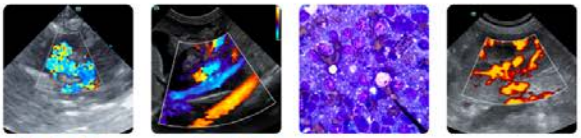


PATIENT

Larry Chrzanowski

SPECIES

Canine

BREED

Havanese

SEX

Neutered Male

AGE

13 Years

WEIGHT

13.4 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Meghan Morse, LVT, CVT

HOSPITAL NAME

Bergen County Veterinary Center

REFERRING VET

Dr. Gioffrie

INVOICE

74053

DATE

3/26/26

PRESENTING CLINICAL SIGNS

Elevated liver values, urinary signs. Current meds: Denamarin, Clavamox

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder contains minimal urine. There are approximately 2 uroliths present that are hyperechoic and causing complete shadowing. The first measures 6.6 mm in width, the second measures 5.4 mm in width. The luminal margin of the urinary bladder has an irregular shape to it, most likely due to chronic inflammation from the presence of the uroliths.

The kidneys are overall normal in size (3.6 cm on the left and 4.0 cm on the right) and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted in both kidneys. There is no evidence of pyelectasia or infarcts observed.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 5.9 m and the caudal pole measures 5.5 mm.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 4.7 mm and the caudal pole measures 4.9 mm.

Spleen

The spleen is normal in size, shape, margination and echogenicity. Hyperechoic lesions of variable size are found throughout the spleen, consistent with benign myelolipomas.

Liver

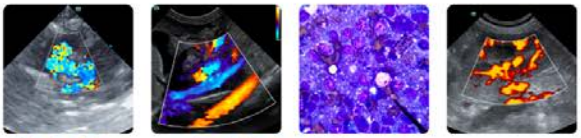
The liver is diffusely enlarged and hyperechoic with rounded margins.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.



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The intestines have normal wall layering and thickness. Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Uroliths.
- Possible early chronic kidney disease.
- Enlarged, hyperechoic liver – likely benign hepatopathy.
- Emerging gallbladder mucocele.
- Full stomach – Patient appears non-fasted for the exam.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend full staging, monitoring and managing of the patient per IRIS guidelines.

If not already started, recommend a dissolution diet strictly for one month, and rechecking either ultrasound or radiographs to determine if uroliths are still present. If they are, then recommend cystotomy and submission of stones to the Minnesota urolith lab to determine the type of urolith present and to formulate an appropriate dietary plan for the patient. If cystotomy is performed to remove the stones, then consider cholecystectomy during that procedure and liver biopsy.

Recommend screening for hyperadrenocorticism. Recommend screening for hyperlipidemia. A GI panel would be recommended to screen for occult gastrointestinal or occult pancreatic disease as cause of the secondary hepatopathy. Also, if not recently performed, consider a thyroid panel to rule out hypothyroidism as a cause of the suspected secondary hepatopathy.

Recommend starting an antibiotic such as Amoxicillin for 6-8 weeks at 20 mg/kg twice daily and Ursodiol and 15 mg/kg per day, which can be split into two daily doses. Recheck lab work and ultrasound and completion of antibiotic and Ursodiol course to determine if any improvement in the appearance of the gallbladder has occurred.

As long as the patient's bilirubin is not elevated, then treating the mucocele medically is appropriate. If at any time the patient becomes clinically ill and/or bilirubin begins to elevate, then cholecystectomy would be recommended at that time. If the patient does have surgery for cholecystectomy, also recommended obtaining liver biopsies at the same time. If bladder stones are still present at that time, consider cystotomy and submission to the Minnesota urolith lab.

It is still recommended to consider the discussed diagnostics for secondary hepatopathy as the cause of the emerging gallbladder mucocele, as it could be one of these metabolic diseases as well.

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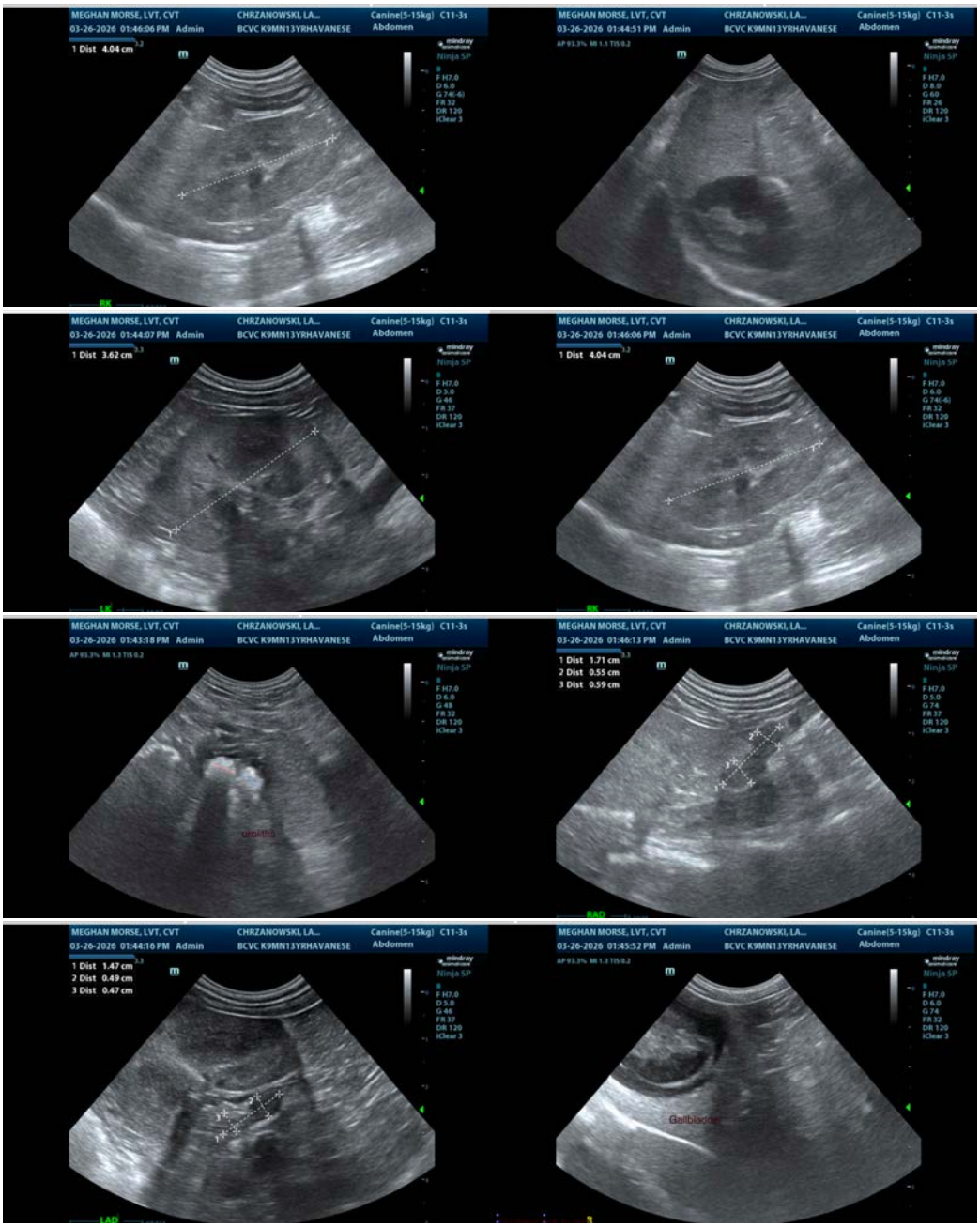

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM) Veterinary Internal Medicine Specialist info@SonoPath.com