



**PATIENT**

Cienna Wilson

**SPECIES**

Canine

**BREED**

Catahoula Leopard Dog

**SEX**

Spayed Female

**AGE**

8 Years

**WEIGHT**

36 kg

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Erin Wicks

**HOSPITAL NAME**

Shores VEC

**REFERRING VET**

Dr. Lupole

**INVOICE**

45447

**DATE**

2/23/23

**PRESENTING CLINICAL SIGNS**

Presented at our hospital for vomiting, lethargy started last night. Has vomited more than 10 times, some blood in the vomit this morning, stool is soft and black. Restless all night, unable to keep anything down. Previous Health Concerns: Liver disease, arthritis, gastroenteritis Current Medications: MSM Appetite/When did they eat last: appetite decreased, ate last night

Abnormal PE/Chem/CBC/UA Results: Temp: 103.8 F Cardiovascular: no murmur heard, est 5-8% dehydration Respiratory: panting, harsh BV sounds all quadrants, no crackles/wheezes heard Abdominal: no obvious mass, difficult to palpate due to tense/painful and large amount intra-abdominal fat Radiographs: mild hepatomegaly noted, visible two SQ sutures on ventral midline, loss of detail cranial abdomen, no obvious mass or foreign material/obstruction noted, unremarkable thoracic lateral radiograph Chemistry: ALT >1000 H (diluted 1593 H), Total cholesterol 348 H, ALP 211 H, GGT 28 H, Total bilirubin 4 H \*icteric serum CBC: stress leukogram, PMN % 85.2 H, Lymph% 8.1 L, Hgb 19.8 H, Plt 20, MPV 6 L (reran CBC and platelets 44 L) EPOC: Lactate 5.03 H, HCT 60% H Pt/aPtt: 18.1 N; aPTT 110.9 H Flex 4: negative Leptospirosis witness test: negative Urine strip (free catch): 1.028 USG, 3+ RBC, 4 urobilinogen, trace protein, 9 pH

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately 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.

The right kidney is normal in size (6.74 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 in size (6.77 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 (0.66 cm at the caudal pole, the cranial pole is not well visualized), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. \*\*See other.

The left adrenal gland is normal in size (2.97 cm long x 0.72 cm at the cranial pole and 0.65 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. 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**

Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



<b>PATIENT</b>	Gallbladder is moderately distended with anechoic bile as well as moderate to marked suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.
Cienna Wilson	
<b>SPECIES</b>	<b>Gastrointestinal</b>
Canine	The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.
<b>BREED</b>	
Catahoula Leopard Dog	The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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.
<b>SEX</b>	
Spayed Female	The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.
<b>AGE</b>	
8 Years	<b>Pancreas</b>
<b>WEIGHT</b>	The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted.
36 kg	<b>Free Abdomen</b>
<b>INTERPRETED BY</b>	There is no evidence of free peritoneal effusion noted in these images.
Beth Johnson, DVM DACVIM	In the cranial abdomen, there is a round hypoechoic 1.5 cm in diameter hepatic lymph node that is enlarged and surrounded by enhanced hyperechoic mesenteric fat.
<b>IMAGING PERFORMED BY</b>	Cranial to the right kidney, there is an oblong structure that measures 1.5 cm thick with a heterogeneous hypoechoic appearance surrounded by enhanced hyperechoic mesenteric fat that appears to be an inflamed enlarged lymph node. It is in an area similar to the right adrenal gland, so a right adrenal mass cannot be 100% ruled out, but is not believed likely based on exact location.
Erin Wicks	<b>ULTRASONOGRAPHIC FINDINGS</b>
<b>HOSPITAL NAME</b>	<ul style="list-style-type: none"> <li>• <b>Hypoechoic hepatomegaly</b> – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.</li> </ul>
Shores VEC	<ul style="list-style-type: none"> <li>• <b>Moderate to marked gallbladder debris</b> - 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. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.</li> </ul>
<b>REFERRING VET</b>	<ul style="list-style-type: none"> <li>• Acute pancreatitis</li> </ul>
Dr. Lupole	<ul style="list-style-type: none"> <li>• <b>Aggressive cranial abdominal lymph nodes</b> – most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.</li> </ul>
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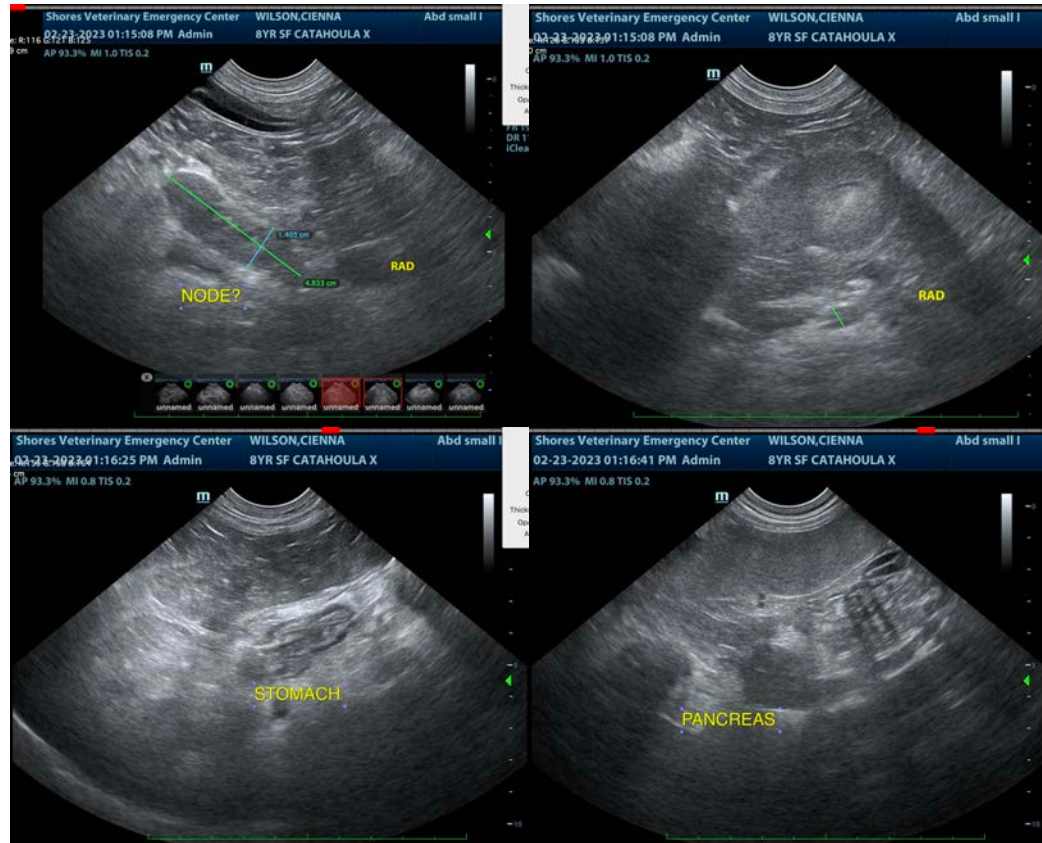
**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Further evaluation of this patient's machine reported thrombocytopenia is recommended via a manual platelet smear to help determine whether thrombocytopenia is a true pathologic process. If patient's coagulation status is appropriate, fine needle aspirates of the liver as well as the enlarged cranial abdominal lymph nodes are recommended.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal exam is recommended if not recently evaluated.

In addition to a hepatopathy of unknown origin, mild pancreatitis and potentially an emerging gallbladder mucocele may be contributing to this patient's abdominal discomfort and gastrointestinal signs. Therefore, while awaiting diagnostic results, medical management of acute pancreatitis, gastritis, cholangitis, etc. with antiemetics, gastroprotectants including sucralfate, appetite stimulants, or nutritional support as needed, pain management, broad-spectrum antibiotics, hepatic nutraceuticals including Ursodiol and fluid therapy are recommended.





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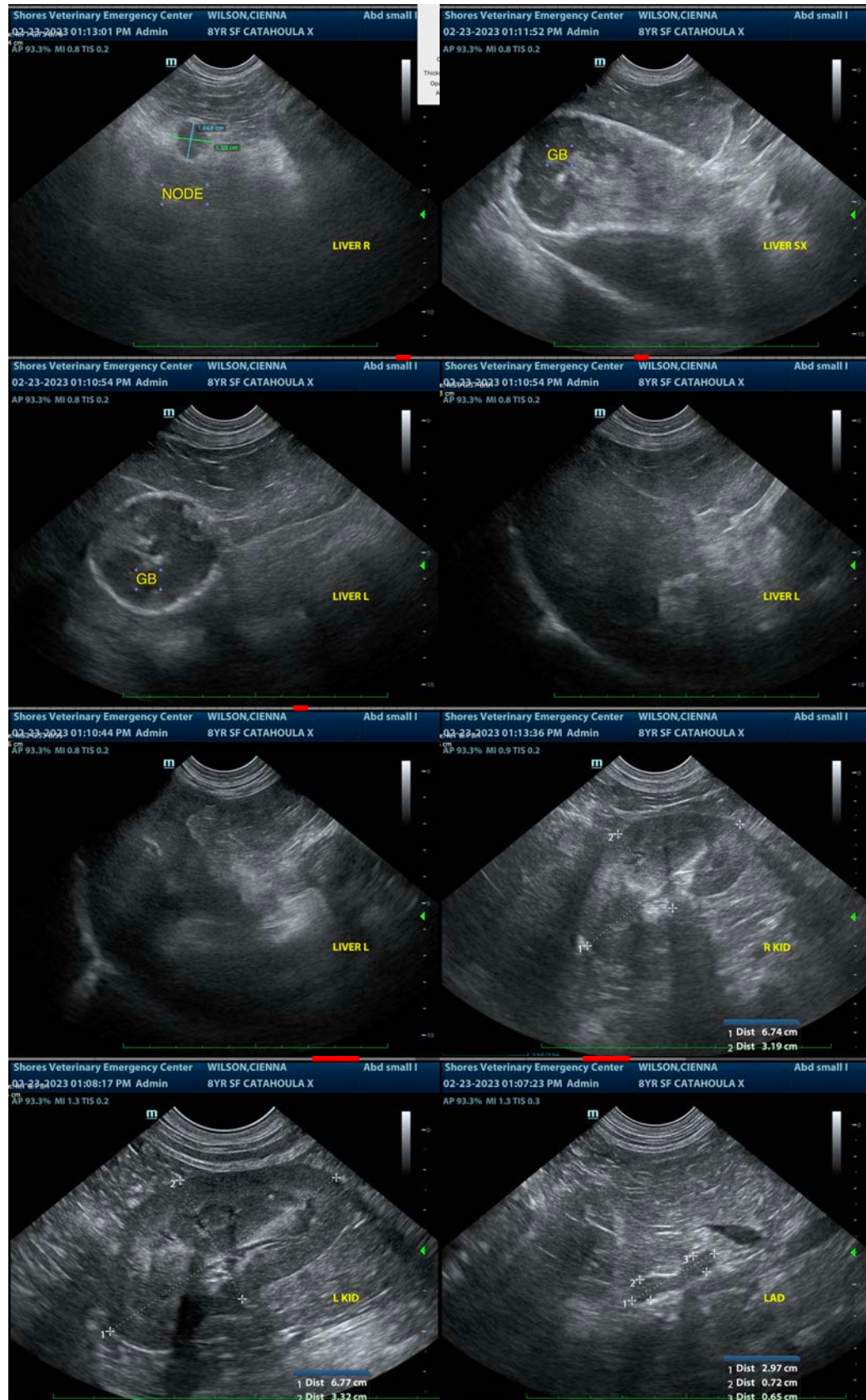
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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**Beth Johnson, DVM, DACVIM**  
Beth.Johnson@sonopath.com