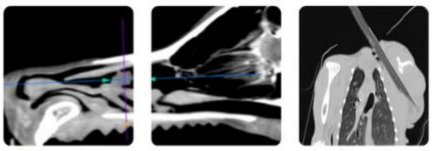


PATIENT

Logan Magwood

SPECIES

Canine

BREED

Labradoodle Mix

SEX

Neutered Male

AGE

7 Years

WEIGHT

61.2 pounds

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Village Centre Animal Hospital

REFERRING VET

Dr. Muthalavi

INVOICE

15075

DATE

04/14/26

PRESENTING CLINICAL SIGNS

Presented for fast growing periorbital mass near left eye. Previous cytology revealed benign basilar epithelial neoplasia, but owner chooses to remove it surgically due to speed of growth and surface changes. No meds. Preanesthetic bloodwork revealed elevated liver values - recommend US prior to surgery.

Abnormal PE/Chem/CBC/UA Results: Please see attached blood values

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 have a smooth capsule and with mild hazing of corticomedullary definition. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. The left kidney measured 6.74 cm in length. The right kidney measured 7.07 cm in length.

Adrenal Glands

The left adrenal gland was visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. The left adrenal gland measured 2.53 cm in length and 0.70 cm at the caudal pole and 0.66 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 2.23 cm in length and 0.79 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.

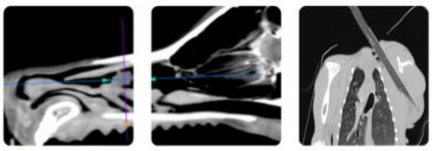
Liver

The liver is enlarged with slightly rounded borders. The parenchyma is normal with no masses or nodules seen.

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.



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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 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.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Hepatomegaly with no parenchymal lesions.
- Mild aging renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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 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.

Induction phenomena are the most common cause for an elevation in ALP. These are systemic illnesses that 'turn on' the liver enzyme. Causes of this include Cushing's disease, dental disease, arthritis, and numerous others. In many cases the exact cause is unclear but as long as ultrasound and bile acids tests are normal most patients do not have progressive changes in their liver. While liver biopsy is not routinely performed, vacuolar hepatopathy is noted on most biopsies. This is often non-progressive but in rare cases can be more severe and lead to liver failure.

• If signs of Cushing’s disease are present, recommend endocrine function testing to evaluate for Cushing’s disease.

• Consider fine needle aspirate to rule out round cell neoplasia.

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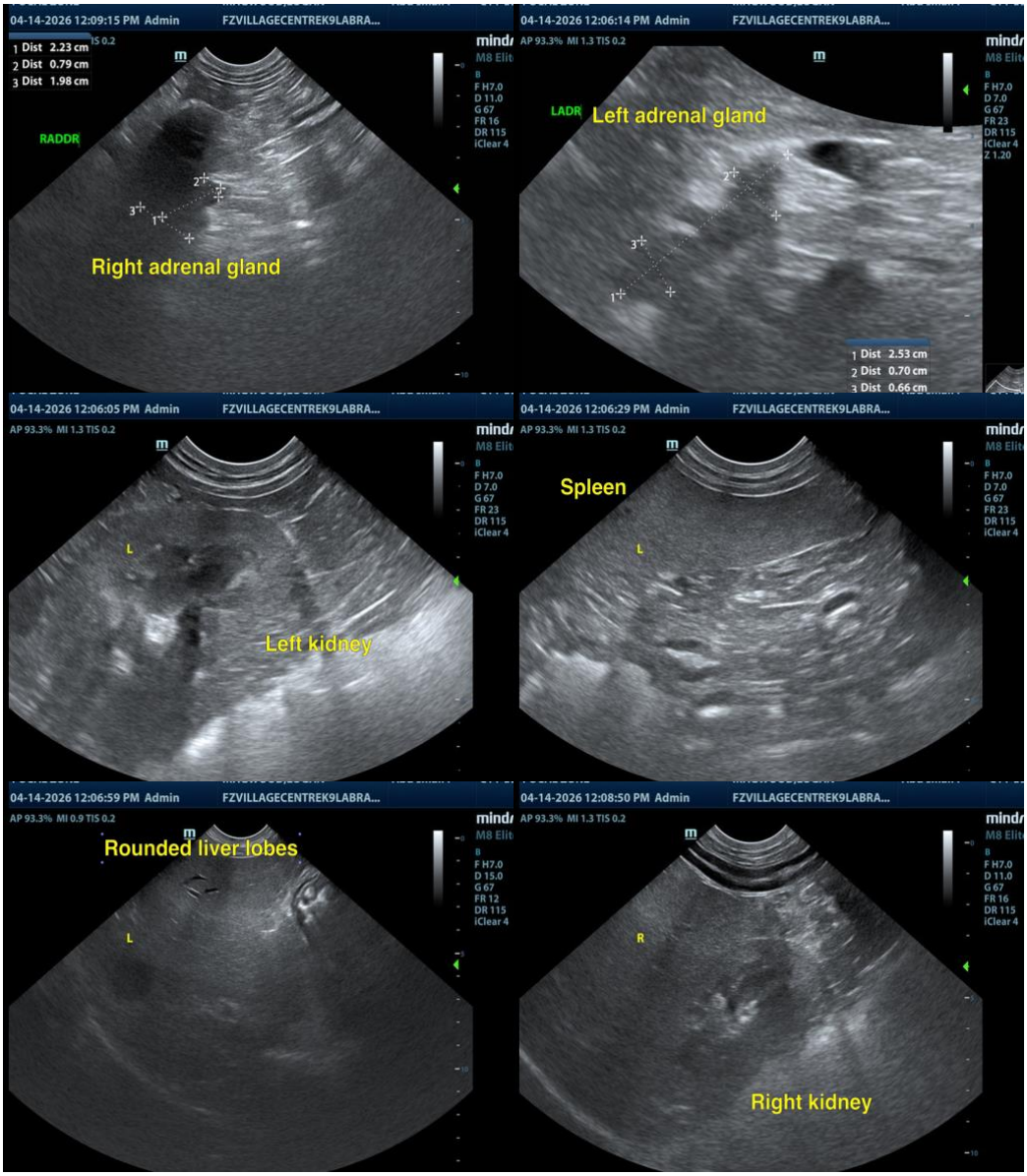
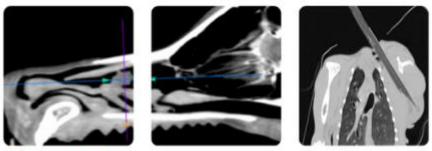
- If a cause for the ALP elevation is not identified: I recommend recheck general blood work every 6 months, ultrasound once per year, and bile acids test every 1-2 years based on other results. If the ALP continues to climb a biopsy should be considered.

- Consider long term use of Denamarin, and monitoring for the signs of Cushing's developing.



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.



SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

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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