

11/1/2013

WEIGHT

54.4 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Kind Care AH

REFERRING VET

Dr. Marino

INVOICE

13452

DATE

2/4/26

PRESENTING CLINICAL SIGNS

Abdominal: The abdomen is mildly distended and tense on cranial palpation. Possible cranial abdominal organomegaly (hepatomegaly) is suspected.
Vomiting.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are mostly 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 (7.35 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. Renal vasculature is normal.

The right kidney is normal in size (7.70 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. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size at the cranial pole and mildly enlarged at the caudal pole (0.55 cm at cranial pole) (0.83 cm at caudal pole). Glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (1.30 cm at cranial pole) (0.74 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 (1.45 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Ill-defined meylolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is normal to prominent in size with normal peripheral contours. The parenchyma is isoechoic to slightly hypoechoic relative to the spleen and subtly mottled in appearance. At least one small ill-defined hypoechoic nodule is visualized left to mid-liver, the nodule measures 1.1 cm in its longest dimension. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of mostly gravity-dependent echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is minimally distended with ingesta and gas. 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 segmentally dilated with gas and chyme. The small intestinal wall is normal in thickness with a

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normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

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.

Other
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

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.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

Secondary Findings:

- Mild bilateral nonspecific, age-related renal changes
- Mild bilateral adrenomegaly

*An obvious cause for the patient's vomiting is not definitively identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the vomiting, consider the following:
  1. Fecal evaluation for internal parasites
  2. GI panel including serum cobalamin, folate, TLI and PLI
  3. 3-4 week limited antigen or hydrolyzed protein diet trial
  4. Initiation of a probiotic (if not already receiving one)
  5. +/- endoscopic or surgical GI biopsies
- Regarding the elevated ALT, consider the following:
  1. Pre and post-prandial serum bile acids

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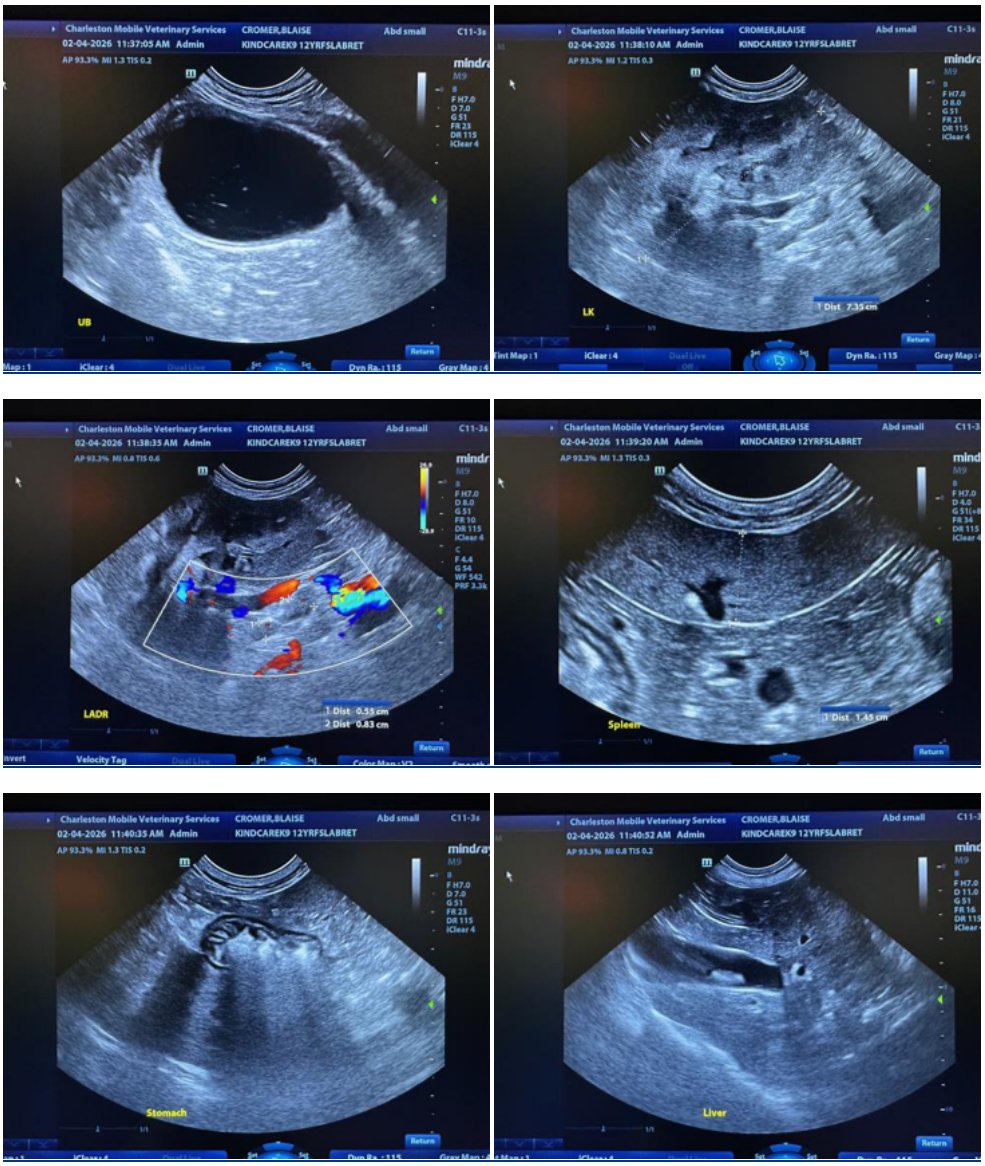
2. Leptospirosis testing (i.e., blood and urine PCR, serology) particularly if clinical suspicion for disease is high
3. Hepatic tissue sampling (i.e., aspirates or biopsies) assuming normal clotting status. If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed. Given the patient's breed, liver biopsies are preferred over aspirates as they are more likely to definitively diagnosis chronic hepatitis and copper hepatotoxicosis which are seen more frequently in Labrador retrievers.

- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.



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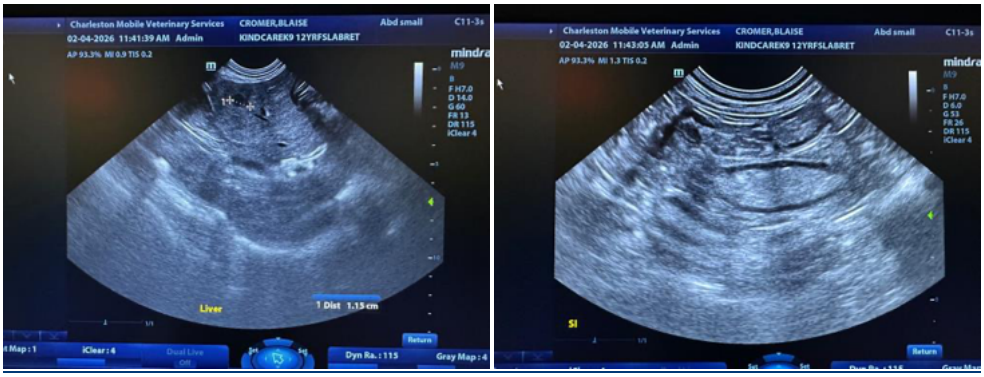

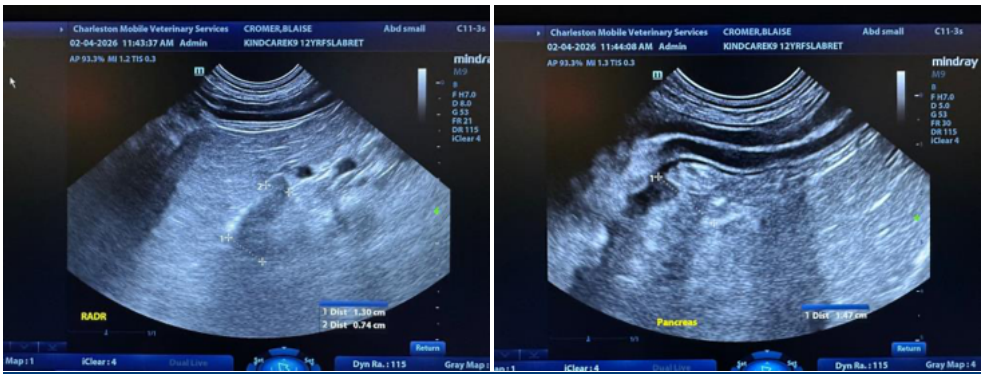

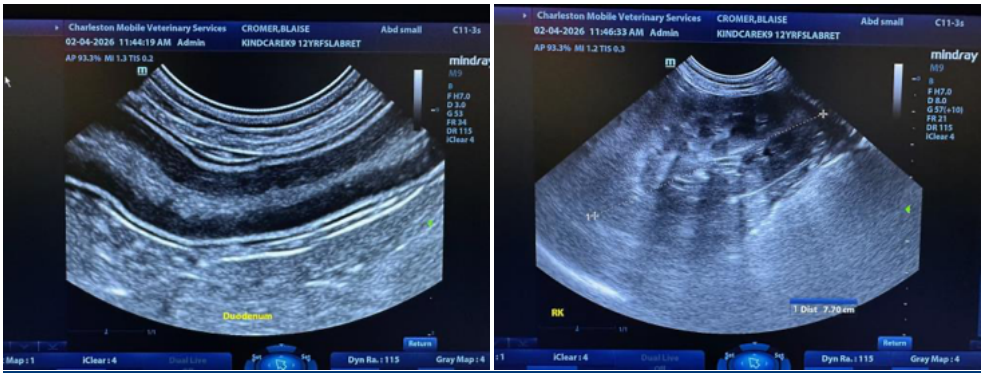

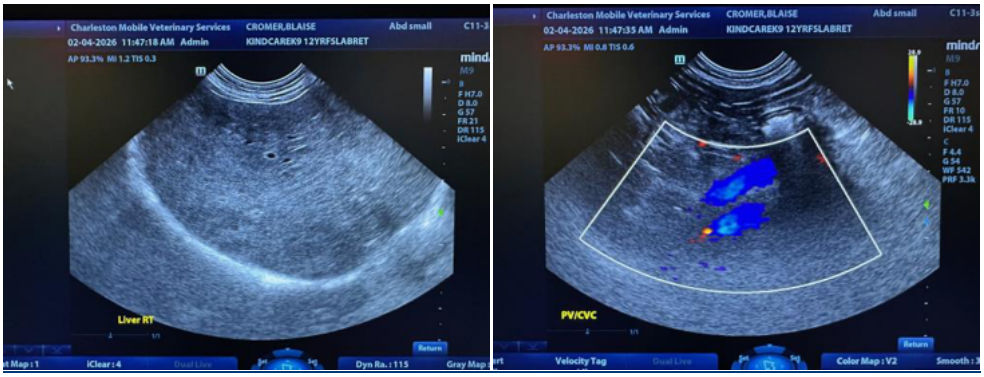

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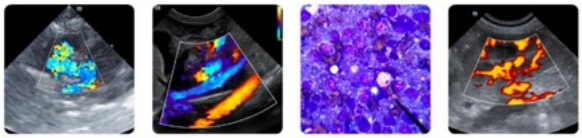

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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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