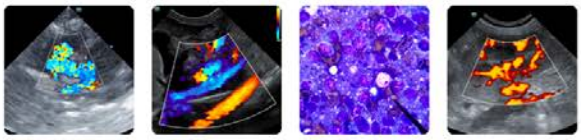

DATE

12/16/25

PATIENT

Louie Meliker

SPECIES

Canine

BREED

Pit Bull x

SEX

Neutered Male

AGE

1/1/20

WEIGHT

56.5 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Greenbrier Veterinary Clinic

REFERRING VET

Dr. Dellinger

INVOICE

72609

PRESENTING CLINICAL SIGNS

Patient History: Presented with weight loss and decreased appetite. Held off on vaccines and BW showing all liver enzymes elevated, BUN decreased ALB decreased. P is still E/D and overall acting normally and is stable. Not overtly icteric on exam 12/15.

Current Medications: Clavamox 375mg 1 BID #14, started on 12/12, Denamarin 425mg 1 SID started on 12/12
Labwork Results: Labwork attached, reported as: 12/5 BW- anemia, alb 2.2, glob 6.3, ALT 726, ALP 1578, AST 191, GGT 26, Tbili 1.4. 12/12 BW at Pet+ ER- ALB 2.6, glob6.4, ALT 903, ALP >2000, GGt 24. Tbili1.4
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Decliined.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal is size (7.7 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (7.1 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.79 cm at cranial pole and 0.69 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.67 cm at cranial pole and 0.63 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively enlarged with moderately irregular margins. Parenchyma is mottled by multifocal ill-defined hypo- to anechoic nodules/masses of varying sizes, many with a cystic or cavitated appearance. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is a mild amount of anechoic free fluid noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The appearance of the liver is concerning for infiltrative neoplasia such as round cell neoplasia versus metastatic neoplasia versus other. Having said that, benign disease including cysts, hematomas, nodular hyperplasia, extramedullary hematopoiesis, inflammatory disease, etc. cannot be ruled out without tissue sampling.

- The mild amount of free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

- Emerging mucocele – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary

disease. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the liver are recommended if patient's coagulation status is appropriate.

Ultimately, if a diagnosis is unable to be obtained cytologically, an exploratory laparotomy for planned excisional biopsies may be necessary for a definitive diagnosis. However, given the diffuse nature of the disease, full resectability of the visible pathology is considered unlikely.

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.

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