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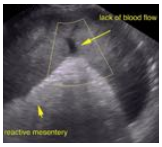
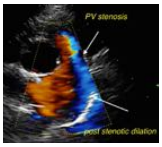
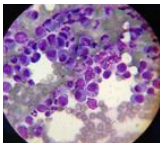
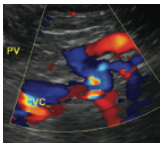

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1-800-838-4268 info@sonopath.com

PATIENT

Bentley O'Brien

SPECIES

Canine

BREED

West Highland White Terrier

SEX

Neutered male

AGE

8 years

WEIGHT

24.9 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Haley Harasimowicz

HOSPITAL NAME

Waterbury VH

REFERRING VET

Dr. Farrell

INVOICE

46559

DATE

8/9/23

PRESENTING CLINICAL SIGNS

History: 2/23: pDVM for suspect ITB, Rx Doxy and Cough Tabs. 3/6: recheck pDVM, thoracic rads suspect bronchitis, Rx Azithromycin and Prednisone. 3/11: recheck pDVM, thoracic rads same, not tolerating Azithromycin, Rx Clavamox. 4/5: IM consult (PEAK) for cough, last dose Pred was given 3/25. CBC leukocytosis Chem ALT 1120, AST 126, ALP 493, T Bili 0.4 UA WNL Hw4dx all neg Fecal w/Gia all neg/NOS Abd US, slight gallbladder sludging, WNL otherwise Rx Panacur 10 days, Ursodiol 100mg PO SID, Denamarin PO SID, Cerenia SID, ID diet 4/22: PEAK IM recheck, ALT 1486, MSU thyroid panel WNL Liver biopsy recommended, owner elected not to pursue as Bentley seemed to be doing well. Finished Denamarin, Ursodiol and ID diet, and did not continue. 8/4: First visit here for wellness, owner considering dental. Reports cough improved, although still occurs with excitement, hears coughing fits every few days. Also sneezing, sounding more wet. Appetite, h2o and UD WNL, no VD. PE unremarkable other than slight icterus of OU and mm. Senior profile and Fecal performed. CBC WNL Chem ALT 334, AST 94, ALP 491, GGT 14, T Bili 6.4 UA SG 1.004, bilirubinuria 2+ T4 1.8 Fecal NOS/neg Restarted Denamarin Advanced and discussed recheck Abd US, owner agreed. NOTE, previous history of intermittent nystagmus, fast phase to R, and intermittent circling to L. Neuro consult and workup WNL 8/2021. No treatment. Occurs regularly still, more than once a week even, no post ictal signs. Elicited by excitement.
4/5: CBC leukocytosis Chem ALT 1120, AST 126, ALP 493, T Bili 0.4 UA WNL Hw4dx all neg Fecal w/Gia all neg/NOS Abd US, slight gallbladder sludging, WNL otherwise 4/22: ALT 1486 MSU thyroid panel WNL 8/4: CBC WNL Chem ALT 334, AST 94, ALP 491, GGT 14, T Bili 6.4 UA SG 1.004, bilirubinuria 2+ T4 1.8 Fecal NOS/neg **NOTE, attached IM records (PEAK), includes their US findings from early April.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **bladder** in this patient was mildly thickened with slight echogenic mural changes. No calculi or masses were noted. Slight micropolypoid changes were noted. This is a frequent finding in older animals and may be linked to a history of chronic urinary tract infection or active urinary tract infection. Urinalysis would be recommended with culture if any evidence of inflammatory sediment is present. The region of the trigone and visible pelvic urethra were normal.

The residual prostate measured 0.5 cm.

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. Slight mineralization was noted in the kidneys. The right kidney measured 4.9 cm. The left kidney measured 4.16 cm with a cortical infarct at the caudal, dorsal cortex.

Adrenal Glands

The right adrenal gland was at the upper limits of normal, slightly swollen and slightly heterogenous. The right adrenal gland measured 0.91 cm at the cranial pole and 0.8 cm at the caudal pole. The left adrenal gland was normal in size and contour. The left adrenal gland measured 0.35 cm at the cranial pole and 0.25 cm at the caudal pole.

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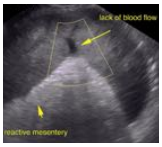

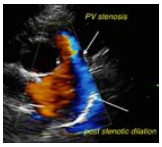

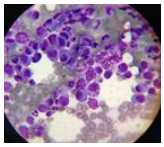
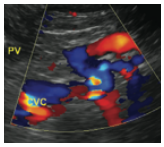

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Spleen

The **spleen** was mildly enlarged and uniform with slight swollen contour.

Liver

The **liver** revealed coarse architecture with increased portal markings. Parenchymal, cystic changes were noted. This is consistent with chronic inflammatory hepatopathy. The gallbladder wall was slightly thickened.

Gastrointestinal

The **gastrointestinal tract** revealed minor variable thickening and echogenic submucosal changes most consistent with low grade end result of chronic GI disease such as IBD and may be related to malassimilation of nutrients if any weight loss is present. Mild areas of hyperechoic, mesenteric remodeling noted. Soft stool is noted in the colon. A 1.35 x 1.33 cm parenchymal and cystic lesion was noted. This is suspected to be a mesenteric lymph node. Power Doppler assessment is warranted prior to sampling, yet sampling of the parenchymal portion of the presumed lymph node as well as drainage of the cystic portion with culture would be ideal. However, attention should be paid towards mesenteric vessels. Separate iliac lymph nodes were also cystic and measured 1.5 x 1.0 cm.

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

Non-specific, acute on chronic inflammatory hepatopathy.

Cystic and parenchymal mesenteric lymph node.

Cystic iliac lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Leptospirosis should be ruled out as a potential underlying factor. The Prednisone may be suppressing a more significant presentation. Sampling of the liver and drainage and cytology of the mesenteric lymph node is indicated. Core liver biopsy is recommended for a more definitive diagnosis. Neoplasia is unlikely.

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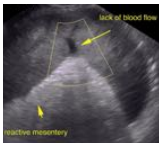
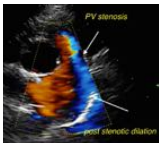
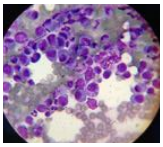
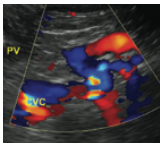

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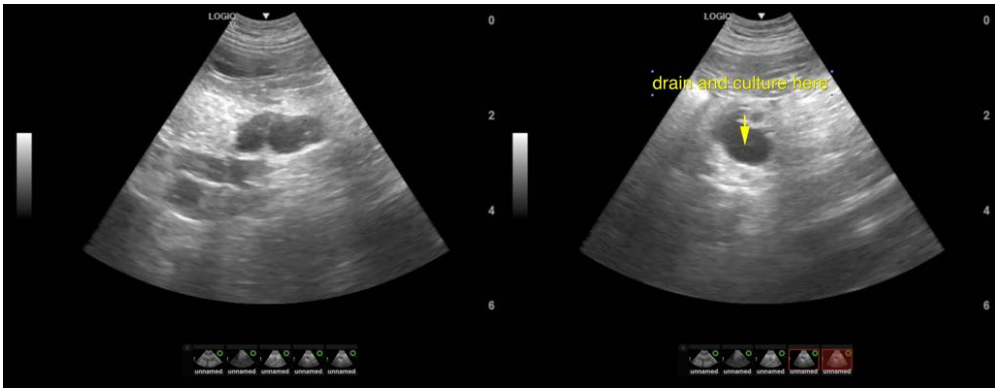

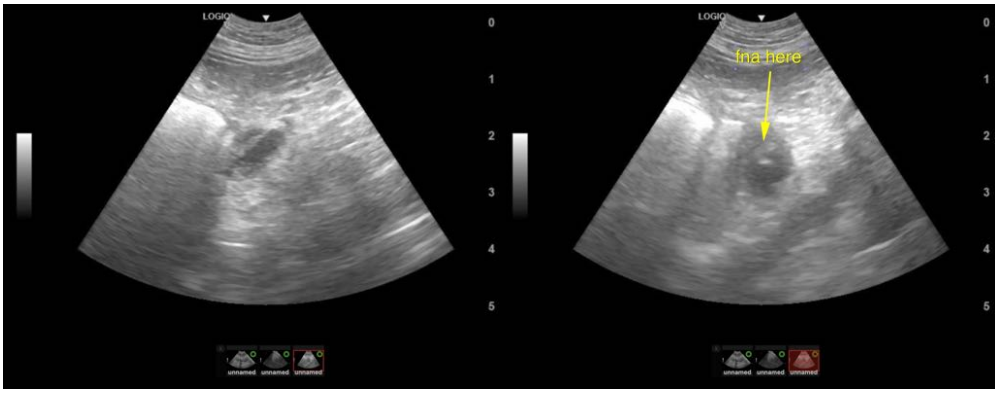

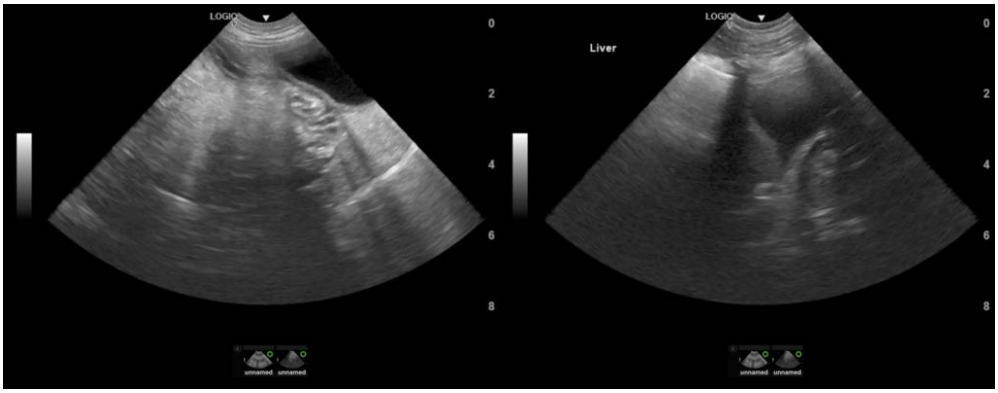

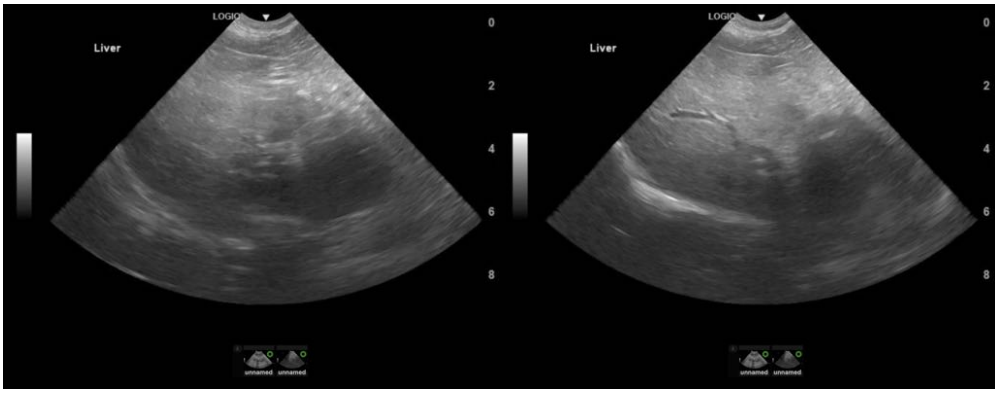

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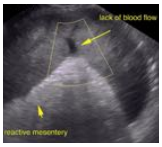
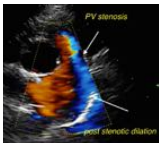
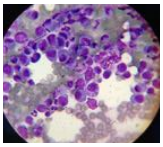
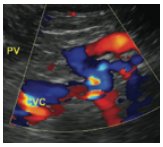

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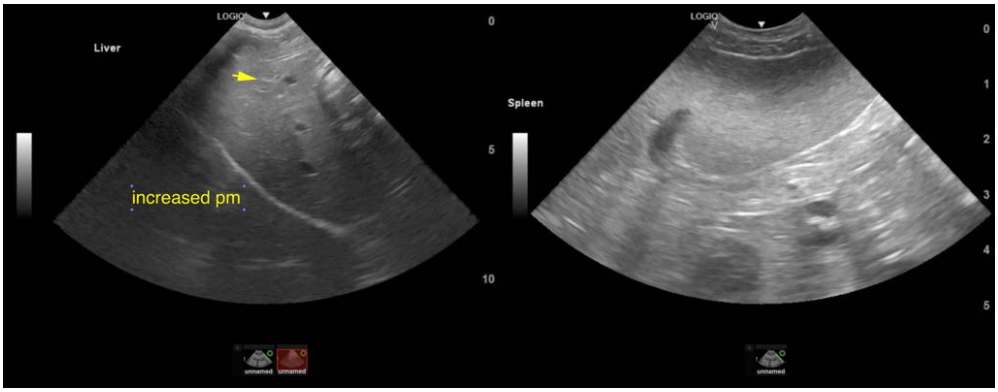

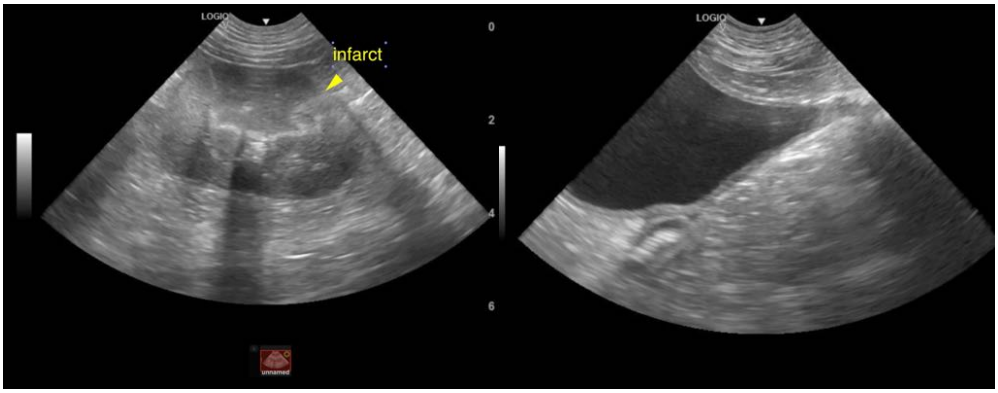

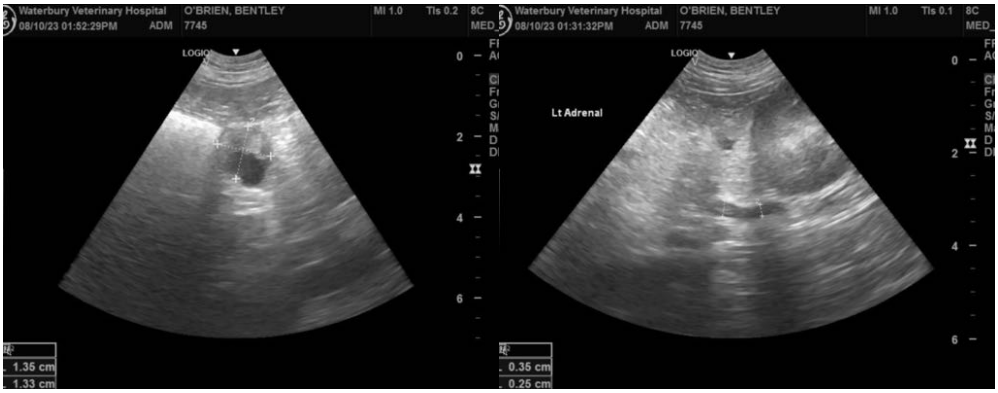

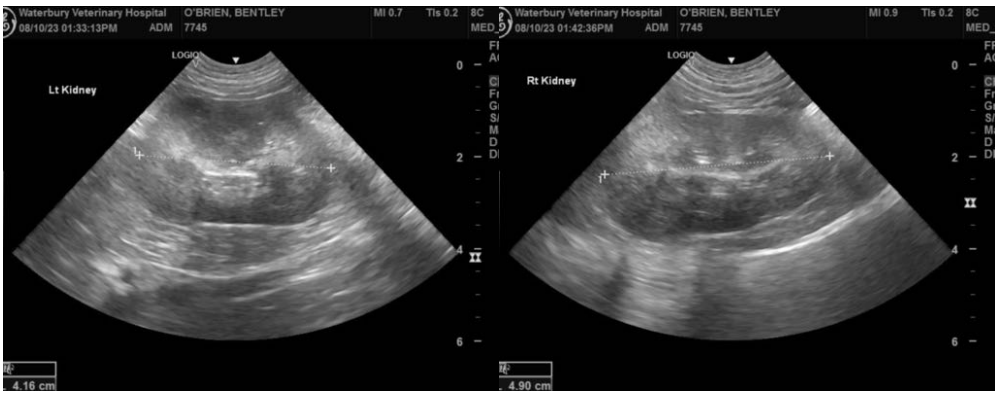

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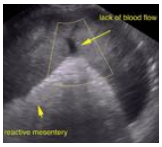
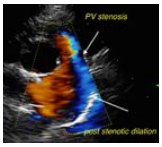
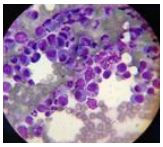
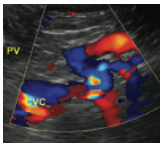

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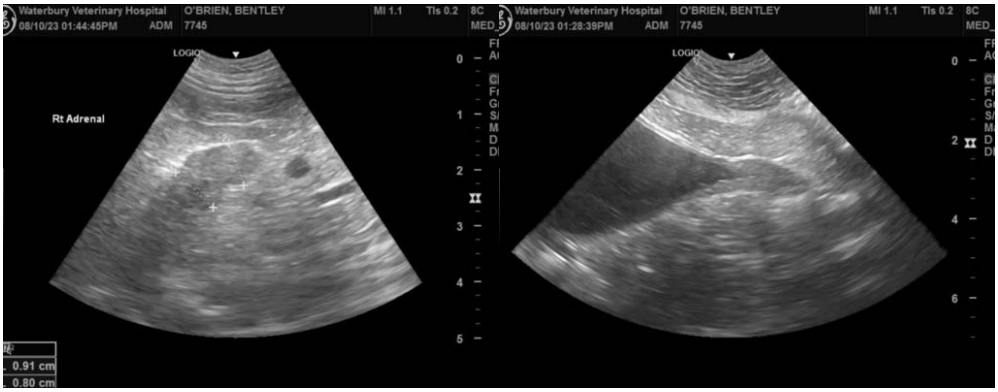

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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