



PATIENT

Mojo Meyers

PRESENTING CLINICAL SIGNS

SPECIES

Canine

BREED

Havanese

SEX

Neutered Mal

AGE

13 Years 3 Months

WEIGHT

11.8 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

MountRose AH

REFERRING VET

Dr. Alex Veach

INVOICE

36119

DATE

3/10/22

Hx of bladder stones (CaOx) and GDV in 2019. P has otherwise been healthy. Trying to do a dental, found elevations in ALT/ALKP – started on Denamrain and aborted procedure. No hx of recent weight loss or other changes. PHYSICAL EXAM: from 3/3/2022 T- 101.9 CRT: <2 BCS: 3/5 P- 140 mm: pink Weight: 11.8# R- pant Hydration: well hydrated EENT: WNL 3-4/4 dental disease CV/Resp: No murmurs or arrhythmias noted; no crackles noted, no increased respiratory effort GI: WNL Musk: No joint abnormalities. Muscles are symmetrical. Integ: WNL LN: Palpate WNL Neuro: WNL Urogen: WNL, no obvious visible or palpable abnormalities LABORATORY FINDINGS: ALKP – 324 (23-212) ALT – 150 (10-125) otherwise NSF RADIOGRAPHIC FINDINGS (email radiographs if available): none recently performed REASON FOR ULTRASOUND: r/o liver dysfunctions, tumors or other changes

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, or masses. There are occasional very small hyperechoic foci in the dependent portion of the urinary bladder. These are typically 1-2 mm in size. In the proximal urethra/prostatic urethra, there is a pile of these very small stones. There is no evidence of a mass effect or significant wall thickening.

The prostate is normal in size (1.2 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, or mass effect. Numerous stones are noted in the periprostatic urethra.

The left kidney has a normal shape and size (4.91 cm) with pinpoint non-obstructive nephroliths. Overall echogenicity is slightly hyperechoic with poor 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 (5.23 cm) with pinpoint non-obstructive nephroliths. Overall echogenicity is slightly hyperechoic with poor 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 0.54 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 0.66 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.



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Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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Liver

The liver is large in size, and normal in echogenicity with slightly irregular shape. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are numerous nodules visualized within the liver. These vary in size, some are hyperechoic and some are more isoechoic. Two hyperechoic nodules are 0.98 cm and 1.01 cm. Two larger more isoechoic nodules are 1.83 cm x 2.21 cm and 2.22 cm x 2.88 cm.

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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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.

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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. Duodenum wall measured 0.32 cm. Jejunum wall measured 0.24 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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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.

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- Too numerous to count small calculi visualized in a pile at the junction of the periprostatic urethra. There is no evidence of an obstruction at this time.

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- Large, irregular, heterogeneous liver with poorly defined hyper- and hypoechoic nodules – The appearance of these nodules trends towards a benign etiology, but unfortunately an

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underlying neoplastic process cannot be excluded as a possibility.

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- Moderate gallbladder debris – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

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SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys with pinpoint non-obstructive nephroliths – The bilateral renal findings are consistent with age-related change. The hyperechoic mineralized foci observed at the corticomedullary junction of the left/right kidney are consistent with small, non-obstructive nephroliths.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The liver enzyme elevations noted are likely associated with the irregularities visualized in the liver. The appearance of these lesions trends towards a benign process, but this cannot be definitively determined without cytology or histopathology. Consider a liver function test and a fine needle aspirate of several areas of the liver with cytologic evaluation.

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There is a small pile containing numerous (likely more than 10) very small calculi. There does not appear to be an obstruction at this time, but there is concern that these are small enough to travel into the distal urethra and cause an obstruction. Recommend urinalysis and culture. Other options include very close monitoring for difficulty or inability to urinate, or cystotomy, where a urinary catheter is placed, stones are flushed back into the bladder, and removed. Correlate these findings with abdominal radiographs, as these are very small stones.

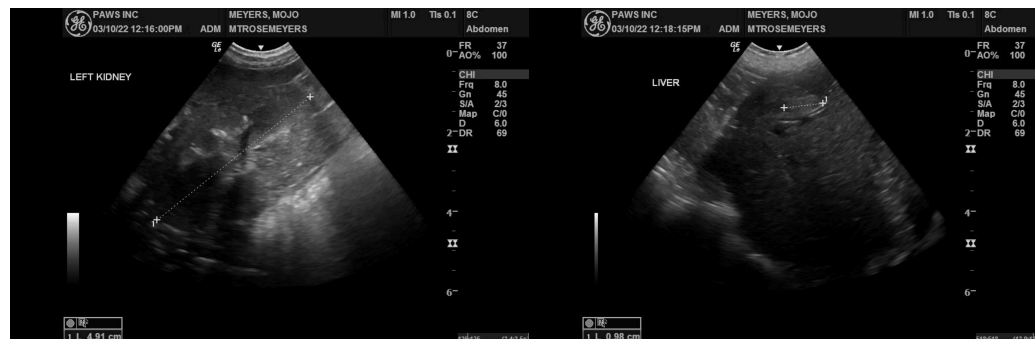
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There is a moderate amount of debris within the gallbladder. The gallbladder itself appears relatively healthy with a normal wall, etc. You could consider starting Ursodiol as a preventative measure.

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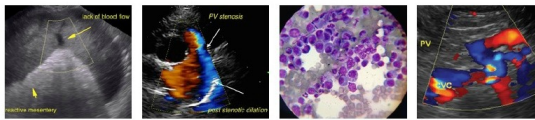
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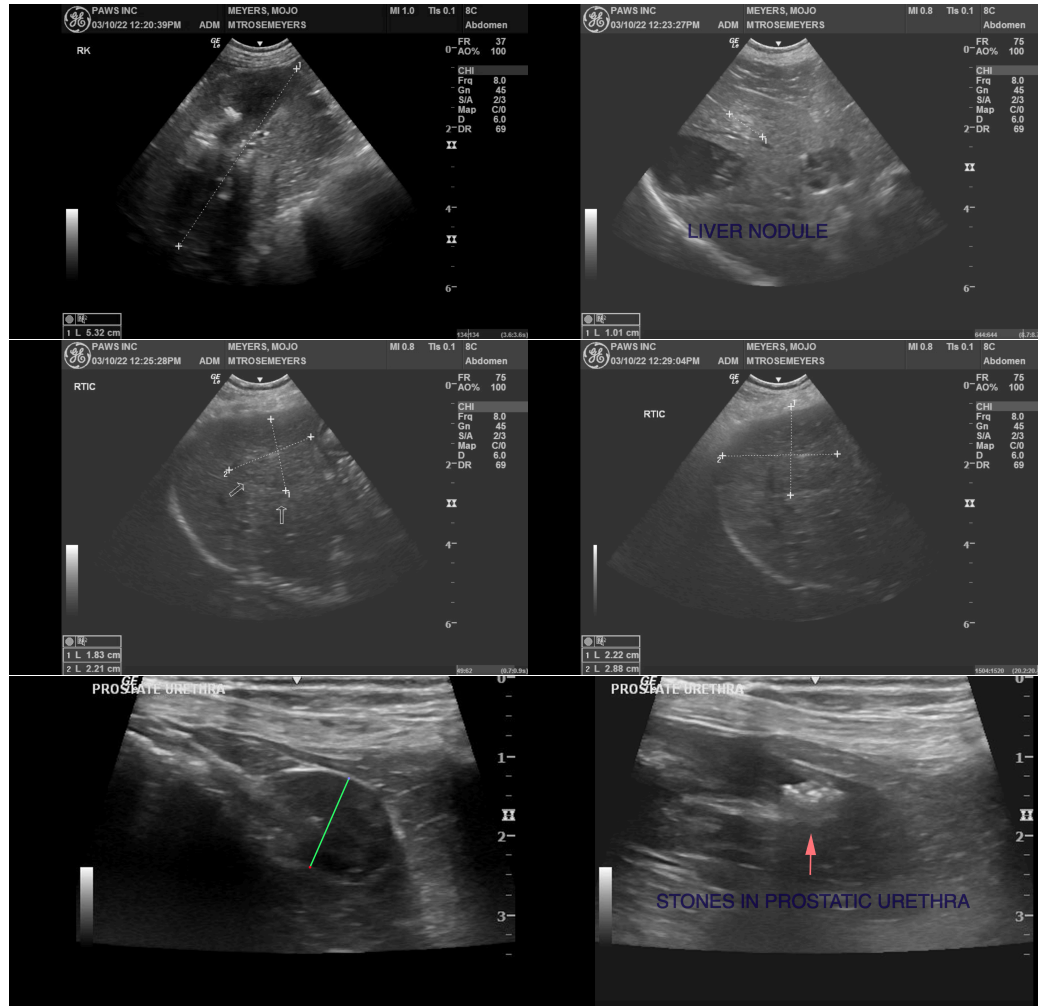
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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