



PATIENT

Alfie Brooks

SPECIES

Canine

BREED

Australian Shepherd x

SEX

Neutered Male

AGE

4.8 Years

WEIGHT

34.8 lbs

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons),
DACVECC

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal
Hospital

REFERRING VET

Dr. Kristen Carpenter

INVOICE

71887

DATE

11/18/25

PRESENTING CLINICAL SIGNS

Patient sedated with butorphanol. Patient originally presented to the ER on 10/29/25 for an abnormal "episode" where patient was unsettled then became stiff and urinated on the bed in the middle of the night. Patient did not lose consciousness at any point and was responsive to O. B/w performed: UA: USG 1.040, rare RBC, no overt signs of infection. NSF with bloodwork except ALT 254 (ALP and tbili normal). Treated with Amoxi/metro x2 weeks to start and hepatoprotectants. Recheck LE after 2 weeks and no improvement ALT 267 (H), ALP 58 (N), tbili 1.0 (H). Patient is otherwise aclinical at home with no further "episodes" noted.

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.

Visible prostate is normal in size has uniform echotexture with no fluid accumulations, masses or other abnormalities

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. Hyperechoic, shadowing foci present in renal parenchyma and calyces bilaterally, consistent with nephrocalcinosis. Left kidney measures 4.56 cm. Right kidney measures 4.96 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. Left measures 1.57 cm in length x 0.45 cm at the caudal pole and 0.44 cm at the cranial pole. Right measures 2.13 cm in length x 0.60 cm at the caudal pole and 0.58 cm at the cranial pole.

Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with 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 moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.



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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 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 not visualized. 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 visible pancreas was observed to be largely isoechoic to surrounding omental fat.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Very mild nephrocalcinosis, incidental.
- Normal liver and gallbladder.
- Otherwise normal abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No ultrasonographic cause of reported stiffening episode was apparent on abdominal ultrasound. Liver value elevation may be completely incidental to reported episode. A primary neurologic event or syncopal event remain top differentials. Evaluation for hypertension is recommended. An ECG and echocardiogram should be considered to further investigate for primary cardiac causes. Ultimately, full neurologic workup may be required, especially if events are recurrent.

The liver parenchyma appears normal and there is no ultrasonographic explanation for the elevated liver enzymes in this patient. There is no significant disruption of architecture noted to suggest significant pathology. Low grade inflammatory hepatopathy/reactive hepatopathy is a likely cause of LE elevations. Fine needle aspirate is recommended and bile acid profile to assess liver function. Bilirubin must be normal to interpret a bile acid profile. The small degree of bilirubin elevation in this patient is suggestive of hemolysis as an underlying cause, likely artifactual from blood sampling. However, if patient is truly repeatably hyperbilirubinemic, bile acid profile cannot be interpreted. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol if bilirubin elevated or gall bladder sludge) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued.



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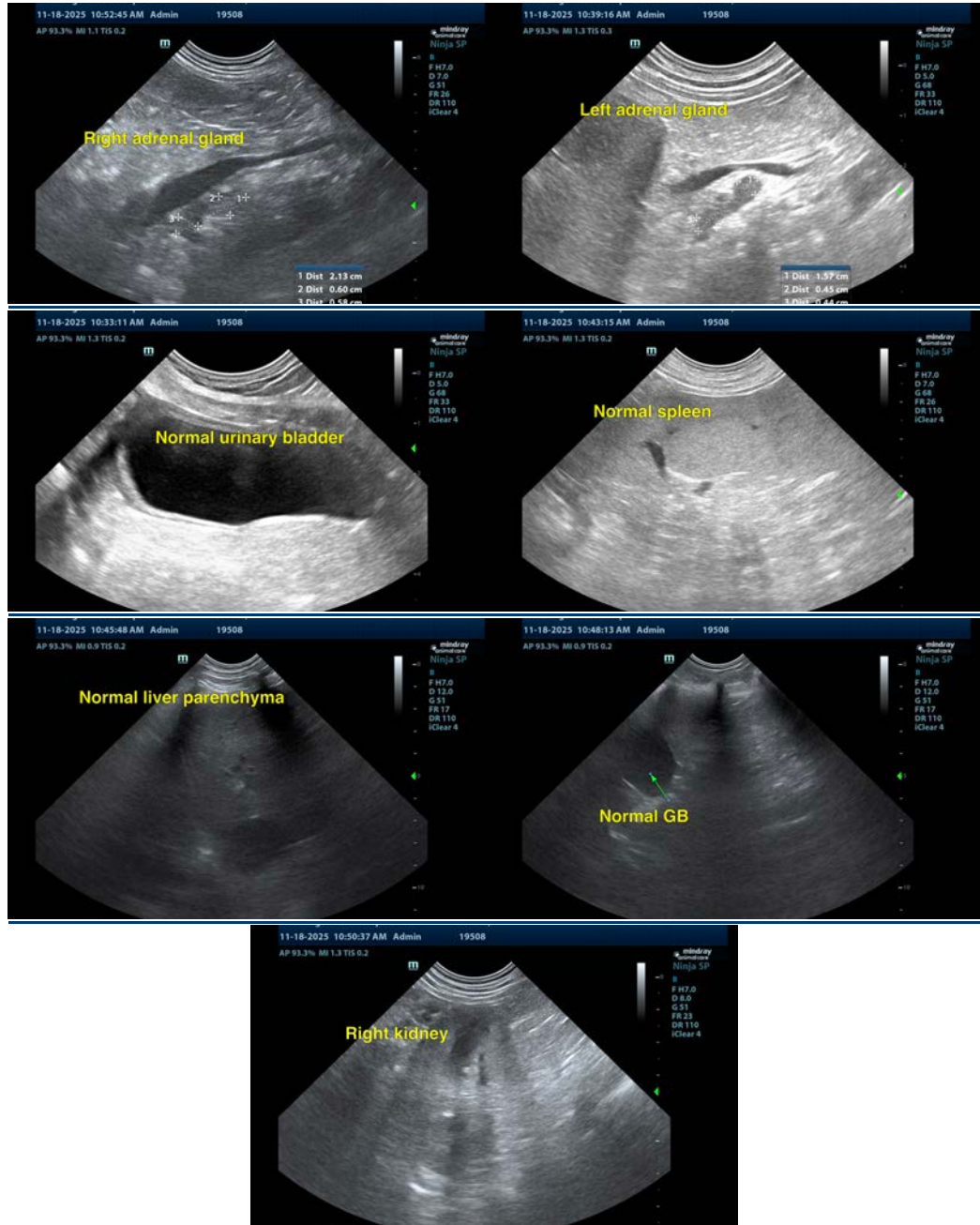
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
info@SonoPath.com