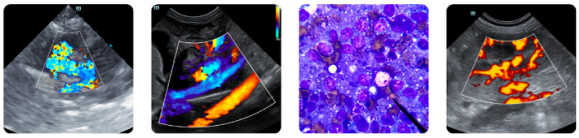


SonoPath www.thefocalzone.com
info@thefocalzone.com 289.808.2608

PATIENT

Oregon Brinoza

SPECIES

Canine

BREED

Lhasa Apso

SEX

MN

AGE

7 years

WEIGHT

36.6 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Creditview Eglington AH

REFERRING VET

Dr. Ghobrial

INVOICE

11767

DATE

4/23/2026

PRESENTING CLINICAL SIGNS

Gradual onset of hind end weakness over the last 2 to 3 weeks, difficulty walking, slow gait, trouble getting up. No obvious limp. Polydipsia persists. Urination is decreased. Panting at night, less than before though. Fur thinning, mostly on tail, tail held down and seems less happy, lethargy, normal appetite. Now showing head pressing symptoms.

Current Meds: Vetoryl for Cushing's Disease.

Abnormal PE/Chem/CBC/UA Results: Please see attached. Elevated ALT, ALKP, GGT, CHol, low Amylase and TT4 less than 0.5(1.0-4.0) elevated PLT and PCT.

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.

Both kidneys have a smooth capsule and with mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci is present in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measures 5.23 cm in length and the right kidney measures 5.60 cm in length.

Adrenal Glands

Both adrenal glands are bilaterally prominent and measure enlarged. They have a hypoechoic echogenicity with no specific nodules or masses seen.

Left adrenal measures 2.85 cm in length, 0.94 cm at the caudal pole and 0.82 cm at the cranial pole. Right adrenal measures 3.21 cm, 0.62 cm at the caudal pole and 1.53 cm at the cranial pole.

Spleen

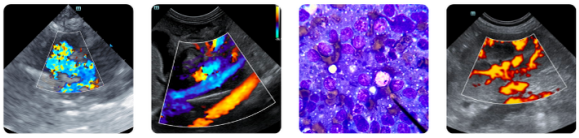
The spleen had hyperechoic pinpoint foci throughout consistent with hyperechoic stippling suggestive of dystrophic mineralization. It had a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. There were no specific masses or nodules seen.

Liver

The liver appears subjectively enlarged with a hyperechoic parenchyma. No specific nodules or masses are visualized. Although, visualization and resolution are hindered by gallbladder wall changes and possibly patient compliance and confirmation.

Gall bladder is moderately distended with anechoic bile. The gallbladder wall is diffusely thickened and hyperechoic. There is gas shadowing along the margins of the gallbladder wall, concerning for emphysematous cholecystitis.

Gastrointestinal



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The stomach contains ingesta and gas obstructing full visualization. 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.

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 pancreas was not distinctly visualized.

ULTRASONOGRAPHIC FINDINGS

- Cholangitis – Suspect emphysematous cholangitis.
- Hyperechoic hepatomegaly.
- Bilateral adrenomegaly – consistent with reported hyperadrenocorticism.
- Hyperechoic stippling in the spleen.
- Mild aging renal changes with nephrocalcinosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gallbladder wall changes are most concerning for emphysematous cholecystitis which is caused by gas producing bacteria within the gallbladder. Abdominal radiographs or abdominal CT scan may be of use to further visualize and confirm the presence of gas within the gallbladder wall. Ultrasound imaging is most consistent with this diagnosis. Emergent cholecystectomy should be considered.

Biliary surgery is not without significant perioperative morbidity and mortality and consultation with a veterinary surgeon is recommended. 24-hour post-op monitoring is recommended until clinically stable. The risk of postponing surgery includes gall bladder rupture, subsequent bile peritonitis, and/or progression to systemic septic shock.

Medical therapy is an alternative option if surgery is not desired though this is not generally recommended. Therapy includes fluid therapy as needed, GI support, pain control, antibiotic therapy and liver supportive medications (N-acetylcysteine, SAM-E, milk thistle, Vitamin E). Empiric antibiotic therapy is not unreasonable and antibiotics that are effective against gram-negative, aerobic, enteric bacteria and excreted into the bile are recommended. Amoxicillin, amoxicillin-clavulanic acid, cephalosporins, and fluoroquinolones are suggested first choices. Metronidazole (7.5 mg/kg PO, IV q 12 hrs) may be added for extra anaerobe coverage. Serial monitoring of vital signs, fluid balance, electrolytes and liver values including bilirubin and imaging is recommended.

Adrenal gland changes and hyperechoic stippling within the spleen are consistent with reported hyperadrenocorticism.

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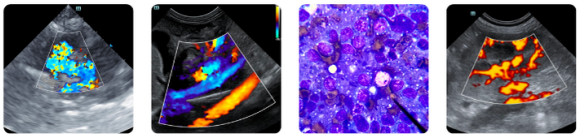

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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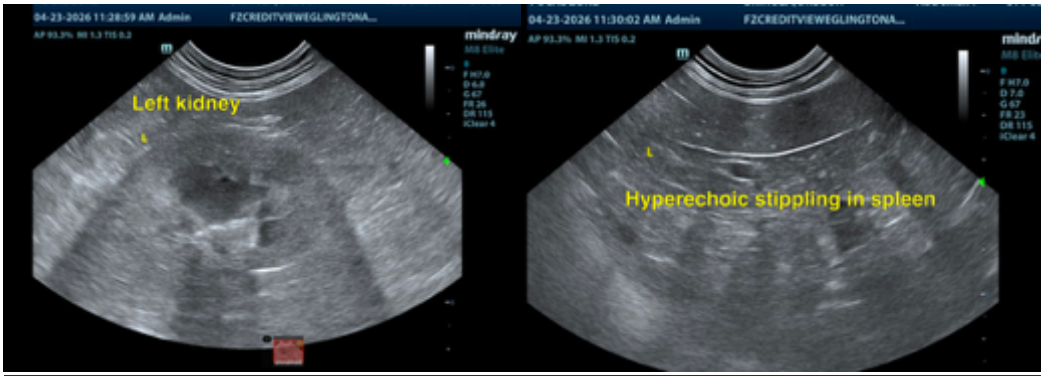

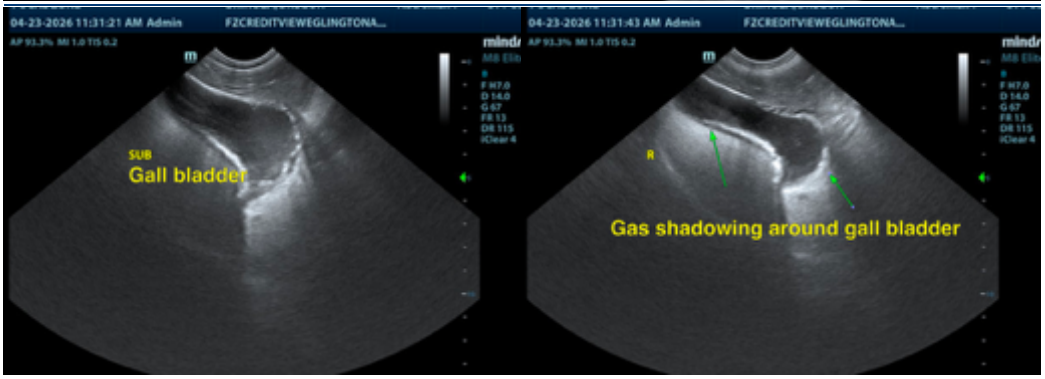

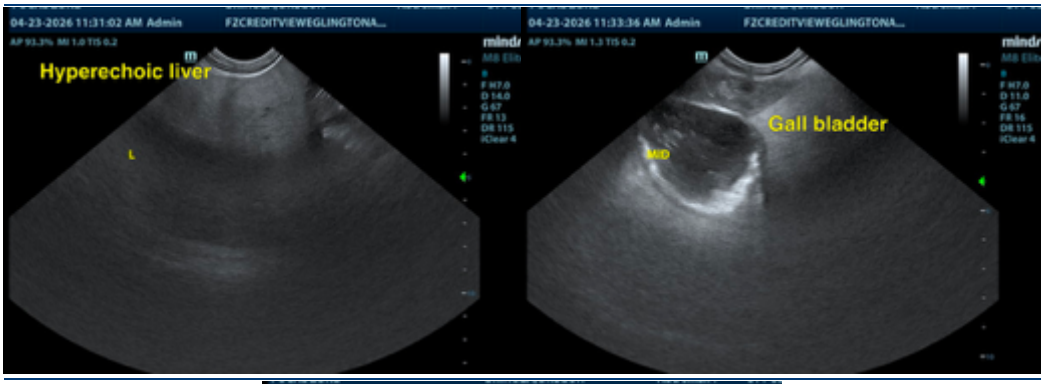

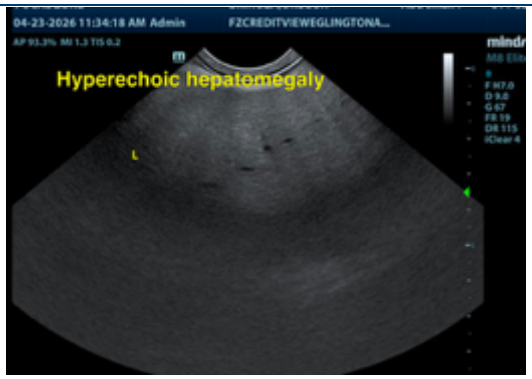

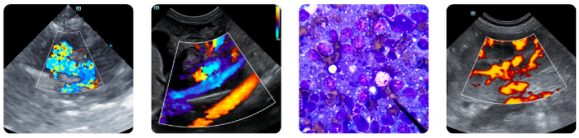

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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