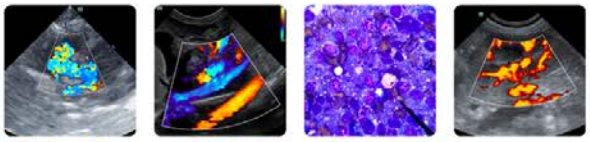


PATIENT

Leah Sofia Conway

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Spayed Female

AGE

9 Years

WEIGHT

3.1 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Joshua Morales

INVOICE

73110

DATE

2/20/26

PRESENTING CLINICAL SIGNS

Px presented as e referral to evaluate progressive increase in liver enzymes (ALT, ALP, and GGT). Started with vomiting 6 days ago, lethargy, and diarrhea. Took to EC 4 days ago and Px was weak. Px had episodes of black diarrhea with mucus. Px is currently hospitalized in EC.

Abnormal PE/Chem/CBC/UA Results: Bloodwork and Radiographs attached as supporting documents: ALT: 487, ALP: 1189, GGT: 29, Glu: 202, K 2.8, Ca: 7.8, Cl: 108

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 measured 3.2 cm. Right kidney measured 3.71 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 1.24 cm in length x 0.44 cm at the caudal pole and 0.49 cm at the cranial pole. Left measures 1.38 cm in length x 0.35 cm at the caudal pole and 0.34 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

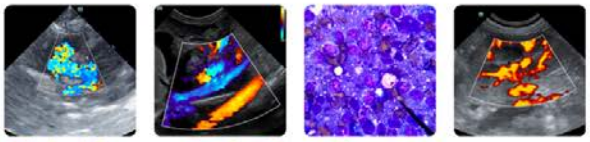
The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing organized debris present. There is no surrounding free fluid or signs of active inflammation.

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.



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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.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Small amount of organized gallbladder debris – not overtly obstructive.
- Otherwise normal abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Gall bladder debris may be an incidental finding given lack of surrounding inflammation. The debris does appear organized and may represent forming choleliths, which are generally incidental, though they can contribute to abdominal discomfort. Abdominal radiographs may be of use to further visualize and diagnose choleliths. This is considered likely to be incidental to patient's current clinical signs. In the face of elevated ALKP ursodiol could be given as a choleretic and empiric treatments (SAM-E, milk thistle, Vitamin E) could be tried. If liver supportive medications do not improve liver enzymes, a course of empiric antibiotics (clavamox, enrofloxacin) could be considered to cover for infectious cholangiohepatitis, though the lack of surrounding inflammation makes this less likely. Imaging should be rechecked on a routine basis for monitoring (q3-6mo) or if further significant increase in liver enzymes and/or new clinical signs are noted. If otherwise clinically indicated, investigation for endocrinopathy such as hyperadrenocorticism or hypothyroidism could be considered as an underlying cause predisposing to gall bladder debris accumulation.

There is no other ultrasonographically evident cause of reported GI signs in this abdominal study. Pancreas and GI tract are within normal limits. Consideration for dietary indiscretion, infectious etiologies (bacterial, viral, parasitic), food sensitivity/allergy or mild inflammatory bowel disease is reasonable. While not sonographically evident, pancreatitis cannot be completely ruled out. Empiric treatment for GI signs including anti-nausea, appetite stimulant and fluid support as clinically indicated is warranted. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically. If signs are persistent or recurrent, additional diagnostics to be considered include baseline cortisol +/- ACTH stimulation test, GI panel (TLI/PLI/cobalamin/folate), fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes. Ultimately GI biopsy may be required for more definitive diagnosis if the patient is not responsive to medical treatment.

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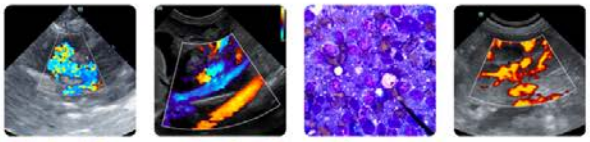

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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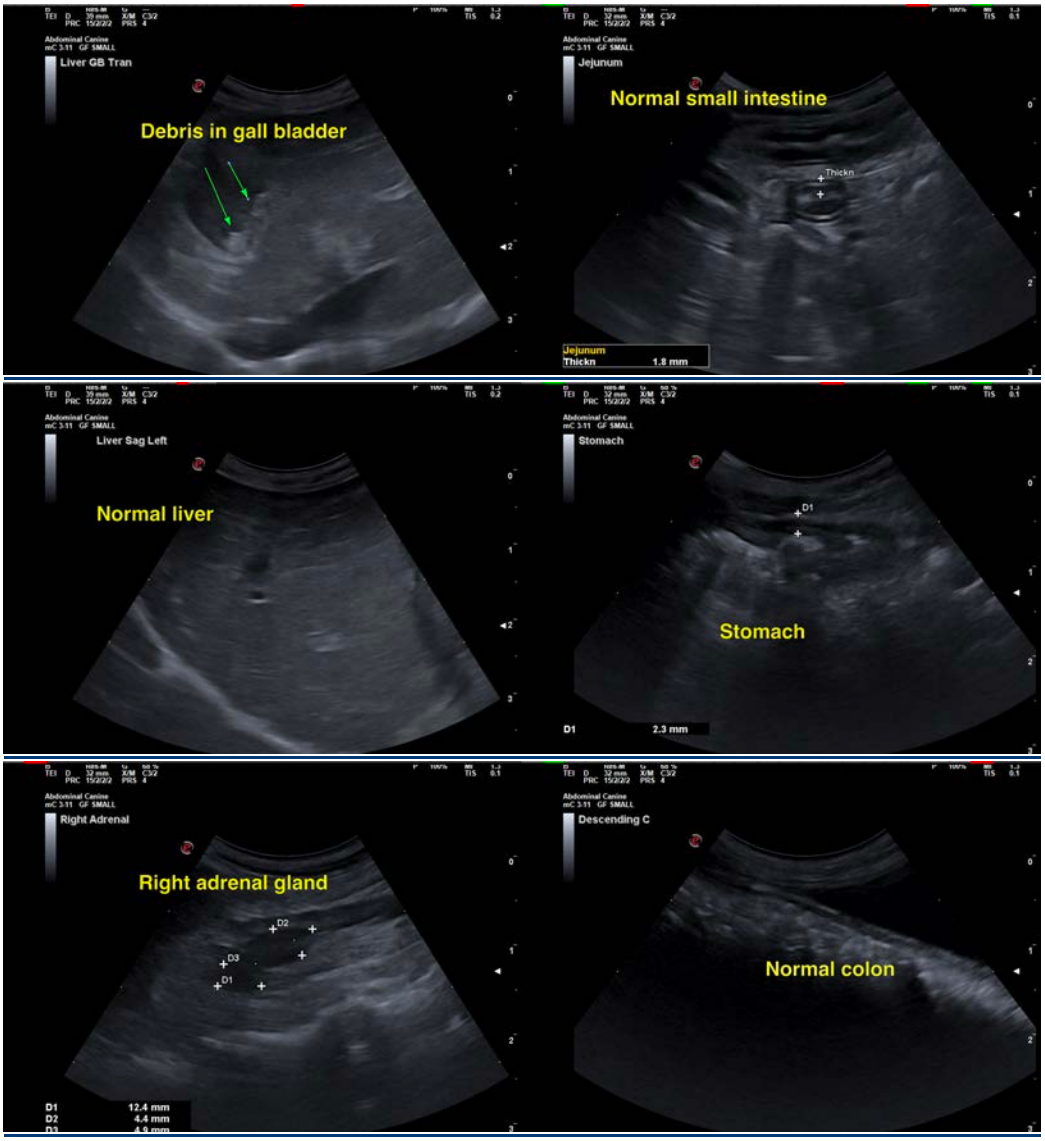

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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