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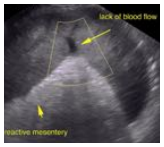

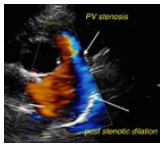

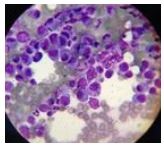
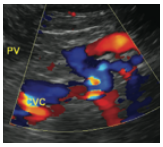

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1-800-838-4268 info@sonopath.com

PATIENT

Logan Eskritt

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Neutered male

AGE

13 years

WEIGHT

15.5 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Brian Klug

HOSPITAL NAME

Sondel Family VC

REFERRING VET

Dr. Mohney

INVOICE

31975

DATE

7/26/22

PRESENTING CLINICAL SIGNS

History: ALK and ALT both elevated (ALK > ALT) recommended AUS since his ALK P is so high, want to rule out GB mucocele. o scheduled for next Tuesday (EF)
Abnormal PE/Chem/CBC/UA Results: 7/13/22 - ALT mild elevation 131 IU/L (normal range 12-118); ALP 1,358 IU/L (normal range 5-131 IU/L).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed a 0.48 cm calculus at the cystourethral junction. A separate bladder calculus was noted and measured 0.41 cm. A smaller amount of bladder sand was noted in the urethra.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. Mineralization was noted in the kidneys.

Adrenal Glands

The right **adrenal gland** was heterogenous with hypoechoic, nodular change with capsular expansion measuring 2.64 x 1.0 cm in maximum width. The right adrenal gland had slight phrenic vein occupation. The left adrenal gland was uniform and measured 0.51 cm at the caudal pole and 0.5 cm at the cranial pole.

Spleen

The **spleen** revealed microcystic nodule at the cranial pole with coarse architecture noted elsewhere. The nodule measured 0.8 cm. The spleen was folded upon itself caudally.

Liver

The **liver** was uniformly swollen with minor, excessive gallbladder debris and over distension with dependent and suspended bile without evidence of overt mucocele formation. However, excessive sludge was present. The liver presented coarse architecture with mildly increased portal markings and subtle, mixed echogenic changes. This is consistent with vacuolar hepatopathy and some level of remodeling and history of inflammatory component. There was no overt suspicion of neoplasia.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

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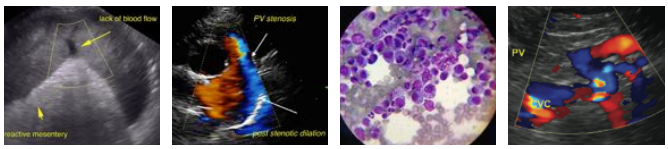

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Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

Bladder calculi, non-obstructive at the time of the sonogram.

Nodular right adrenal gland. Carcinoma, pheochromocytoma and hyperplasia with phrenic clot are all possible.

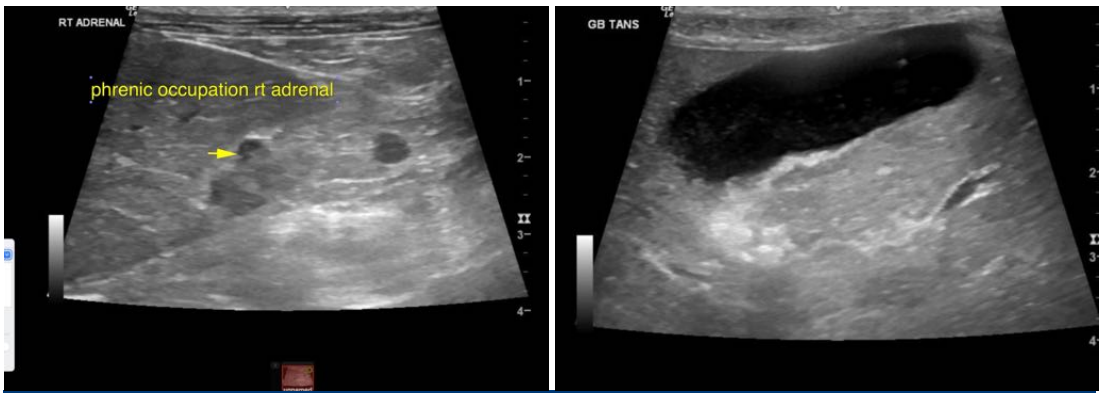
Cystic splenic nodule, likely benign.

Vacuolar hepatopathy with age related changes.

Gallbladder sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assessment for history of passage of urinary calculi is warranted. Blood pressure measurements are indicated. Justification to right adrenalectomy, splenectomy, cystotomy and bladder lavage could all be considered as well as liver biopsy. However, structurally the liver appears subjectively benign. If the patient appears Cushingoid then work-up for adrenal dependent Cushing's is indicated. If blood pressure measurements are elevated then Cushing's or pheochromocytoma are possible. There is no evidence of mucocele, yet a minor amount of excessive debris was noted.



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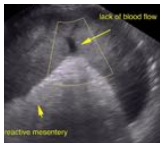
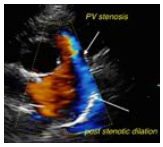
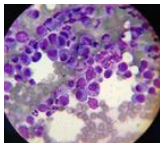
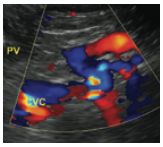

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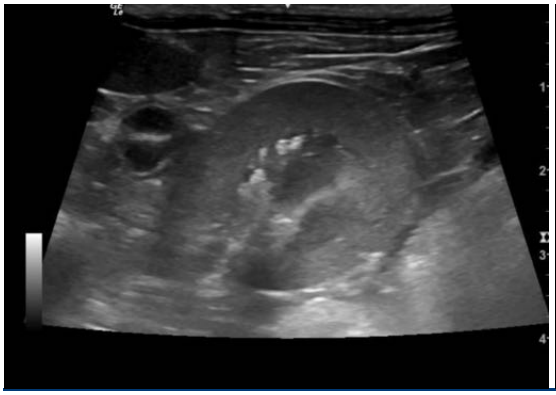
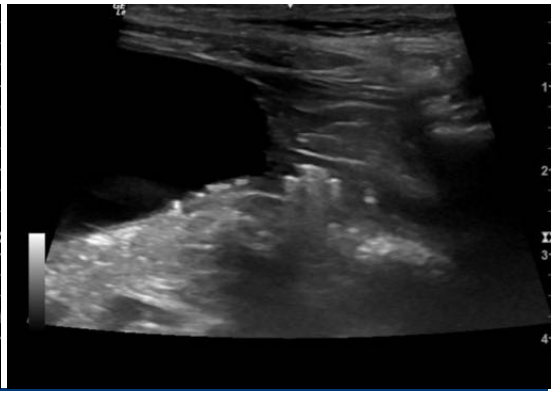
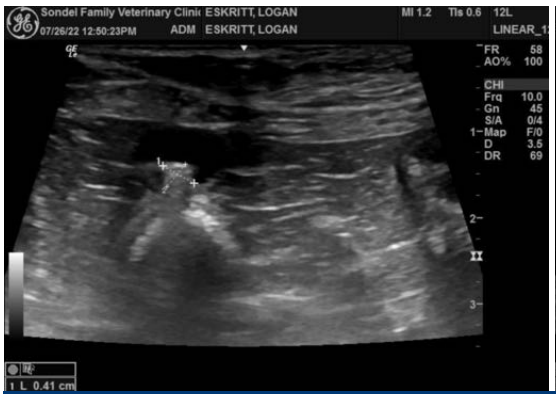

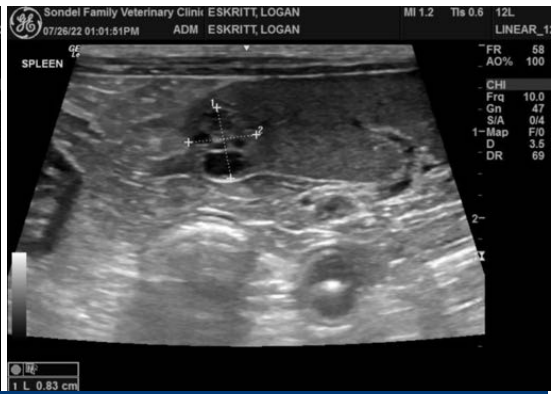

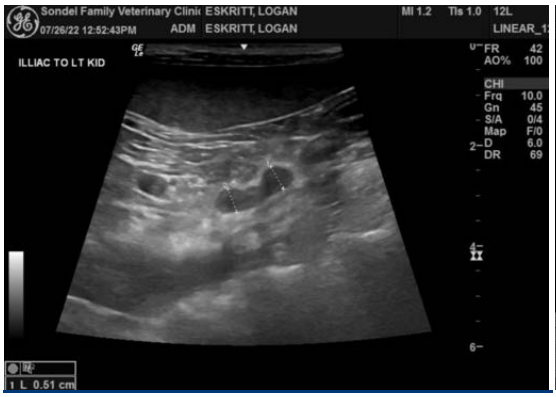

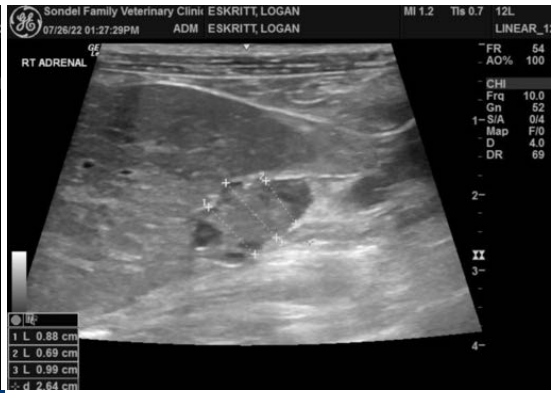

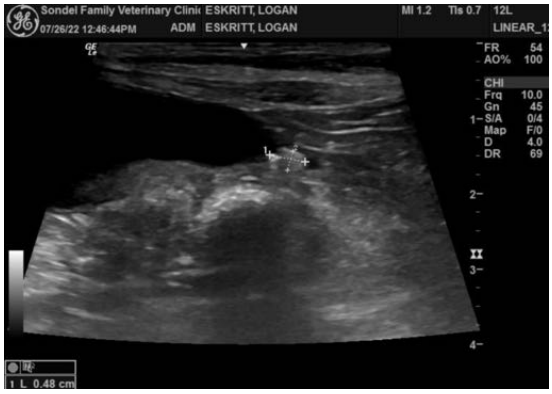

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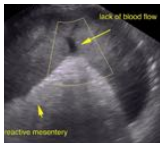

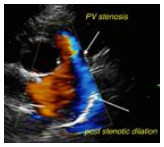

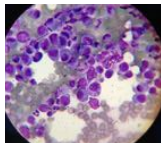
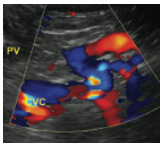

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com