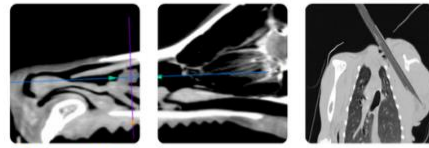


PATIENT
Rory Hyrsko

SPECIES
Canine

BREED
Westie

SEX
Neutered Male

AGE
14 Years

WEIGHT
10.7 kg

INTERPRETED BY
Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY
Kelly Reschny

HOSPITAL NAME
Bronte Village AH

REFERRING VET
Dr. McGrath

INVOICE
15059

DATE
04/13/26

PRESENTING CLINICAL SIGNS

Presenting Concerns: Worsening breathing, wheezing, and coughing. Historical Conditions: Allergic bronchitis. Drinking/Urination: Owner reports patient has always been a good water drinker; no excessive drinking noted. V/D/C/S: Coughing daily, particularly in the morning. Wheezing increased respiratory effort, and restlessness noted at home, worse at night. Respiratory rate at home reported as 34-42 breaths per minute. HR 110 RR panting, pulses strong and synchronous. A grade 2/6 systolic heart murmur was auscultated.

Current Medications: Doxycycline 100mg, Gabapentin, Trazodone, Prednisone 5mg, Flovent inhaler 125mcg

Abnormal PE/Chem/CBC/UA Results: Wellness 1A done 4-7-2026: MCHC 319.1 Eosinophils 0.11 Platelets 539 ALT 167 ALP 579 Hemolysis + Radiographic Findings radiographs done 4-7-25: "Large globoid heart- peribronchial pattern noted, - collapsing trachea suspected at the base of the heart. Enlarged spleen? or lobe of liver noted- r/o prednisone use, right sided heart failure, Cushing's disease, mass effect, has been tested for ticks this year.", "Liver border enlarged?" labs and rads attached

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, or abnormal thickening visualized. A gravity dependent cystolith present measuring 0.30 cm.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. Spherical anechoic fluid accumulation consistent with cortical cysts, the largest of which measured approximately 1.3 cm x 1.4 cm. The left kidney measured 4.79 cm in length. The right kidney measured 4.31 cm in length.

Adrenal Glands

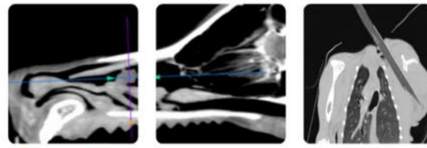
The left adrenal gland was visualized and were subjectively small for a patient this size, with normal shape, position and echogenicity for this breed. The visualized phrenic vasculature, glandular echogenicity and detail were unremarkable. The left adrenal gland measured 1.41 cm in length and 0.40 cm at the caudal pole and 0.34 cm at the cranial pole.

Right adrenal gland was visualized and measured on still image only. Resolution is inadequate to assess glandular detail or confirm measurement. The right adrenal gland measured 1.99 cm in length and 0.81 cm in thickness.

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



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The liver is enlarged with slightly rounded borders. The parenchyma is diffusely coarse with multifocal, variably sized hypoechoic nodules. The largest and most well-defined nodule measures approximately 2.0 cm x 3.4 cm and is in a left liver lobe.

Gall bladder 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 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

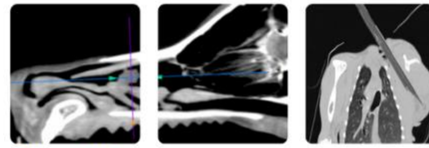
No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Hepatomegaly with nodules- likely vacuolar hepatopathy.
- Degenerative renal changes.
- Urinary bladder cystolith.
- Slightly small left adrenal gland.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Liver changes are most consistent with a vacuolar hepatopathy, though this diagnosis cannot be definitively made with ultrasound imaging alone. Vacuolar degeneration is a common nonspecific indicator of hepatocyte injury which is most commonly secondary to exogenous steroid exposure, hyperadrenocorticism, or an idiopathic age-related change, though other endocrinopathy (hypothyroidism), infectious or inflammatory hepatitis (bacterial, viral, auto-immune other), and neoplasia among other things remain possibilities. In the face of elevated liver enzymes liver aspirate is recommended to further characterize these ultrasonographic changes. Ultimately liver biopsy is generally required for definitive diagnosis and should be considered if significant clinical signs or severe liver enzyme elevations are progressive despite empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol). Bile acid profile could be considered to assess liver function if clinically indicated.



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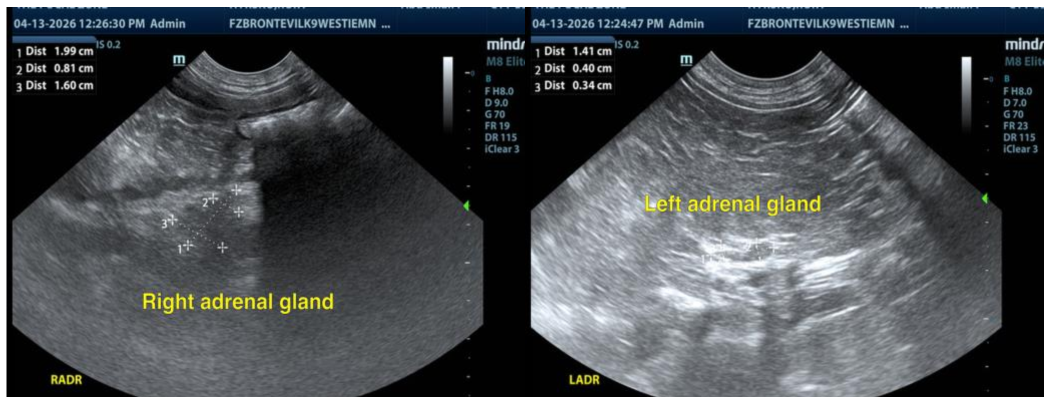
Clinical signs associated with vacuolar hepatopathy often reflect underlying disease. Idiopathic vacuolar hepatopathy may be asymptomatic and treatment is not necessarily indicated or effective at reducing liver enzymes. Imaging should be rechecked on a routine basis (q3-6mo) or if further significant increase in liver enzymes and/or new clinical signs are noted.

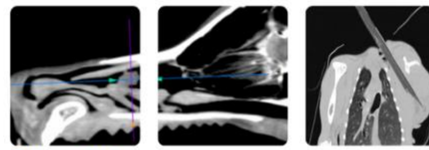
The visible left adrenal gland measured small for this patient. This is likely secondary to reported prednisone use. Prednisone use is also a likely explanation for hepatic parenchymal changes.

Renal changes are likely age-related degeneration. Correlate clinical significance with semi-annual blood work/urinalysis findings and clinical signs.

Urinary bladder cystoliths may lodge in the urethra causing obstruction, with male pets carrying a higher risk due to smaller urethral size. They may also act as a nidus of infection and inflammation. Dissolution diets (hills c/d, royal canin urinary S/O, purina proplan UR, etc) may be tried if struvite stones are suspected with serial imaging used to monitor progress. If small enough in relation to patient size, urohydropulsion under general anesthesia may successfully remove stones. Surgical removal of stones should be considered if risk of urethral obstruction is unacceptable or dietary therapy is not successful. Cystoscopic removal of stones, with or without lithotripsy may be considered if locally available. A flexible cystoscope is required for male dogs. Calcium oxalate, struvite, urate, and cystine stones are all susceptible to laser lithotripsy. Some dogs are not considered good candidates for laser lithotripsy including:

1. Male dogs less than 15 pounds: The endoscope may be too large to traverse the urethra.
2. Male dogs with more than two bladder stones greater than 5 mm in diameter (depending on the size of the dog)
3. Female dogs whose entire bladder is full of stones greater than 5 mm in diameter
4. Dogs with uncontrolled urinary tract infection: Once infection is controlled, lithotripsy can be considered.





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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