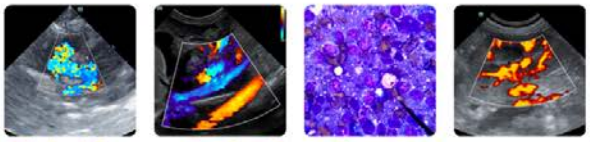


PATIENT

Blizzard Torres

SPECIES

Canine

BREED

Siberian Husky

SEX

Neutered Male

AGE

9 Years

WEIGHT

50 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Laura S. Solis

INVOICE

72564

DATE

1/29/26

PRESENTING CLINICAL SIGNS

Presented for evaluation of Icterus, elevated liver enzymes, lethargy and anorexia. Pt developed these clinical signs 8 days ago. Pt was hospitalized for 2 days at an EC. PT has not vomiting or diarrhea, but has been having PU/PD. By O pt is up to date in vaccines

Abnormal PE/Chem/CBC/UA Results: PE: Icterus, lethargic Bloodwork attached as supporting documents Tbili: 15, GGT: 92, ALT" 557, ALP: too high did not read WBC: 19k, Neu17k

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. Left kidney measures 7.02 cm. Right kidney measures 6.95 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Right measures 2.89 cm in length x 0.67 cm at the caudal pole and 0.66 cm at the cranial pole. Left measures 2.66 cm in length x 0.61 cm at the cranial pole and 0.61 cm at the caudal pole.

Spleen

The spleen had a generally smooth homogeneous parenchyma and a smooth capsule with a solitary hyperechoic nodule visualized most consistent with benign myelolipoma. There was normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

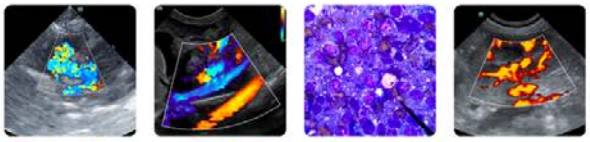
The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is severely distended with multiple shadowing objects within the lumen, one of which is angular measuring 2.1 cm in length. The other is curvilinear measuring 2.0 cm in length. The cystic and common bile duct are severely dilated to the level of the duodenal papilla, where a 4.0 mm shadowing cholelith is visualized.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall



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layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The right limb of the pancreas is prominent and hyperechoic.

Free Abdomen

Gastric lymph nodes are enlarged, rounded, lobulated and hypoechoic, with the largest measuring approximately 2.0 cm x 2.4 cm.

No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Obstructive cholelith at the level of the duodenal papilla.
- Multiple or large complex cholelith within the gallbladder.
- Pancreatitis.
- Perigastric lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of choleoliths is the likely explanation of reported liver value elevations. Their presence can cause inflammation and may cause subclinical or clinical cholangitis which can cause elevations in liver values. GI signs of inappetence or vomiting may be seen as their presence can cause intermittent abdominal pain and nausea. Their presence may act as a nidus of infection and predispose to cholangiohepatitis. They have the potential to move into the common bile duct causing obstructive cholangitis.

The visible mineral material at the level of the duodenal papilla and concurrent gall bladder distension are consistent with biliary tract obstruction. Emergency abdominal exploratory surgery is recommended to further investigate. This may be both diagnostic and curative. Biliary surgery is not without significant perioperative morbidity and mortality and consultation with a veterinary surgeon is recommended. 24 hour post-op monitoring is recommended until clinically stable. The risk of postponing surgery includes gall bladder rupture and subsequent bile peritonitis, which is commonly fatal.

Medical therapy is an alternative option if surgery is not desired. Therapy includes fluid therapy as needed, GI support, pain control, antibiotic therapy and liver supportive medications (N-acetylcysteine, SAM-E, milk thistle, Vitamin E). Empiric antibiotic therapy is not unreasonable and antibiotics that are effective against gram-negative, aerobic, enteric bacteria and excreted into the bile are recommended. Amoxicillin, amoxicillin-clavulanic acid, cephalosporins, and fluoroquinolones are suggested first choices. Metronidazole (7.5 mg/kg PO, IV q 12 hrs) may be added for extra anaerobe coverage. Serial monitoring of vital signs, fluid balance, electrolytes and liver values including bilirubin and imaging is recommended.

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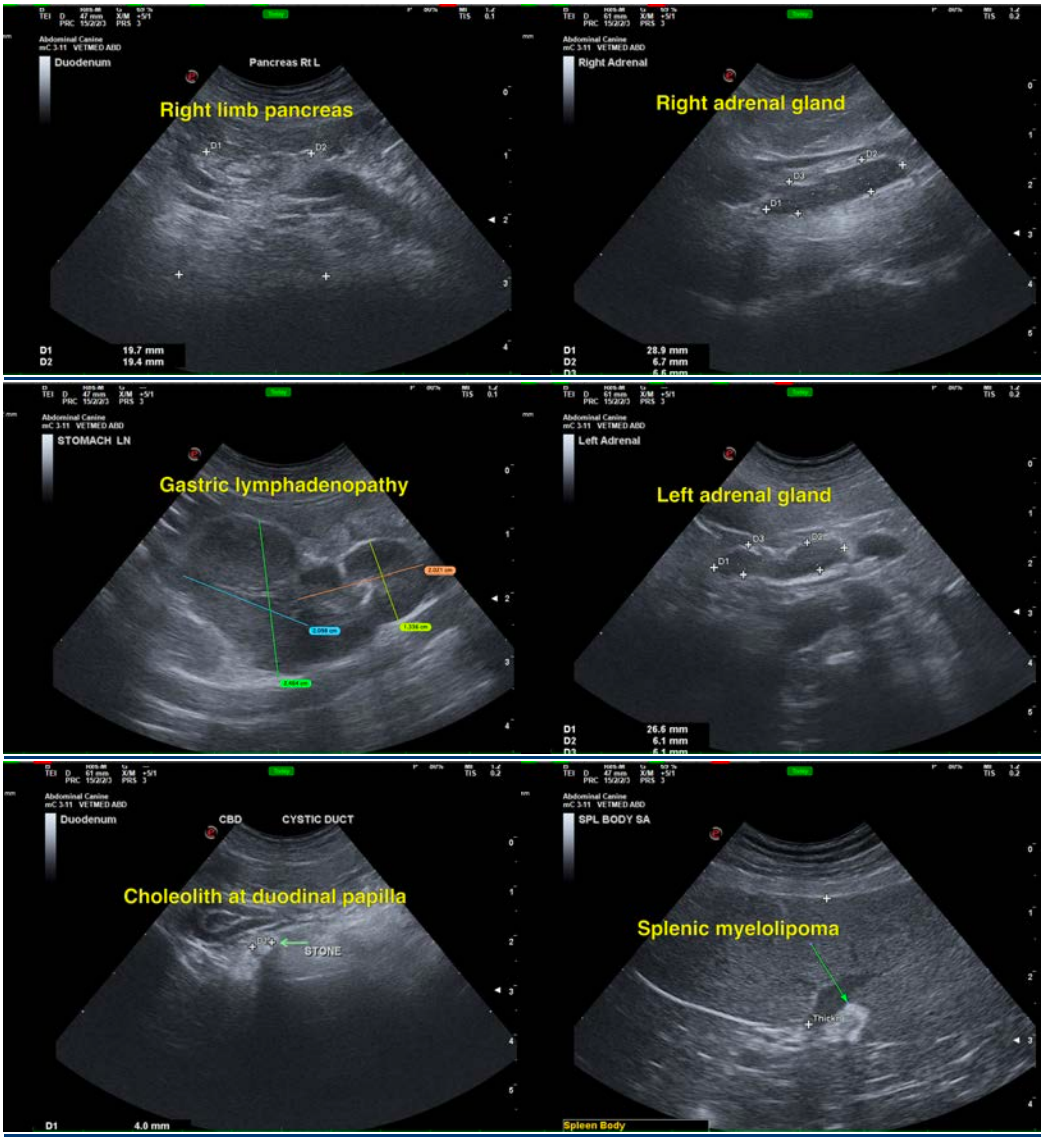
The apparent pancreatitis is likely secondary to inflammation caused by biliary obstruction.

Gastric/peripancreatic lymphadenopathy is of uncertain clinical significance. It may represent infiltrative disease such as lymphoma. Further explore and lymph node biopsy at the time of surgery is recommended. It may also be caused by the severity of inflammation from gallbladder obstruction.



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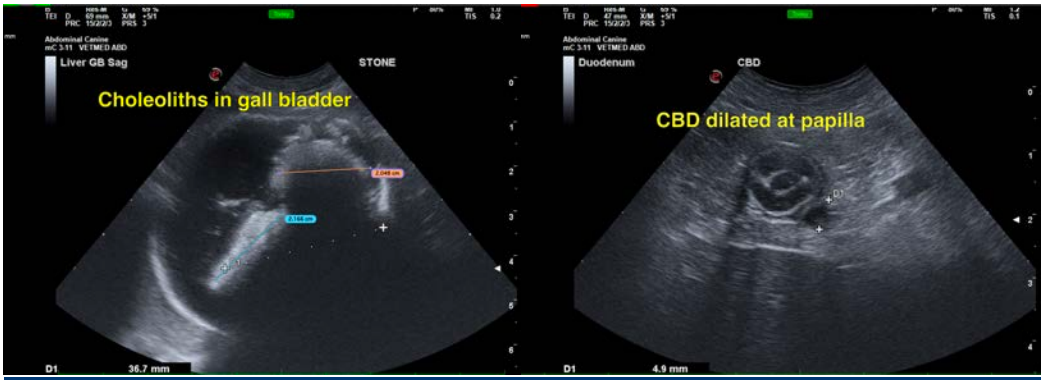

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com