



PATIENT

Seamus Idol

SPECIES

Canine

BREED

Pitbull

SEX

Neutered Male

AGE

12 Years 3 Months

WEIGHT

57 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Cathleen Whitcraft

HOSPITAL NAME

Craig Road AH

REFERRING VET

Dr. Cathleen Whitcraft

INVOICE

16883

DATE

8/16/22

PRESENTING CLINICAL SIGNS

History: Dog has had mildly elevated ALT for over 2 years. An ultrasound 6 months ago caused us to presumptively treat for hepatitis with amoxicillin and metronidazole. Initially the liver value dropped, then it increased. Adding on denamarin did not help. Dog got sick on ursodiol so could not complete a course. Currently on liver diet and Vit E. Has a chronic history of diarrhea that resolved with ABX therapy.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

Left kidney is normal is size (6.04 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 is size (6.37 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 (0.51 cm at cranial pole and 0.49 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.54 cm at cranial pole and 0.53 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

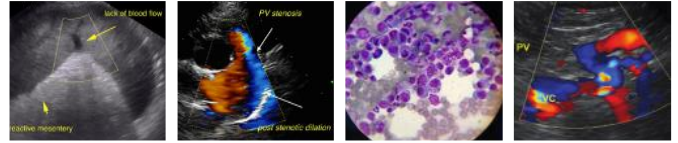
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is relatively normal in size and contour. Parenchyma is mildly heterogenous and coarse with mild likely age-related parenchymal remodeling noted. 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 with some echogenic debris noted. 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.

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The visible small intestines are normal in wall thickness and layering. Hyperechoic mucosal fogging or speckling is noted. 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.

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

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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.

Free Abdomen

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A very scant amount of anechoic free fluid is noted in the cranial left abdomen. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

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- Age-related hepatic remodeling. Chronic smoldering inflammatory hepatopathy cannot be ruled out.
- Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- Mild acute pancreatitis or potentially acute on chronic smoldering pancreatitis is suspected.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patients reported chronic diarrhea prior to the resolution on antibiotics, combined with the mucosal speckling and the suspicion for mild pancreatitis, 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.

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Additionally, given the reportedly increased ALT, other recommendations include an "antigen search" for sources of reactive hepatopathy (including testing for Leptospirosis), followed by a course of empirical antibiotics and hepatic nutraceuticals, with monitoring of ALT for improvement. If improvement is not noted and/or enzyme increase progresses, a liver biopsy may be warranted.

REFERRING VET

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Given that this is a recurrence of an increased ALT, following a course of antibiotics, a fine needle aspirate of the liver could be considered if patients coagulation status is appropriate. However, this current increase could be secondary to mild acute pancreatitis and therefore, recommendations include transition to a low-fat diet, as well as the empirical therapy antibiotics, hepatic nutraceuticals, etc. recommended above, combined with any symptomatic therapy of GI signs, etc., followed by monitoring of the ALT for improvement/progression, etc., as this may result in resolution prior to more advanced diagnostics such as liver sampling.

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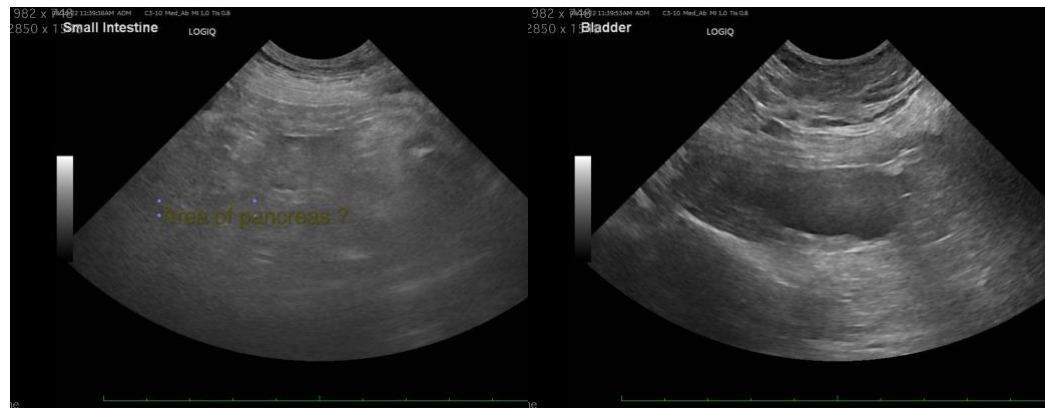
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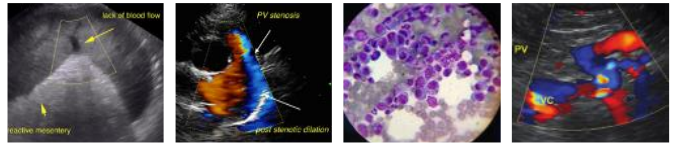
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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