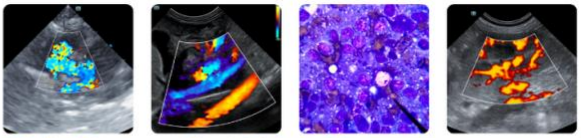


PATIENT

Guiness Krystofik

SPECIES

Canine

BREED

Pitbull

SEX

Neutered Male

AGE

12 Years 2 Months

WEIGHT

65 Pounds

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Advanced VC

REFERRING VET

D., Voigt

INVOICE

36839

DATE

4/27/26

PRESENTING CLINICAL SIGNS

History: Elevated liver enzymes, weight loss, (unexplained) Pu/Pd- R/O neoplasia, prominent spine, abdomen tense, Temp N, App is excellent, had one seizure last week (ever had before) poss. ammonia breath? Meds: Lactulose.

Abnormal PE/Chem/CBC/UA Results: WBC 5.4 L, BUN 38 H, Chlor 105 L, ALT 323 H AST 62 H, ALP 432 H Creatine Kinase 210 H Urine: USG 1.020 Low, marked Cocci > 40, Urine protine 3+, WBC 15-25, 4DX Pos Lyme.

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. Ventral to the trigone/proximal urethra is a mildly tortuous tubular to ovoid appearing anechoic structure, measuring 0.76 cm in diameter.

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

Kidneys are normal in size and contour. A relatively uniform hyperechogenicity is observed with mildly decreased corticomedullary distinction. No mineral is observed. Trace pyelectasia is noted in the left kidney. No overt masses/nodules are observed. The left kidney measured 7.24 cm. The right kidney measured 7.43 cm.

Adrenal Glands

Left adrenal gland is normal in size (0.9 cm at cranial pole and 0.9 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.5 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

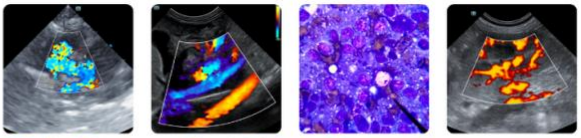
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively normal 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



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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

- The appearance of the kidneys could be consistent with chronic interstitial nephritis or glomerular nephritis with potentially an acute on chronic insult such as a toxic insult and or infectious disease including pyelonephritis, leptospirosis, other infectious diseases, etc. Having said that, these changes are relatively mild/subtle and should be interpreted in combination with any suspicion for renal disease and or supporting laboratory or urinalysis changes.

- The structure described above ventral to the trigone could represent a mildly dilated tortuous ureter, potentially even an ectopic ureter, although there's no dilation elsewhere to suggest or confirm it. Other differentials, including even a cystic lymph node or atypical prominent vessel can't be definitively ruled out.

- An obvious cause for the reported increased liver enzymes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia, etc. cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not already pending, a urine culture could be considered.

Especially given patients reported leukopenia, comprehensive infectious disease evaluation could be considered, including determining whether or not the positive Lyme value warrants treatment, as well as considering testing for leptospirosis.

In the meantime, especially given the reported recent seizure, and the increased ALT, bile acids are recommended if patient's total bilirubin is not increased.

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I suspect that the PU/PD and weight loss are likely related to potential hepatopathy, emerging kidney disease, infectious disease, or a combination of those things, given reported lab work abnormalities, etc. Having said that, if another underlying cause for the weight loss is not determined, then especially given the normal appetite, further evaluation of digestion and absorption is also recommended including a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, for further evaluation of GI and pancreatic function.

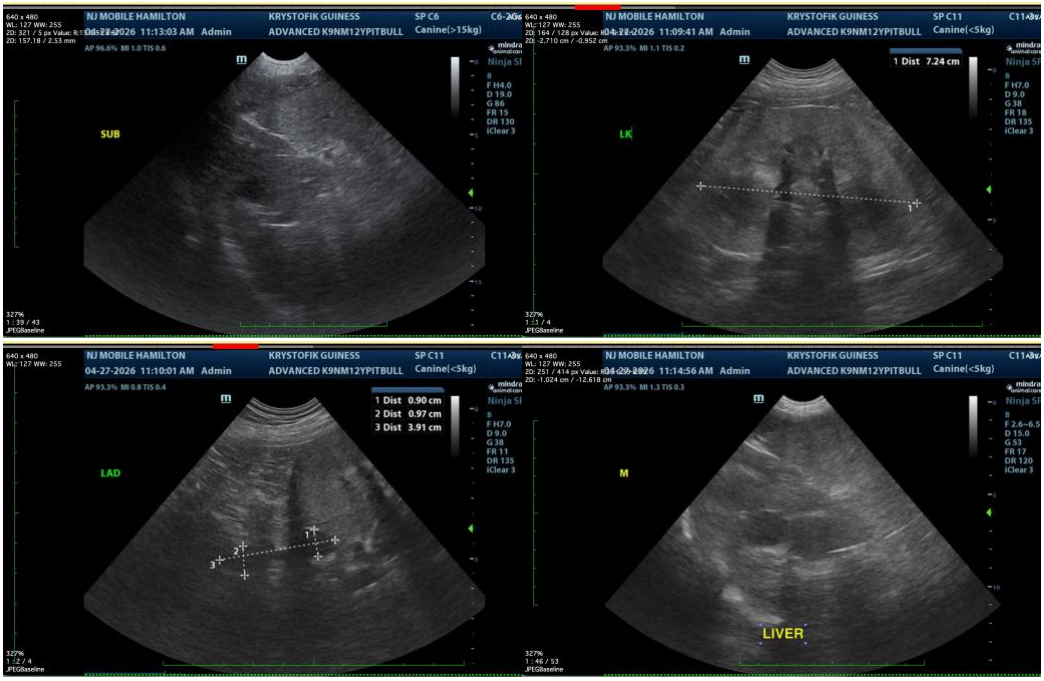
The abnormal caudal abdominal structure is of unknown relation to patients reported clinical history, but advanced imaging, such as a contrast abdominal CT scan could be considered.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.

Addendum:

**Due to gas and rib artifact and overall difficulty appreciating detail and contrast in the cranial abdomen, evaluation of the liver, while thorough, was difficult and is a little bit of a challenge to interpret.

After further consultation with the sonographer, there is an approximately 2.9 cm in diameter anechoic density in the mid liver, originally thought to be associated with the gallbladder, and definitive association with the gallbladder can't be ruled out, but this density could represent an anechoic structure/cyst adjacent to the gallbladder. If it is a hepatic cyst, it trends in appearance toward benign and does not change recommendations, unless sampling is desired, in which case, finding the last bit of the structure could be considered if patient's coagulation status is appropriate.



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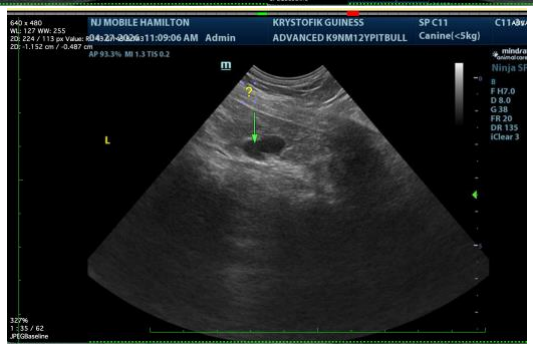

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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