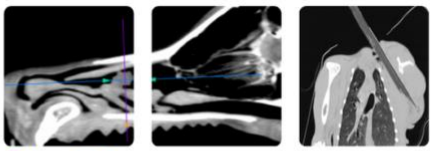


PATIENT

Haggis Nissen

SPECIES

Canine

BREED

Basset Hound

SEX

Neutered Male

AGE

8 Years

WEIGHT

28.8 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Conestoga Veterinary Clinic

REFERRING VET

Dr. Doering

INVOICE

15068

DATE

04/13/26

PRESENTING CLINICAL SIGNS

Presenting Complaint: acute onset anorexia, polydipsia/polyuria, lethargy, and jaundice over the past 2–3 days. Bright, alert, responsive. Generalized icterus: sclera OU, oral mucous. Abdomen soft, non-painful, no palpable organomegaly or masses. Cardiopulmonary exam unremarkable. Problem List: 1. Jaundice (icterus) 2. Severe hepatopathy based on bloodwork 3. Anorexia and weight loss 4. Polydipsia and suspected polyuria 5. Acute onset lethargy 6. Mucoid diarrhea 7. Pre-existing uveitis, left eye more affected
Current Medications: Maropitant 60 mg SID; Clavaseptin 500 mg BID; Ursodiol 250 mg SID

CBC/Chemistry: Marked hepatopathy: ALT >1000 Elevated ALP, GGT, total bilirubin Low urea (consistent with decreased hepatic function) Mild hemoconcentration WBC and platelets WNL cPL: WNL Leptospirosis PCR neg Primary Question to Be Answered in This Exam Any evidence of enlarged liver? Liver masses? Other areas of concern in the liver? Any evidence of gall bladder sludge/ mucocele etc? Any other concerns in the gastrointestinal tract? (Pet has a history of appetite issues/ hunger strikes

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

The area of the prostate is examined without evident prostatic pathology.

Left kidney is normal in size (7.5 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.

Right kidney is normal in size (6.6 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

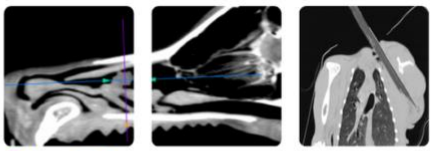
Left adrenal gland is normal in size (0.40 cm at cranial pole and 0.67 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.4 cm at cranial pole and 0.51 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large 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. The spleen is folded upon itself, which is a positional non-pathologic variant.

Liver



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Liver is subjectively mildly decreased in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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 no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is not a definitive ultrasonographically visible explanation for patient's reported laboratory changes. Ultimately, if further infectious, inflammatory, reactive hepatopathy workup does not result in a diagnosis, a liver biopsy may be necessary for a definitive diagnosis and therefore to further guide medical management. Assessment of patient's coagulation status is recommended prior to sampling. In the meantime, while of unknown if any relation, fine needle aspirates of the spleen can be considered if patient's coagulation status is appropriate.

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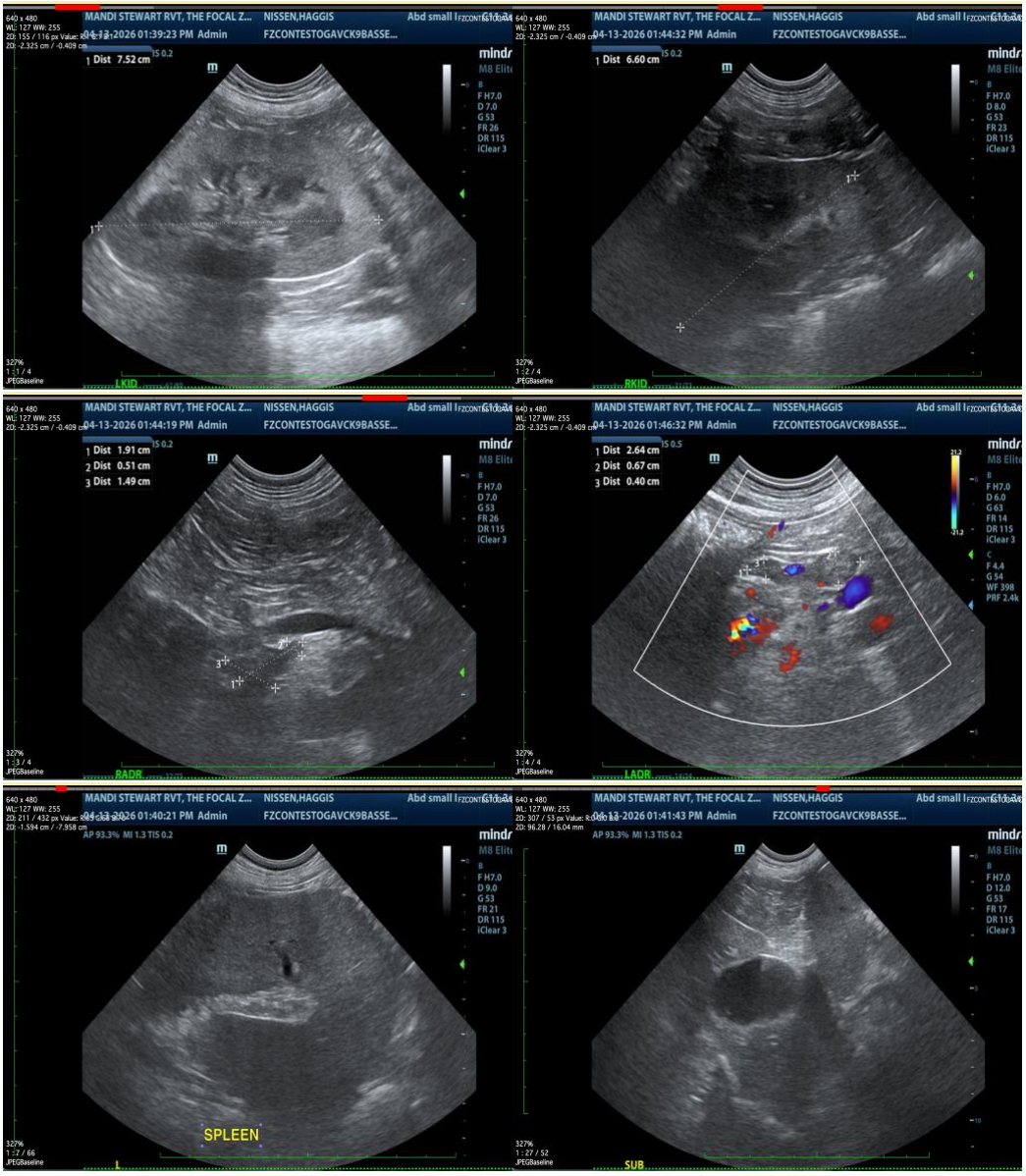

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@sonopath.com