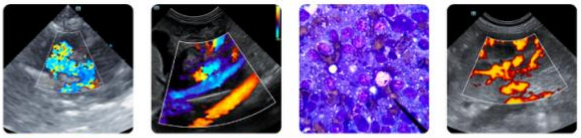


PATIENT

Maya Coates

SPECIES

Canine

BREED

Husky

SEX

Spayed Female

AGE

9 Years

WEIGHT

62.8 Pounds

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Meghan Morse, LVT, CVT

HOSPITAL NAME

Newburgh VH

REFERRING VET

Dr. Harlec

INVOICE

35708

DATE

2/6/26

PRESENTING CLINICAL SIGNS

- Had a single seizure episode on 1/16/26, bw showed ALKP 2500
- Exam WNL, no continuous neuro signs, no evidence of PU/PD etc according to owner
- Current meds: Keppra 750mg q8 hours
- Abnormal PE/Chem/CBC/UA Results: ALKP 2492 Chol 430 Trig 1111 USG 1.009

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. Amorphous hyperechoic partially shadowing debris present in the urinary bladder. 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 (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The right kidney measured 6.19 cm in length. The left kidney measured 6.76 cm in length.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 2.82 cm in length and 0.56 cm at the cranial pole and 0.46 cm at the caudal pole. The right adrenal gland measured 2.81 cm in length and 0.97 cm at the cranial pole and 0.45 cm at the caudal pole.

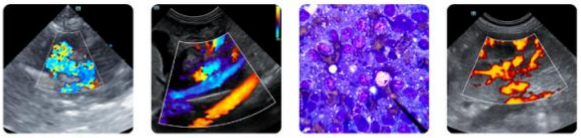
Spleen

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.

Liver

The liver is subjectively normal in size with normal contours and structure. The parenchyma is heterogenous with a coarse appearance. Multifocal variably sized generally small poorly defined hypoechoic nodules were present throughout parenchyma. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

Gall bladder is moderately distended with normal wall thickness and generally anechoic contents. A curvilinear object with complete acoustic drop out is visualized in the gall bladder lumen most consistent with a gall bladder cholelith (1.5 cm). 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 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.

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

- Gallbladder cholelith
- Coarse liver
- Urinary bladder sand

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of choleliths is the likely explanation of reported liver value elevations. Choleliths are often an incidental finding. 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. Abdominal radiographs may be of use to further visualize choleliths.

Liver changes are a common benign age-related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. 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 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.

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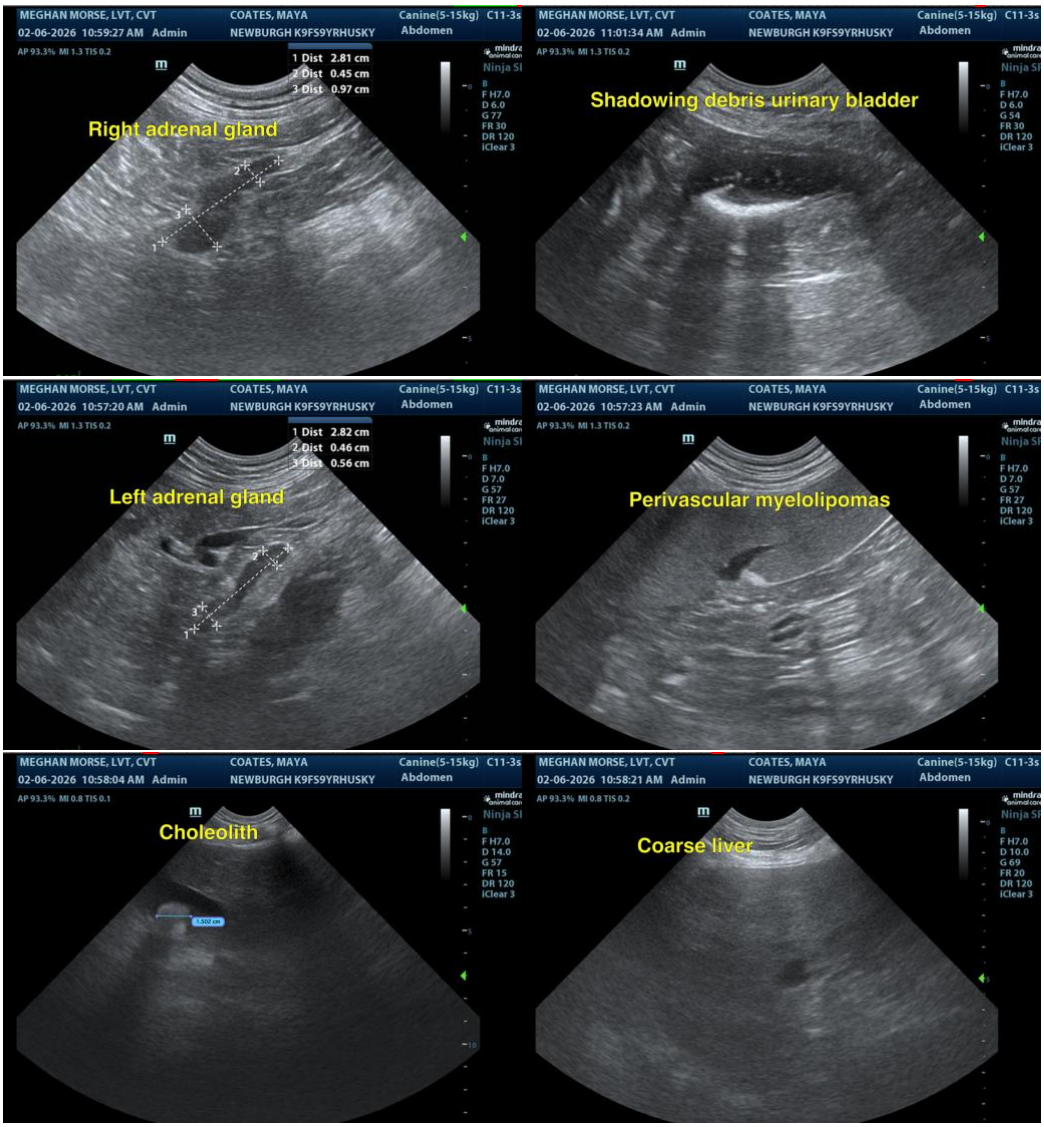
Urinary bladder debris is most consistent with bladder sand. Continue to correlate its significance with semi-annual blood work and urinalysis findings, and clinical signs.



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