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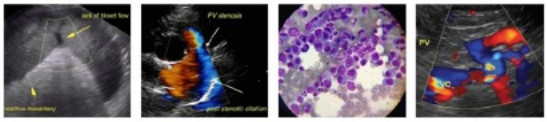


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Maddie Jensen

SPECIES

Canine

BREED

German Shorthaired Pointer

SEX

Spayed Female

AGE

4/28/2016

WEIGHT

25.6kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Desert Hills Animal Hospital

REFERRING VET

Dr, Michelle Caldwell

INVOICE

10346

DATE

7/18/2023

PRESENTING CLINICAL SIGNS

No sedation- MEDS: Phenobarbital 64.8 mg- 1 1/2 tabs PO q12 hours; KBr+ 500mg 1 tab Po q12 hours - History * P has a long history of seizures going back to 2017. Had been fairly well regulated on phenobarbital, then started having some breakthrough seizures May 2, 2023, with 3 seizures occurring when O ran out of phenobarbital for a few days. Was restarted on phenobarbital & had 3 more seizures 6/28/23. P was hospitalized, dose of phenobarbital was increased & KBr was added w/ no further seizures since, P also started on Purina Neurocare Working diagnosis R/O Epilepsy vs High Triglycerides vs Space occupying brain lesion.

Abnormal PE/Chem/CBC/UA Results: 6/29/23: Superchem- AST=100 (15-66), ALT=199 (12-118), Alk Phos=2189 (5-131), Triglyceride=3129 (21-291) CBC- Hgb=22.1, MCH=29.1, Monocytes=880 T4=1.5-WNL Urinalysis SG 1.011 pH=8.0 Protein=2+ Phenobarbital=20.0-WNL (15-35) UPC Ratio=1.0-High 6/14/23: Cholesterol/Triglyceride results and UA results: Triglycerides still high at 984 (29-291). Cholesterol WNL at 268 (92-324). PSL elevated at 183 (24-140), without GI upset, feel this is clinically insignificant. UA: USG 1.013 1+ proteinuria today, thus UPC not measured. 3+ occult blood and 11-20 RBC's/HPF likely due to cysto. Rest WNL/NSF

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 left kidney has a normal shape and size (7.51 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

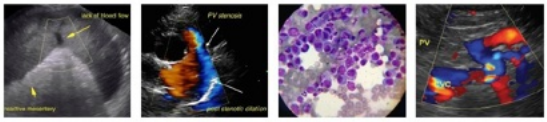
The right kidney has a normal shape and size (6.88 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.56 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 0.47 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



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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.

Liver

The liver is subjectively large in size with smooth peripheral margins. The parenchyma is hyperechoic and mildly heterogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. There are numerous very ill-defined hypoechoic nodules visualized within the parenchyma.

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.

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 jejunum measured as normal (0.33 cm.) 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 area of 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.

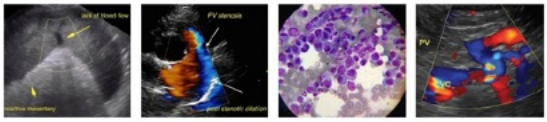
Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or significant lymphadnopathy. A prominent mesenteric lymph node is visualized measuring 0.68 cm. The omentum is of normal echogenicity.

PRIMARY FINDINGS

- Large, heterogenous liver with ill-defined hypoechoic nodules. The diffuse hepatic changes are non-specific and can be seen with vacuolar hepatopathy, reactive change, nodular hyperplasia or, less likely, inflammatory/immune-mediated disease, infiltrative neoplasia, or other hepatopathy. The appearance of the ill-defined hypoechoic nodules trends toward a benign process (hyperplasia, etc.) Recommend continued monitoring.

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



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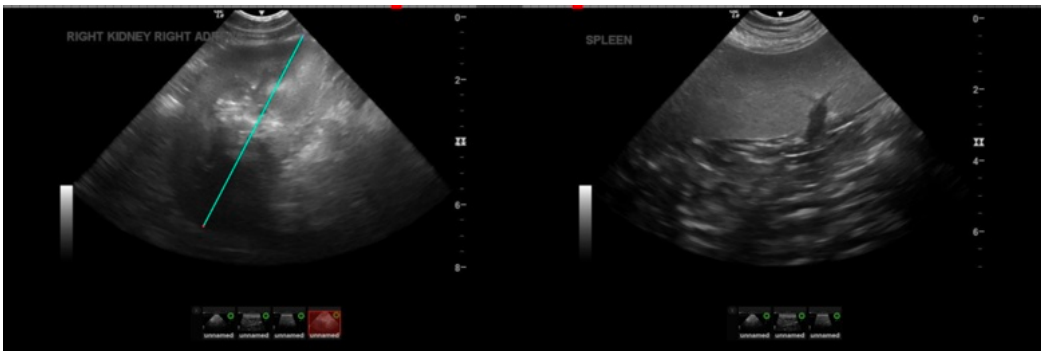
fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No significant ultrasonographic lesions were visualized on today's exam. The changes in the liver are likely somewhat associated with phenobarbital use. There were some ill-defined hypoechoic within the liver, which I suspect are consistent with hyperplasia, remodeling, etc. Continued monitoring is warranted as an underlying neoplastic process cannot be definitively ruled out.

Recommend continued monitoring of the triglyceride levels and a prescription low-fat diet to begin if this has not already been done.

Recommend a referral to a veterinary neurologist to rule out the possibility of intracranial disease as a source for the seizures described.



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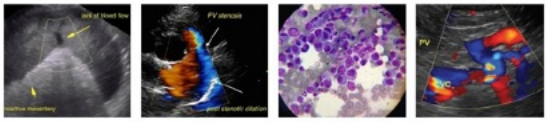

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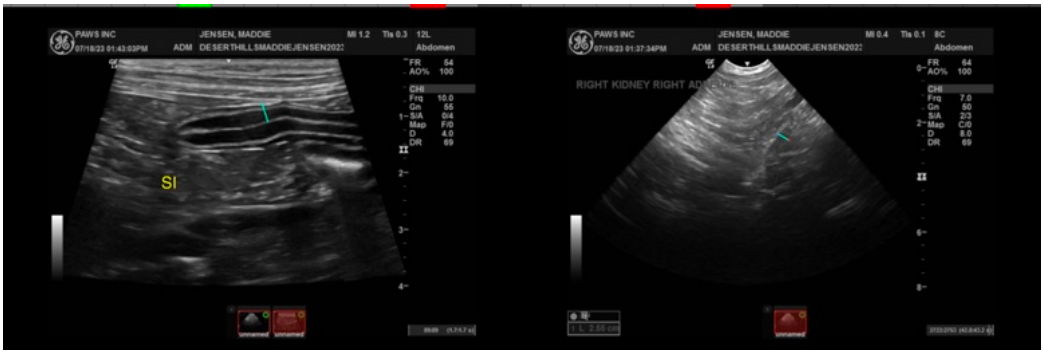

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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