



PATIENT

Carl Breton

SPECIES

Canine

BREED

Bernese Mountain Dog

SEX

MN

AGE

7 years

WEIGHT

95 lbs

INTERPRETED BY

Dr Brittany Sinclair,
 BVSc(hons),
 DACVECC

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Dog and Cat Clinic of
 Niagara

REFERRING VET

Dr. Habib

INVOICE

11627

DATE

4/7/2026

PRESENTING CLINICAL SIGNS

Acute vomiting today (4/6/26). Did bloodwork and it shows elevation of kidney and liver values. Did a leptospira snap test that showed negative. Has history of foreign body. Current Medications: Sulcrate, Denamarin, Gabapentin

Abnormal PE/Chem/CBC/UA Results: SDMA 16 Creatinine 246 Urea (BUN) 11.5 ALT 487 Total Bilirubin 18 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, uroliths or abnormal thickening visualized. Urine was anechoic. 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. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis are noted bilaterally. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. Left kidney measures 6.35 cm in length, and the right kidney measures 5.59 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. Left adrenal measures 2.25 cm in length, 0.79 cm at the caudal pole and 0.63 cm at the cranial pole.

The right adrenal gland was visualized and measured on still images only. Resolution is inadequate to assess glandular detail or confirm measurement. Right adrenal measures 1.92 cm in length, 0.53 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 subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is significantly distended with anechoic bile. There is hyperechoic gravity dependent non-shadowing debris present. The common bile duct is not visibly distended. The duodenal papillae is not distinctly visualized.

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.

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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.

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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.

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Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

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ULTRASONOGRAPHIC FINDINGS

- Gallbladder distension.
- Bilateral nephrocalcinosis in the kidneys.

WEIGHT

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver parenchyma appears normal and there is no ultrasonographic explanation for the elevated liver enzymes in this patient. There is no significant disruption of architecture noted to suggest significant pathology. Low grade inflammatory hepatopathy/reactive hepatopathy is a likely cause of LE elevations. Fine needle aspirate is recommended and bile acid profile to assess liver function. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol if bilirubin elevated or gall bladder 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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Gallbladder distension is likely due to decreased emptying secondary to acute GI signs. Continued monitoring of liver values for elevation and total bilirubin if patient is not quickly recovering from GI signs is advisable.

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There is no ultrasonographically evident cause of reported GI signs in this abdominal study. Pancreas and GI tract are within normal limits. Consideration for dietary indiscretion, infectious etiologies (bacterial, viral, parasitic), food sensitivity/allergy or mild inflammatory bowel disease is reasonable. While not sonographically evident, pancreatitis cannot be completely ruled out. Empiric treatment for GI signs including anti-nausea, appetite stimulant and fluid support as clinically indicated is warranted. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically. If signs are persistent or recurrent, additional diagnostics to be considered include baseline cortisol +/- ACTH stimulation test, GI panel (TLI/PLI/cobalamin/folate), fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes. Ultimately GI biopsy may be required for more definitive diagnosis if the patient is not responsive to medical treatment.

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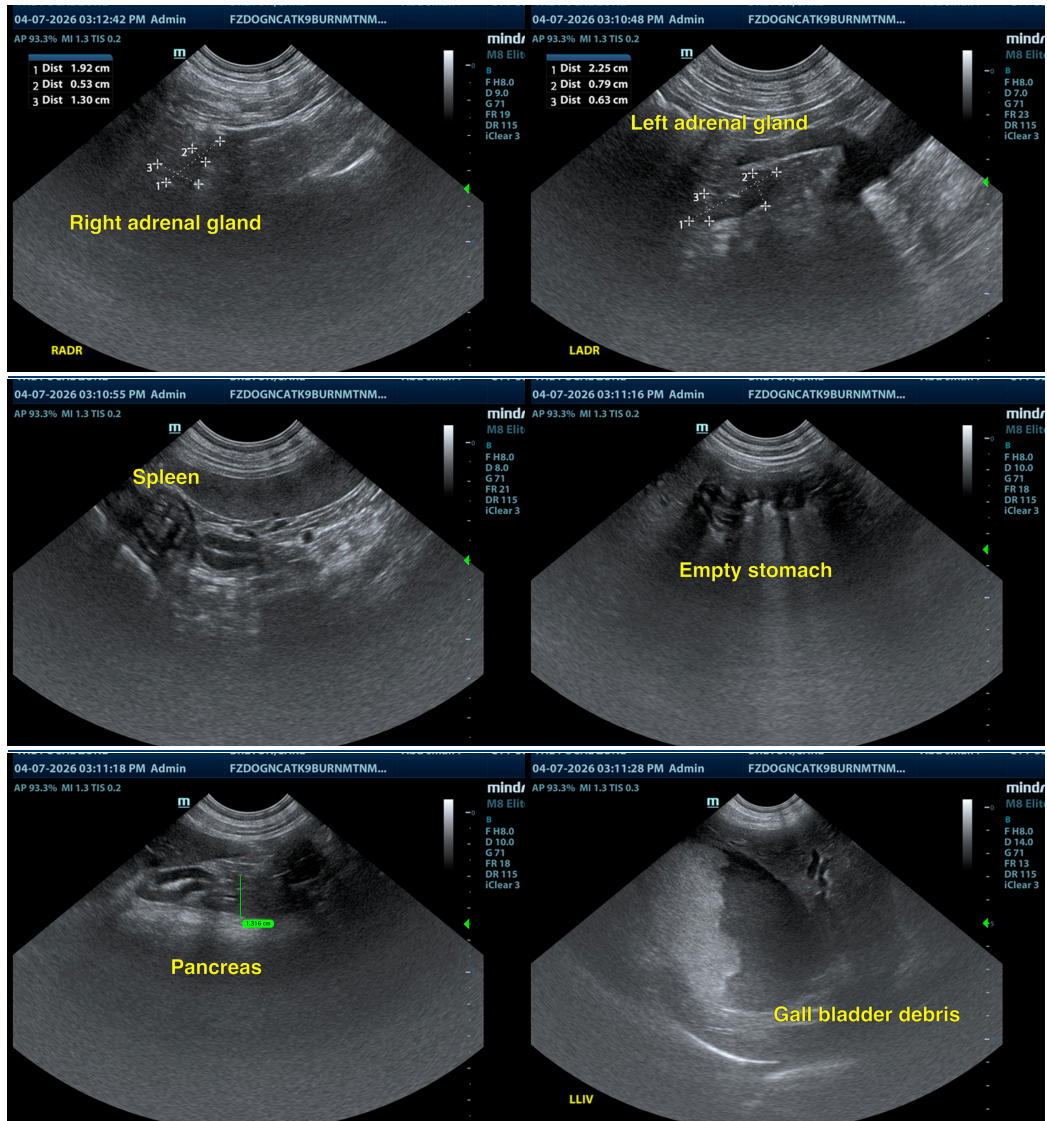
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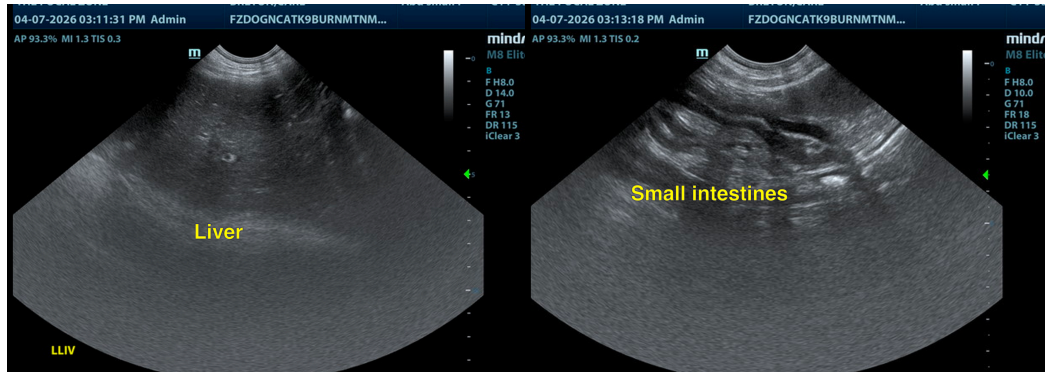
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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