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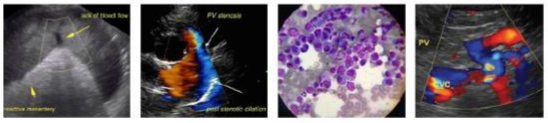

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Lily Cazalot

SPECIES

Canine

BREED

Chihuahua Mix

SEX

Spayed Female

AGE

8 Years

WEIGHT

8.87 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

South Reno VH

REFERRING VET

Dr. Schmitt

INVOICE

16810

DATE

8/10/22

PRESENTING CLINICAL SIGNS

History: elevated liver values- AUS advised prior to dental cleaning/anesthesia- dog doing well at home- Gave torb IV due to seeming painful when applying pressure scanning GB area

Abnormal PE/Chem/CBC/UA Results: Bile Acids 15.1 BILE ACIDS - POST 18.1 TOTAL PROTEIN 7.6 ALBUMIN 2.0 GLOBULIN 5.6 AST (SGOT) 94 ALT (SGPT) 295 Alk Phosphatase 225 RADS: microhepatica

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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.26 cm). Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. Pinpoint nonobstructive nephroliths were noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

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Adrenal Glands

The left adrenal gland is normal in size measuring 0.47 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 0.42 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 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 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. The gallbladder wall measures 0.2 cm. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris in the dependent portion of the gallbladder. The proximal bile duct appears mildly dilated and has some mucoid material within the lumen, measuring 0.35 cm.

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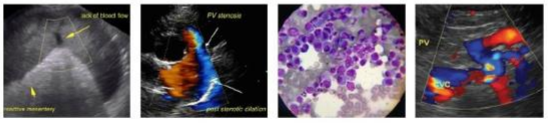

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Gastrointestinal

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 uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. The duodenum measures 0.41 cm. The jejunum measures 0.28 cm.

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

There is scant free fluid present. No lymphadenopathy is noted. The omentum is generally of normal echogenicity.

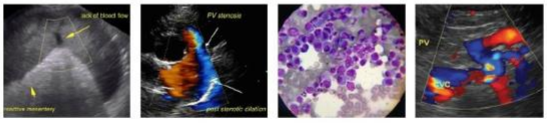
ULTRASONOGRAPHIC FINDINGS

- Mildly reduced corticomedullary distinction in both kidneys with pinpoint nonobstructive nephroliths. The bilateral renal findings are consistent with age-related change.
- 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.
- Large gallbladder debris. There is a large amount of debris in the gallbladder and it is moderately distended. There is no surrounding free fluid or significant inflammation, but the gallbladder wall appears mildly thickened, measuring 0.2 cm.
- Mildly thickened small intestine. The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gallbladder is large and distended with a small amount of proximal bile duct dilation. I recommend medical management with chronic Ursodiol therapy +/- antibiotics and continued monitoring of this to check for progression to a surgical lesion.

Both kidneys have mildly reduced corticomedullary distinction and pinpoint nonobstructive



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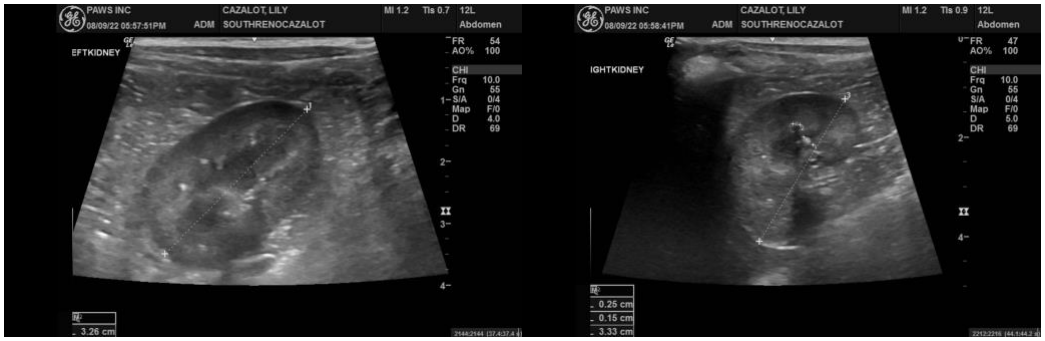
nephroliths. This is likely associated with age-related change, but given the low albumin levels reported, I recommend a urine/protein/creatinine ratio and urinalysis with a blood pressure.

The small bowel appears subjectively thickened but has normal intact layering, so this could be within normal limits for this patient. If you are looking for a cause of the hypoalbuminemia reported, I would typically consider a liver function test to look for lack of production from the liver (this was done, and it appears normal). Alternately, I would consider evaluation of urine/protein/creatinine ratio and a GI panel (to Texas A & M) for a qualitative PLI, TLI, cobalamin and folate to look for evidence of small intestinal disease. If proteinuria is ruled out, then I would consider GI disease as the most likely source and consider work up for underlying gastrointestinal disease, while continuing to monitor the gallbladder, etc. (I recommend recheck in 6-8 weeks or sooner if liver enzymes continue to rise or abdominal pain develops).



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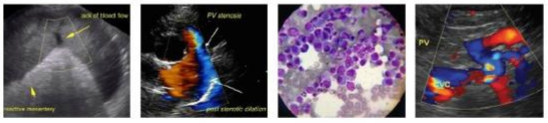

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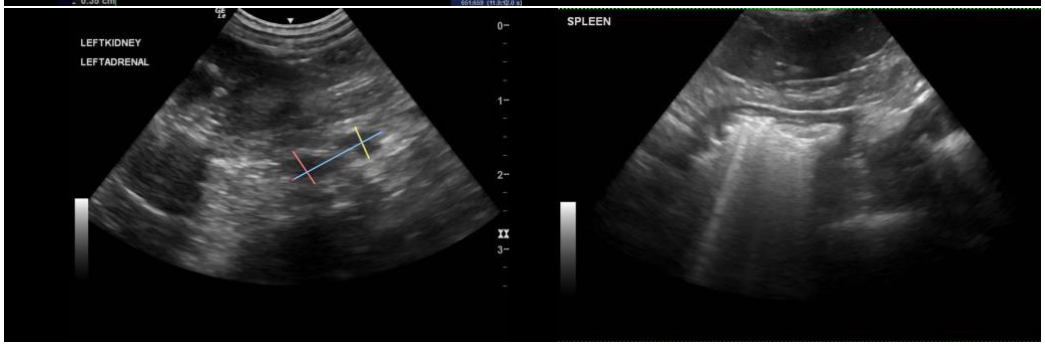

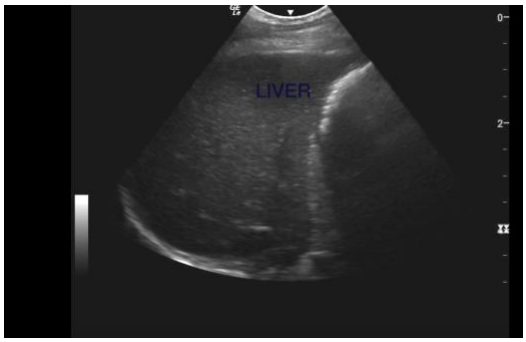

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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