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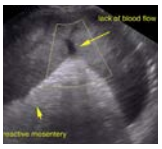
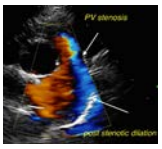
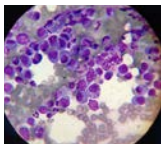
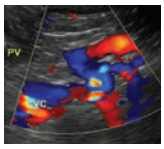

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1-800-838-4268 info@sonopath.com

PATIENT
Oakley Corry

SPECIES
Canine

BREED
Hound X

SEX
Neutered Male

AGE
13 Years

WEIGHT
53 Pounds

INTERPRETED BY
Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY
Dr. James Hornbuckle

HOSPITAL NAME
Golden Isles AH

REFERRING VET
Dr. James Hornbuckle

INVOICE
33159

DATE
12/1/21

PRESENTING CLINICAL SIGNS

Oakley presented for a peracute onset of gastrtitis with vomiting, anorexia and lethargy of 3 days duration. He is BAR but generally lethargic, less playful etc. AUS was ordered after rads were mildly suspicious for gastric FB and to further investigate elevated liver values. He does take alprazolam as needed for anxiety although this is becoming less and less
Abnormal PE/Chem/CBC/UA Results: ALT 247

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (6.58 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (7.0 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.79 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.83 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The areas of spleen visualized were subjectively normal in size. Echotexture was homogeneous. The splenic capsule appeared smooth with no irregularities. No focal parenchymal abnormalities were visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is significantly distended. Some areas of the gallbladder wall appeared thickened and irregular. There is a large amount of stippled debris within the gallbladder, showing early organization. Findings are most consistent with an early mucocele. The cystic and common bile ducts are normal/not visible.

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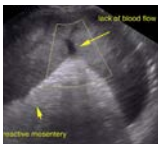
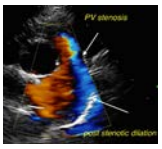
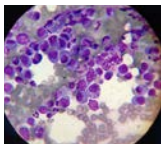
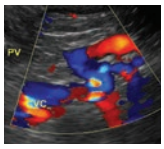

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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. 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. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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 is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

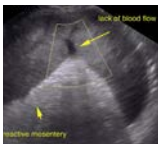
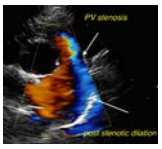
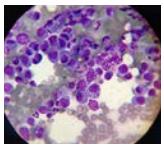
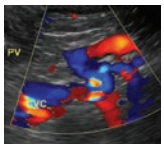
- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

- Gallbladder mucocele – The gallbladder changes are most consistent with a developing mucocele. There is no surrounding inflammation noted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed in the liver are non-specific. No focal lesions were observed. Additionally, the gallbladder is somewhat distended with organized debris, suggestive of an early mucocele. No inflammation is noted surrounding the gallbladder. Most commonly with biliary issues, you are going to see an elevation in the ALP, and the history suggests only an elevation in ALT, so this is more supportive of a primary hepatopathy, but the gallbladder should be closely monitored.

- Consider close evaluation of history for possible toxic changes, exam medications, diet, dietary indiscretion, etc.
- Consider PCR on urine/serum for Leptospirosis (if not on antibiotics)/serology if recent antibiotic history.
- If not already done, consider pre- and post-prandial bile acids to evaluate liver function.
- Consider fine needle aspirate if round cell (25-guaage needle/normal coags). Consider starting Ursodiol, Denamarin, and a course of antibiotics for possible cholangiohepatitis.
- If not response to medical supportive care, then consider liver biopsies with samples obtained for histopathology, culture and copper levels. Recommend referral to a veterinary surgeon, as evaluation of the gallbladder for removal should be considered (does not appear to be a

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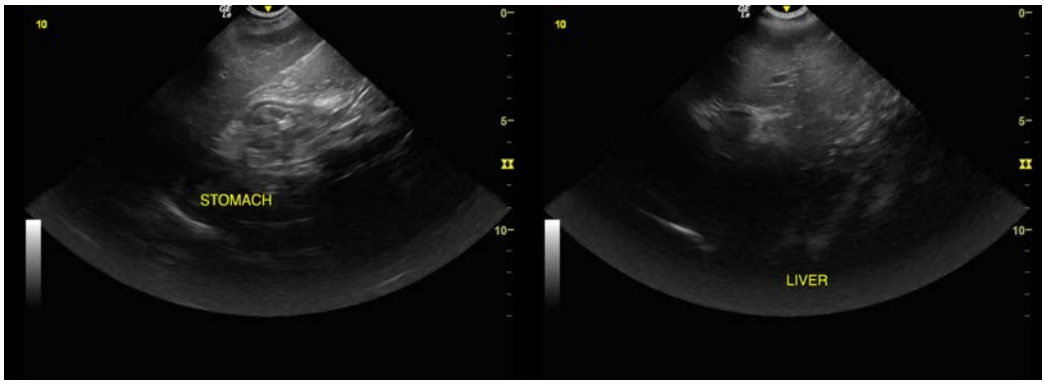
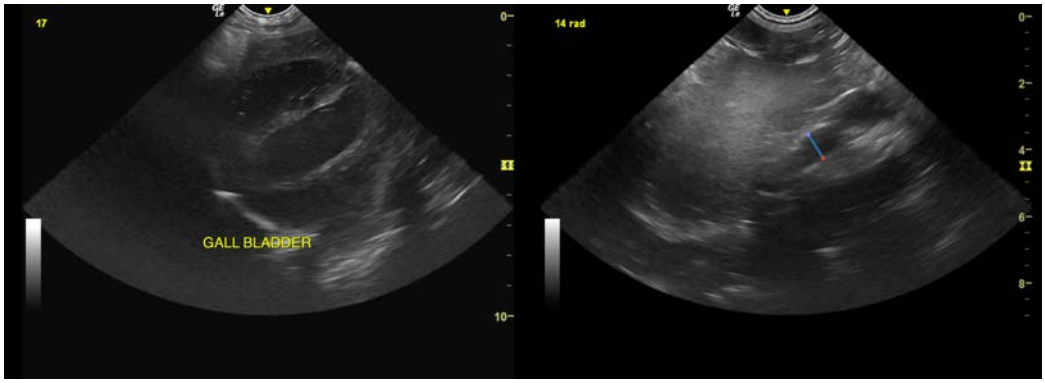
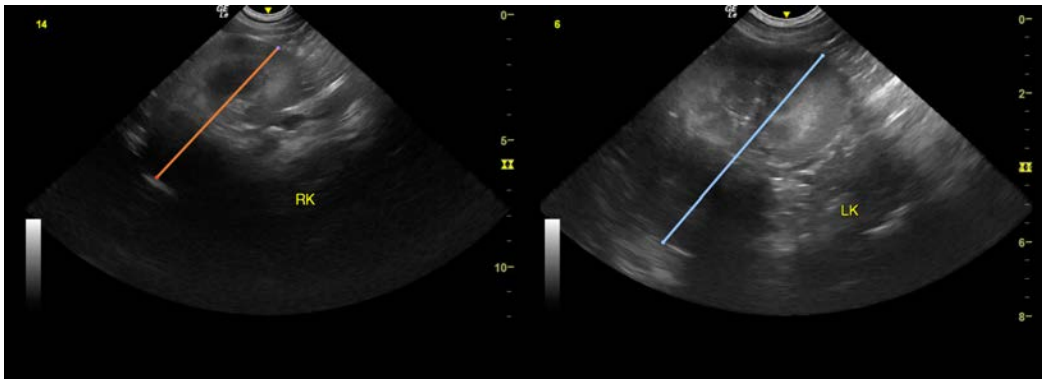
surgical gallbladder at this time).

An obvious cause for the vomiting and anorexia is not noted. This could be related to the liver/gallbladder issues, or could be a separate issue. No pathology associated with the GI tract was noted, but ultrasound can be insensitive in picking up enteritis, some foreign material, etc.







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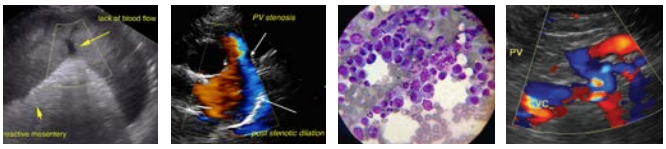

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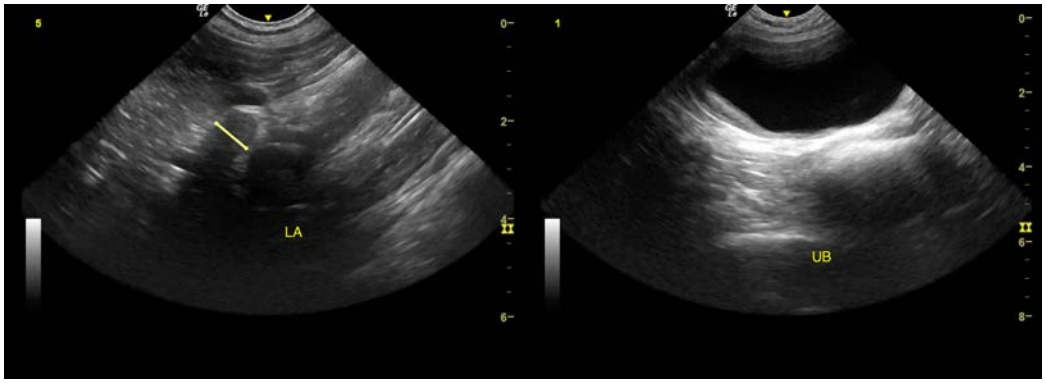

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
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