PATIENT

Easton Smith

SPECIES

Canine

BREED

Havanese

SEX

Neutered Male

AGE

7 Years

WEIGHT

9.6 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Hamilton Region Veterinary Emergency Center

REFERRING VET

Dr. Diane

INVOICE

12373

DATE

11/21/25

PRESENTING CLINICAL SIGNS

History of 1 week of lethargy & anorexia, rDVM bloodwork showed mild hepatopathy and suspected Leptospirosis. Patient had a recent history of being on allergy medication for skin disease, PUPD & polyphagia observed shortly after starting medication, O unsure if prednisone was one of the medications. O unsure if patient is vax'd for Lepto. rDVM started patient on doxycycline about 1 week ago. rDVM records have not yet been sent to us. On PE: laterally recumbent, 8-9% dehydrated, painful abdomen on palpation, increased lung sounds in RIGHT cranioventral hemithorax, stertorous upper airway noises, TFAST excess B lines in right cranioventral quadrant, AFAST free fluid score 0/4, painful during probing of kidneys

Current Medications maropitant, methadone, propofol (for NG tube placement), ampicillin, enrofloxacin

Abnormal PE/Chem/CBC/UA Results: BP 150-160mmHg systolic, stress leukogram (lymphopenia, eosinopenia), Cr 57, BUN 2.0 (mildly low), Na 166 (moderately elevated), ALT 203 (mildly elevated), ALP 4750 (markedly elevated), cholesterol 8.43 (mildly elevated, fasted sample), lipase 2211 (mildly elevated), pancreatic lipase 943 (moderately elevated), cystocentesed urine sample revealed USG 1012, quiet sediment

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 left kidney was normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. The left kidney measured 5.07 cm in length with visualized cortical mineralization.

The right kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. The right kidney measured 4.51 cm in length. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis.

Adrenal Glands

The left adrenal gland is enlarged, rounded and hypoechoic. The left adrenal gland measured 2.08 cm in length and 0.68 cm at the cranial pole and 0.71 cm at the caudal pole.

Visualization of the right adrenal gland is somewhat limited yet measures slightly enlarged for a patient of this size. The right adrenal gland measured 2.08 cm in length and 0.61 cm in thickness.

Spleen

The spleen had a generally smooth homogeneous parenchyma and a smooth capsule with perivascular hyperechoic nodules visualized most consistent with benign myelolipomas. 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.

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Liver

The liver is subjectively enlarged in size with rounded contours. The parenchyma is heterogenous with a coarse appearance. No specific nodules are visualized. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. 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. Visualized peristalsis appears appropriate. 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 area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

ULTRASONOGRAPHIC FINDINGS

- Adrenomegaly.
- Hepatomegaly with coarse echotexture.
- Aging renal changes, right more significant than left.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No definitive cause of lateral recumbency and severe hydration were identified on abdominal ultrasound. Adrenomegaly may represent stressful illness or hypercortisolemia. Adrenal gland function testing should be done after patient has recovered from current episode.

Liver changes are a common benign age related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. No significant disruption of architecture noted to suggest significant pathology. In the face of elevated liver enzymes, fine needle aspirate is recommended to further characterize parenchymal changes, and bile acid profile to assess liver function, especially if any weight loss is noted or for baseline cytological assessment. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol if

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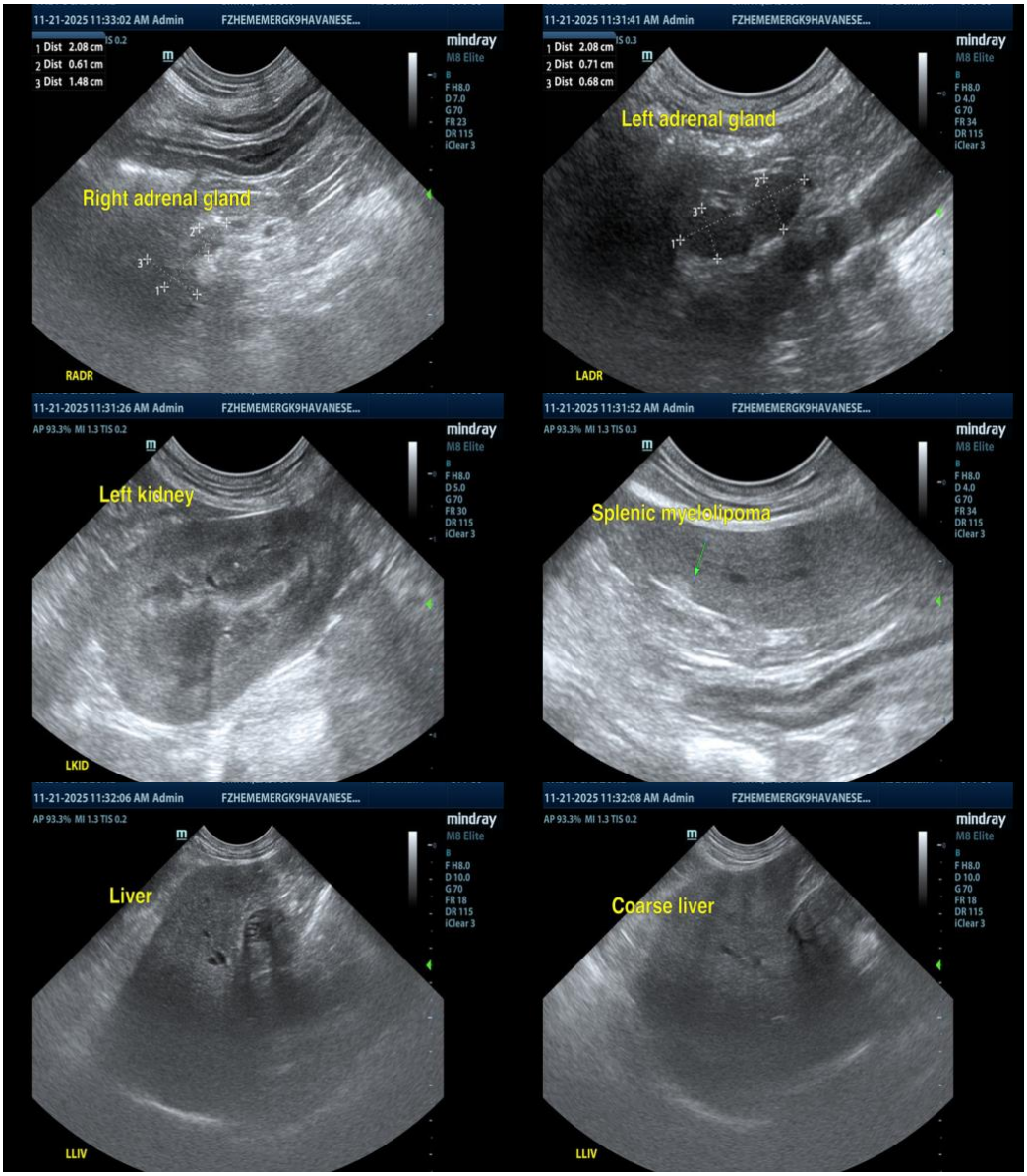
bilirubin elevated or gallbladder sludge) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued.

Further assessment may include chest radiographs, ECG, full neurologic ocular and orthopedic evaluation.



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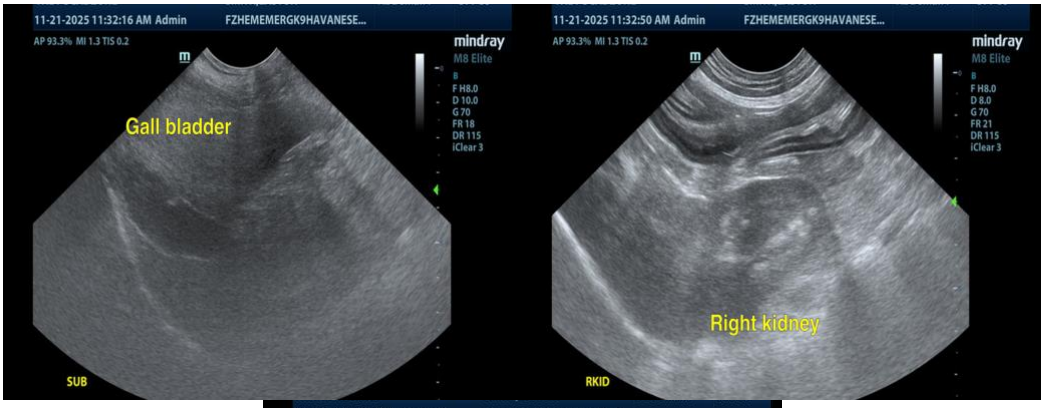

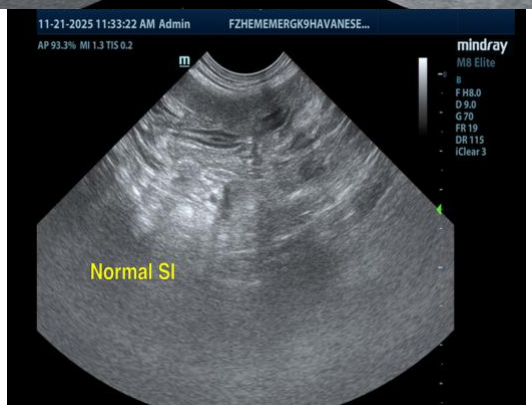

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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