PATIENT

Derby Cook

SPECIES

Canine

BREED

Beagle

SEX

Spayed Female

AGE

11 Years

WEIGHT

21 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

East Plains Animal Hospital

REFERRING VET

Dr. Visconti

INVOICE

14793

DATE

04/02/26

PRESENTING CLINICAL SIGNS

O noted unknown area of discomfort and lethargy on walk. Sitting down, tucking tail and had to be carried home. Could not isolate area of pain on PE today. U/A was normal but dilute USG 1.009 - history of stranguria and lower urinary tract disease, has been straining more often to urinate lately but this is "normal" for her. Sudden increase in thirst for the last few weeks. BW revealed liver elevation which is climbing. Has been on Metacam, Gabapentin, Hepaticlear Pro Chews

Abnormal PE/Chem/CBC/UA Results: ALT March 2026 565 April 2026 934 U/A low USG otherwise NSF

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is distended with anechoic urine. The 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. 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. The left kidney measured 5.36 cm in length. The right kidney measured 5.79 cm in length.

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. The left adrenal gland measured 2.31 cm in length and 0.56 cm at the caudal pole and 0.44 cm at the cranial pole. The right adrenal gland measured 2.55 cm in length and 0.42 cm at the caudal pole and 0.64 cm at the cranial pole.

Spleen

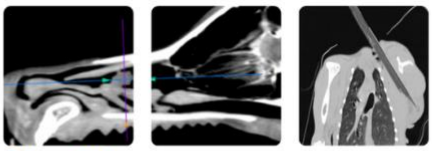
The spleen was normal with age-appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with a slightly coarse parenchyma consistent with age. Margins are generally normal and sharp with some areas of slight irregularity. There is an ovoid hypoechoic nodule noted in the central liver measuring approximately 2.7 cm x 1.1 cm. There are no specific masses seen.

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

Gastrointestinal



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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 gas throughout with no overt distention. 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

- No cause of discomfort and lethargy was found on abdominal ultrasound.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further assessment may include chest and spinal radiographs, ECG, blood pressure measurement, and full neurologic, ocular and orthopedic evaluation.

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) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued. Liver changes are not suspected to be related to current clinical signs.

The most common causes of PU/PD in dogs include renal disease, diabetes mellitus and hyperadrenocorticism. No explanation for PU/PD clinical signs was identified on ultrasound or reported lab work. Early renal insufficiency is a possible cause but is considered unlikely given normal renal values. Urine culture is recommended to screen for occult UTI as a possible cause, though this is also unlikely. Adrenal gland function testing is recommended despite normal appearance of adrenal glands, as hyperadrenocorticism cannot be ruled out based on normal appearing adrenal glands and is a common cause of significant PU/PD. If adrenal function testing is normal, rarer causes of PU/PD should be considered such as hyperthyroidism, hypercalcemia, diabetes insipidus (central or

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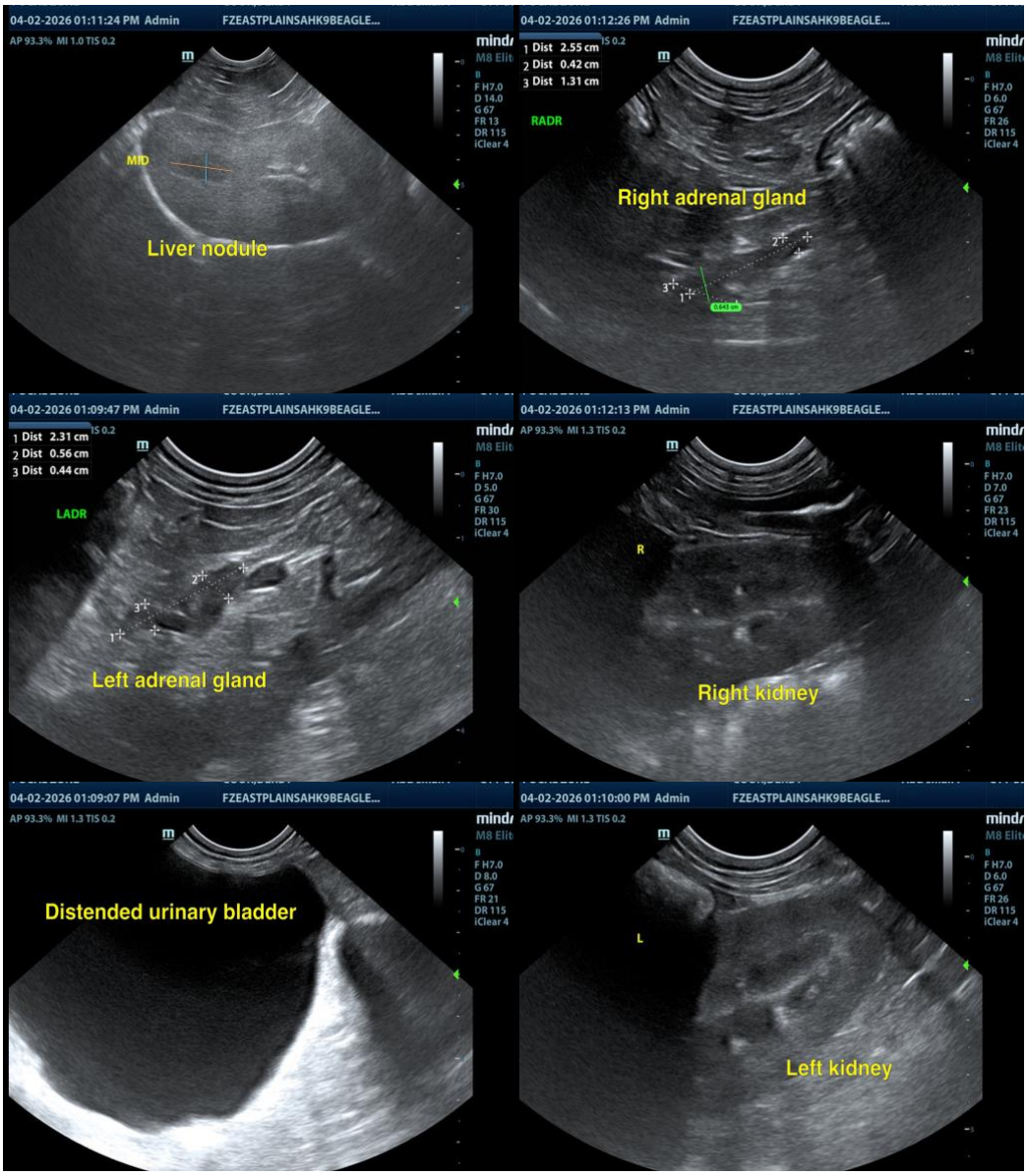
nephrogenic). Additional tests to be considered include ionized calcium measurement (even if total is normal), thyroid testing, bile acid profile, leptospirosis testing, and ultimately a desmopressin trial to investigate for central diabetes insipidus if other causes have been ruled out. Ultimately MRI may be required to screen for primary neurologic causes. Psychogenic polydipsia is an idiopathic cause of PU/PD and is a diagnosis of exclusion.



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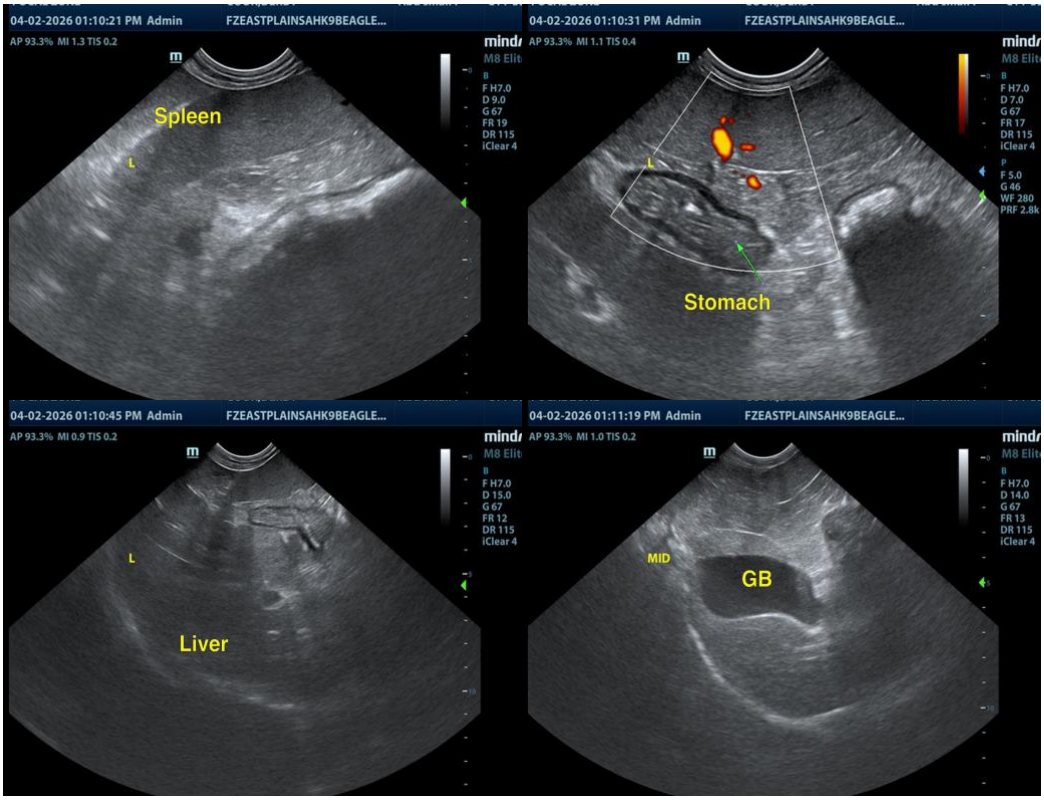

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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