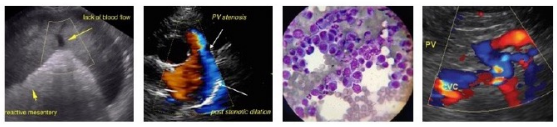

PATIENT

Chico Smart

SPECIES

Canine

BREED

Havanese

SEX

Neutered male

AGE

11 years

WEIGHT

7.2 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kelly Reshny, RVT

HOSPITAL NAME

Oxford County VC

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PRESENTING CLINICAL SIGNS

History: no clinical symptoms, but history of a climbing ALT, rechecked 8/11/22, and now ALP elevation occurring
Abnormal PE/Chem/CBC/UA Results: ALT : 910 (N: 18 - 121 U/L) Prev: 547 ALP 472 (N:5 - 160 U/L) Lymphopenia - 0.9 (N:1.1 - 5.0 x10^9/L) Neutropenia - 2.2 (N:2.9 - 12.7 x10^9/L) Leukopenia- 3.7 (N:4.9 - 17.6 x10^9/L) Fecal float with Giardia negative-

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.

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

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia or infarcts observed. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted in both kidneys. The left kidney measured 4.5 cm and the right kidney measured 4.96 cm.

Adrenal Glands

Left adrenal gland is normal in size (1.54 cm long, 0.44 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 (1.25 cm long, 1.1 cm at cranial pole and 0.22 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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

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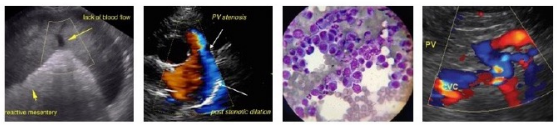

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Liver

Liver is subjectively small in size with slightly undulating or scalloped capsular contour or margins. The parenchyma is diffusely heterogenous with increased portal markings and coarse architecture. Patchy, ill-defined, areas of increased echogenicity are present. No focal lesions are observed.

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 mildly distended with very echogenic reverbation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. 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

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

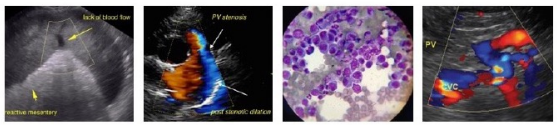
There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- **Hepatic Fibrosis Pattern –** This appearance is most consistent with chronic hepatitis with fibrosis and/or early cirrhosis. These changes can occasionally be seen with resolved past inflammatory episodes and should therefore be interpreted in combination with clinical signs and/or associated laboratory changes (including bile acids).
- **Chronic active pancreatitis is suspected.**



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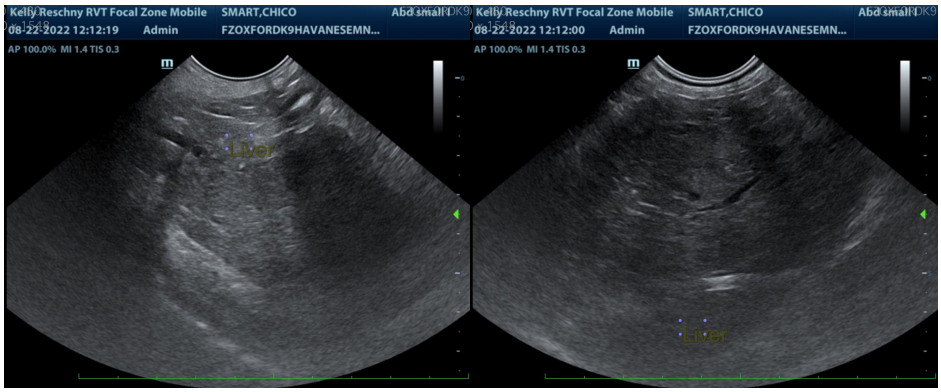
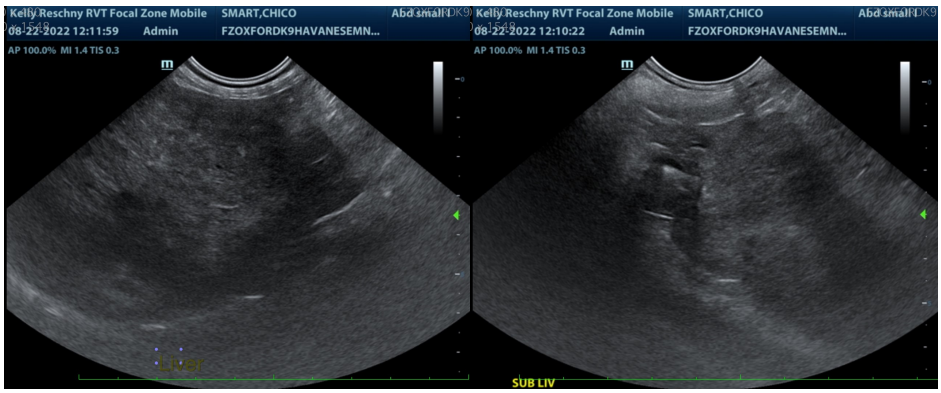
Secondary Findings

- **Hyperechoic splenic nodules –** most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- **Age related renal** changes and age related renal changes with non-obstructive dystrophic mineralization bilaterally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Testing for Leptospirosis is recommended. Bile acids are recommended, if tbili is not increased. An empirical course of antibiotics and hepatic nutraceuticals may be tried empirically; however, ultimately, tissue sampling is likely warranted. FNA of the liver can be performed to assess inflammatory cell type, rule in/out round cell neoplasia, etc. If round cell neoplasia is not diagnosed, a liver biopsy (including copper level assessment) may be required to definitively diagnose the underlying hepatopathy.





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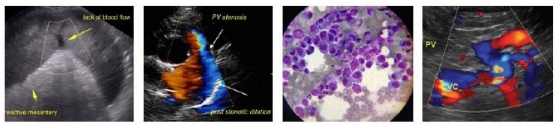

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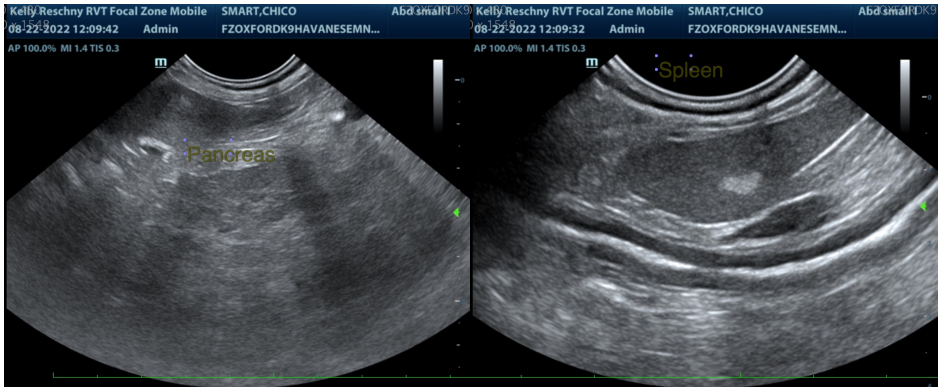

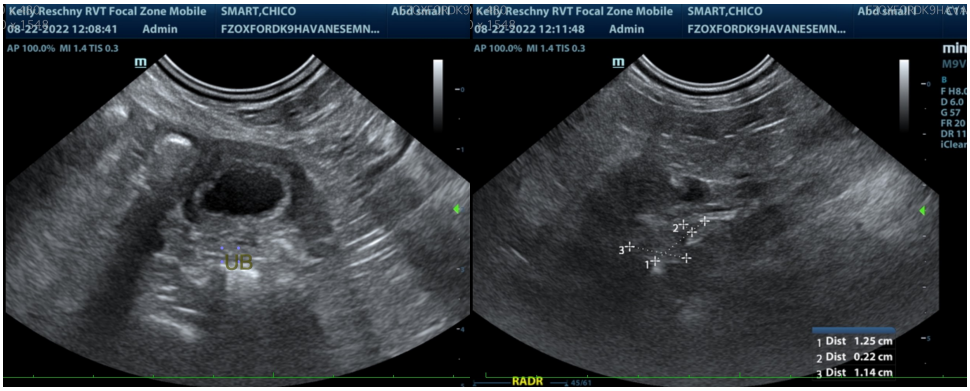

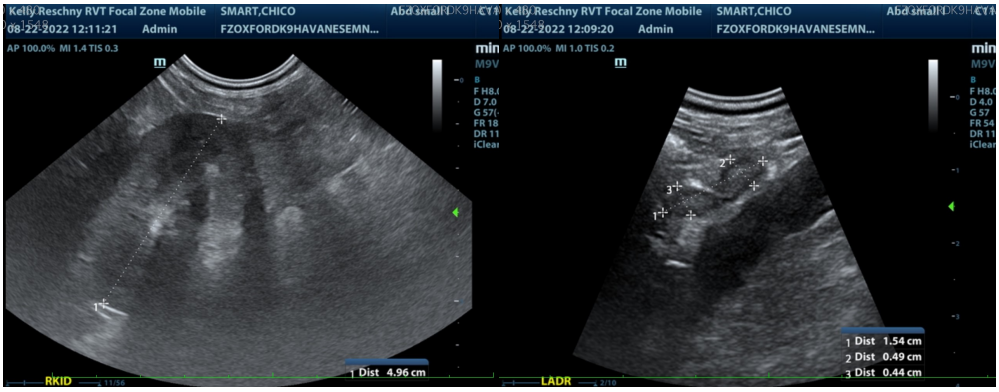

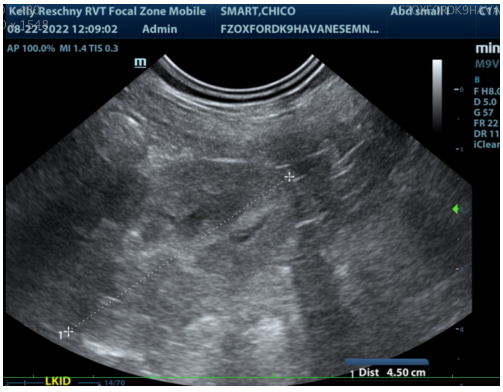

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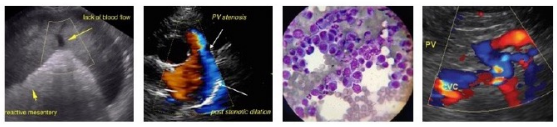

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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