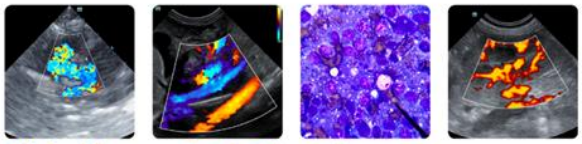


PATIENT

Pablo Nossett

SPECIES

Canine

BREED

Chihuahua

SEX

MN

AGE

10yr

WEIGHT

5.31kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Lindsay Powell, CVT

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Brittany Lang

INVOICE
23519

DATE
01/13/2026

PRESENTING CLINICAL SIGNS

Vomiting and lethargy since Saturday morning, drank a very large quantity of water then continued vomiting, last vomited this morning. went to vet today, they recommended they come here- septic abdomen and GB mucocele. EENT/oral: pink/slightly icteric moist mm, crt <2s, bilateral clear nasal discharge, pyorrhea, severe dental disease H/L: No a, snappy pulses, referred upper airway sounds, eupneic, gr V/VI murmur Abd: Tense and mildly nauseous on palpation, lip licking Musc: Over-conditioned, BCS 4/5, no lameness At RVM 1/12/26 Chemistry/Liver panel: ALT 832, GGT 55, Tbili 7 (H), ALP unreadable, glucose 62, Chol 369 (H) Na 139 (L), Cl 95 (L) CBC: WBC 36.66k, Neut 26.37k with left shift, lymphocytosis (7.13), monocytosis (3.10) Radiographs (outside records): Cardiomegaly with mild tracheal elevation. Abdomen NSF

Abnormal PE/Chem/CBC/UA Results: At HAEC 1/12/26 POCUS: No free abdominal fluid detected. NO pericardial effusion or pleural effusion noted. GB enlarged but no obvious mucocele or free fluid around GB observed. Spot BG: 105 PCV/TP: 42/8, icteric PT/PTT: both elevated PT (17.7), PTT (131.5) UA pro (30), blood (50), bili (6), urobili (8) EPOC: respiratory alkalosis (pH 7.470, pCO2 29.8), hyponatremia (132), hypochloremia (100) cPL: WNL lepto witness test: negative Cardiopet:Sinus rhythm with mildly increased R-wave amplitude suggestive of ventricular enlargement.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. Mild right kidney pyelectasia was present. Mild bilateral medullary mineral was present. The left kidney measured 3.7 cm in length. The right kidney measured 4.0 cm in length.

The area of the aortic trifurcation was free of pathology.

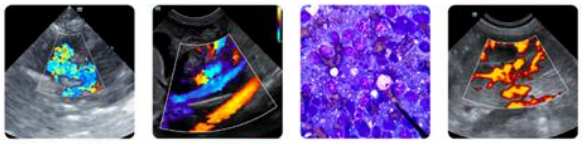
The area of the residual prostate appeared normal and free of pathology

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.53 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.43 cm width at the caudal pole.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.



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Liver/Gallbladder

The liver presented mildly enlarged in size. The hepatic parenchyma was non-homogenous and revealed diffuse reduced echogenicity compared to the spleen and renal cortical parenchyma with a mild coarse echotexture. Mild increased portal vein prominence was evident. The capsule of the liver exhibited minor asymmetry. Distinct masses or nodules were not evident. The hepatic and portal vasculature were normal in appearance.

The gallbladder was non-distended in size with primarily anechoic luminal content and minor hyperechoic non-organized bile sediment. No evidence of gallbladder/peripheral gallbladder inflammation or wall edema was present. The common bile duct was mildly dilated approaching the level of the duodenum without overt evidence of obstructive criteria.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained minor retained hyperechoic non-shadowing chyme and lumen gas with no signs of obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was mildly prominent in size with capsule asymmetry and isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Perihepatic to increased cranial abdomen omental echogenicity was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Hepatopathy-subjective acute or potentially acute on chronic.
- Normal non-inflamed gallbladder with mild non-organized hyperechoic bile debris- not consistent with mature mucocele criteria, no evidence of gallbladder rupture.
- Prominent non-homogenous pancreas.
- Mild gastritis, normal empty small intestine.
- Chronic renal changes exhibiting medullary mineral and mild right kidney pyelectasia.
- Normal adrenal glands.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the hepatopathy may include nonspecific hepatitis, (viral bacteria, leptospirosis, toxin) vacuolar or non-obstructive cholestatic hepatopathy, hyperplasia, or other with occult hepatic neoplasia not definitively excluded. Further assessment may include assuming normal clotting status, hepatic FNA cytology, +/- leptospirosis titer / PCR.

No indication for immediate surgical intervention. Although normal CPL, chronic pancreatitis may be

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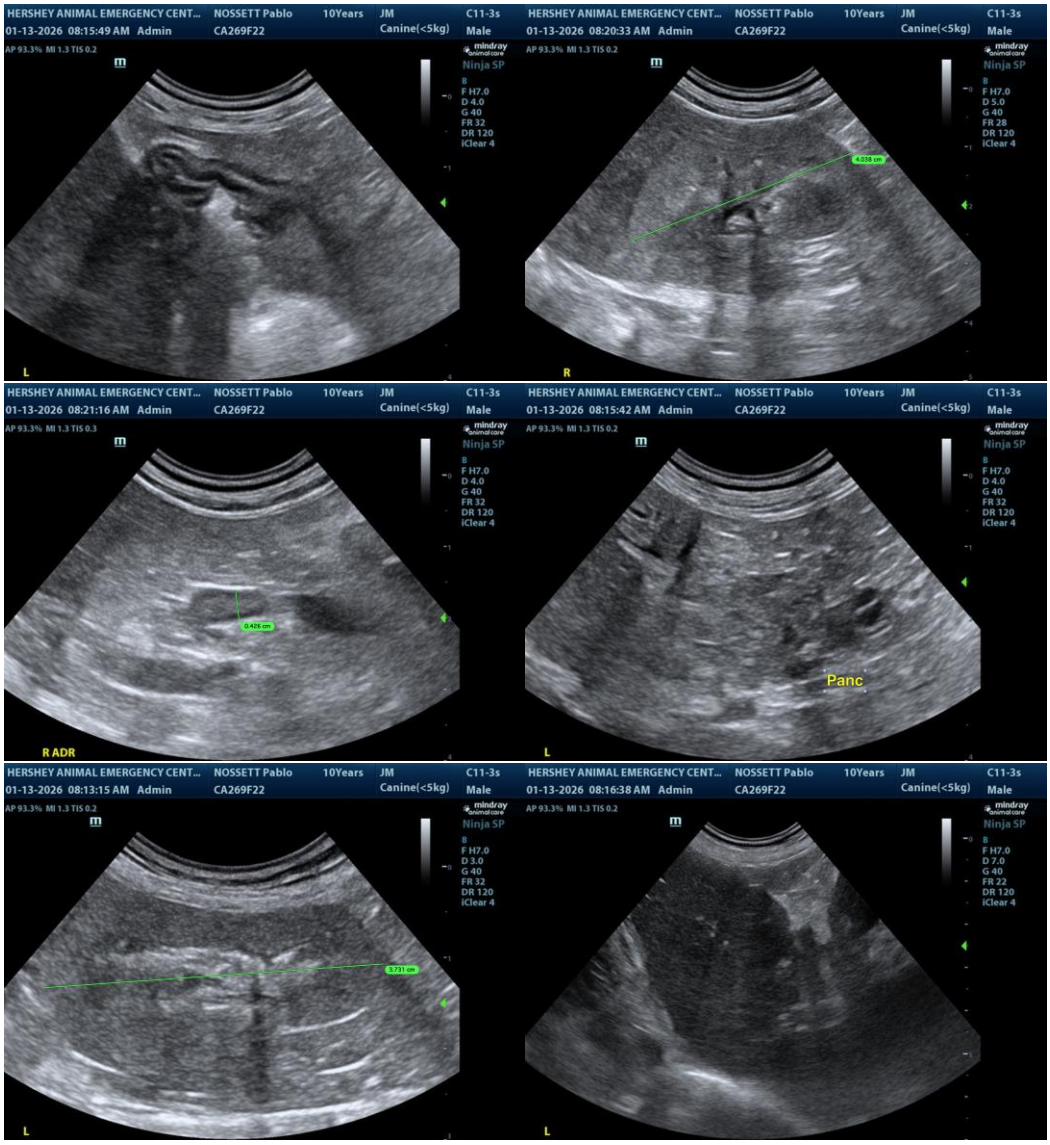
suspected if cranial abdomen or subxiphoid discomfort on palpation is present.

Hepatogastrointestinal support recommended with clinical monitoring and sonographic reassessment if evidence of progressive hepatopathy or clinical signs.

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.



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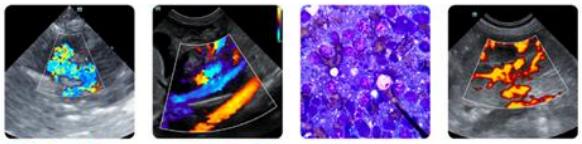

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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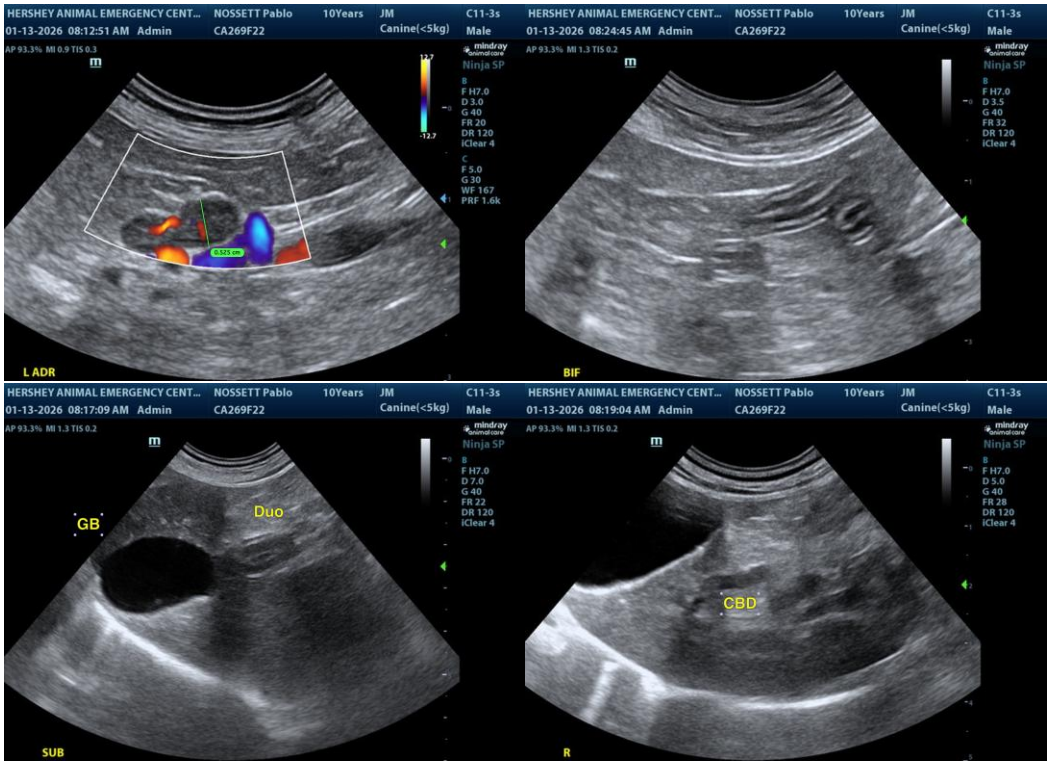

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com