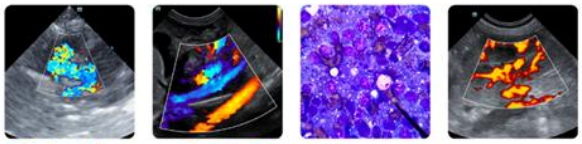


PATIENT

Leo Padovani

SPECIES

Canine

BREED

Havanese

SEX

MN

AGE

7yr

WEIGHT

6.14kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Heatherlynn McFarlane, DVM (Internal Med)

REFERRING VET

Blue Pearl Wyomissing

INVOICE
23629

DATE
01/20/2026

PRESENTING CLINICAL SIGNS

- AUS to further evaluate acute onset of excessive vomiting, lethargy, loss of appetite that started 1/17/26. Acute marked liver enzyme elevations and marked GGT elevation. Currently seeing IM for a relapse of ITP that occurred Dec 2025 (ITP is back in remission, currently on prednisolone 7.5mg AM, 5mg PM, cyclosporine 25mg q12hr). Saturday, 1/17/26, began to vomit excessively, stopped eating, very lethargy. No history of dietary changes/indiscretion, access to medications, other toxins, plants, etc.
- Exam findings: QAR to dull, dehydrated ~7%, mildly incr RR/RE but clear lung sounds, non-repeatable abdominal discomfort, weight loss of 0.6kgs in 2 weeks.
- Chronic medications: Prednisolone 7.5mg AM, 5mg PM; Cyclosporine 25mg q12hr
- Current hospitalization: IVF (LRS and Plasmalyte to slowly incr Na) with KCl supplementation, Dexamethasone equivalent to prednisolone, Ondansetron, Buprenorphine

Abnormal PE/Chem/CBC/UA Results: - CBC: WBC 24.88K (H), Neut 23.55K (H), Lymph 0.68K (L), Eos 0.04K, HCT 39.8%, PLT 554K - Blood smear: 28-31 PLT/HPF, one clump seen on feather edge, neutrophilia with no significant abnormal WBC morphology. Normal RBC morphology. - PCV/TS: 40%/9.2g/dL (H) - Chem: TP 7.7 (H), Alb 4.2 (H), Glob 3.5, Creat 0.7, BUN 32.8 (H), ALT 491 (H), ALP >993 (H), GGT >1200 (H), TBil 0.7 (H), Chol >450 (H), Ca 8.7 (L), Glu 535 (H), Phos 5.2 (H) - GGT (x2 dilution): 1904 (H) - ALP (x2 dilution): >1980 (H) - EPOC: pH 7.115 (L), PCO2 35.6, HCO3 11.4 (L), Creat 1.09, BUN 29 (H), Na 125 (L, corrected for hyperglycemia 131), K 1.6 (L), Cl 102 (L), iCa 1.16, Glu 535 (H) - IH cPLI: >2000 (H)

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 mild non-dependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

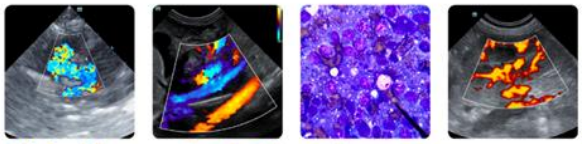
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 4.9 cm in length. The right kidney measured 5.4 cm in length.

The area of the aortic trifurcation was free of pathology.

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 0.5 cm width at the caudal pole. The right adrenal gland was uniform in



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size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.41 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.

Liver/Gallbladder

The liver presented increased in size. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was non-homogenous with a mild coarse echotexture. Pinpoint hyperechoic parenchyma foci were present, which could indicate pinpoint areas of parenchymal mineralization or fibrosis. No visualized definitive hepatic mass. The capsule of the liver was rounded and symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with primarily dependent to peripheral lumen mildly shadowing mineral extending into the area of the gallbladder neck. No evidence of gallbladder/peripheral gallbladder inflammation or wall edema was present. The cystic duct and common bile duct were not visualized without evidence of post-hepatic obstruction.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, 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 left and right pancreas were normal in size and contour with isoechoic, mildly heterogeneous parenchyma compared to adjacent, non-reactive omentum. Normal to prominent right pancreatic duct present.

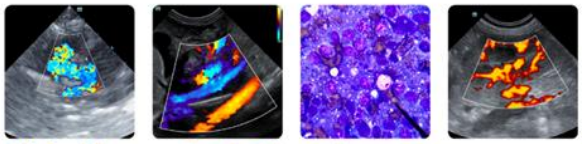
Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Enlarged mild non-homogenous hypoechoic liver- consistent with acute on chronic hepatopathy



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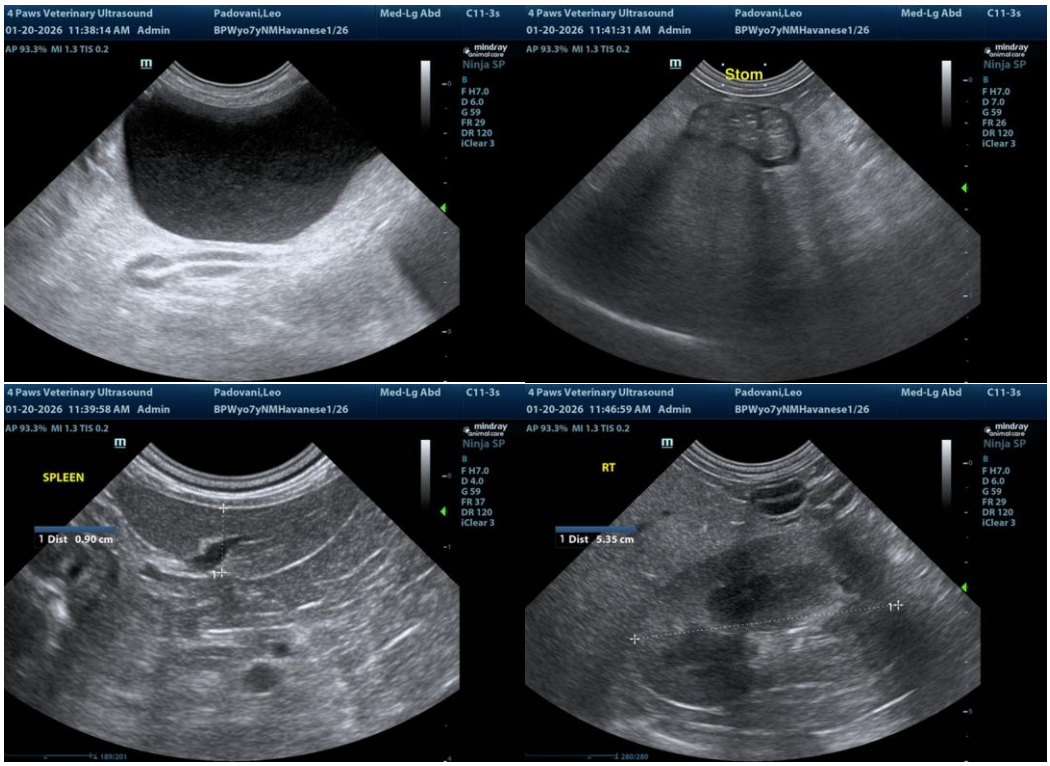
- Non-distended non-edematous gallbladder with dependent to peripheral lumen mineral- no evidence of post-hepatic obstruction
- Empty gastrointestinal tract
- Non-enlarged mild non-homogenous pancreas- no evidence of significant or active pancreatic inflammation
- Mild urine sediment
- Normal bilateral kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild to chronic pancreatitis may present in similar sonographic manner and may be suspected if cranial abdomen/subxiphoid discomfort on palpation. Hepatogastrointestinal support, empirical therapy for mild to chronic pancreatitis with clinical monitoring and as needed sonographic reassessment if evidence of progressive hepatopathy or gastrointestinal signs is recommended. Urine C/S is indicated if evidence of inflammatory sediment or glucosuria on UA with consideration for additional diagnostics if clinical concern for diabetes.



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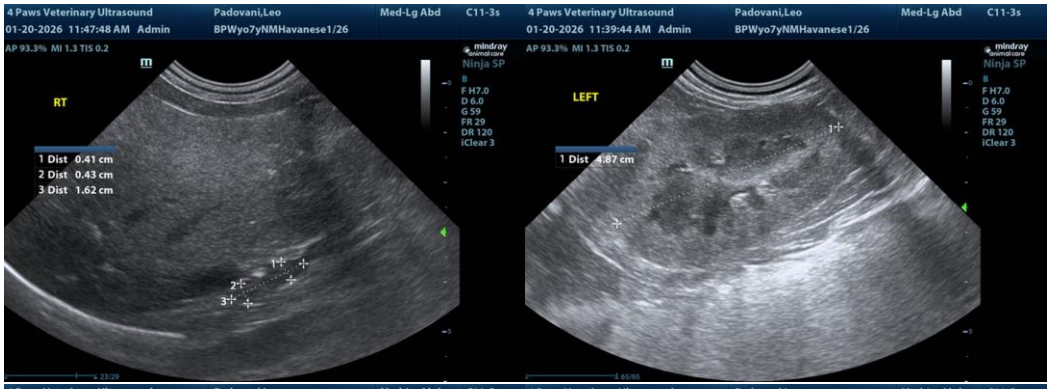

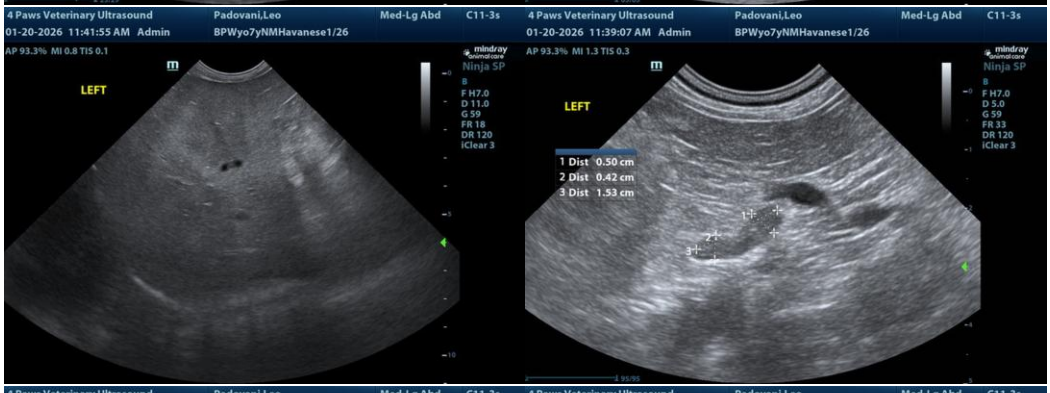

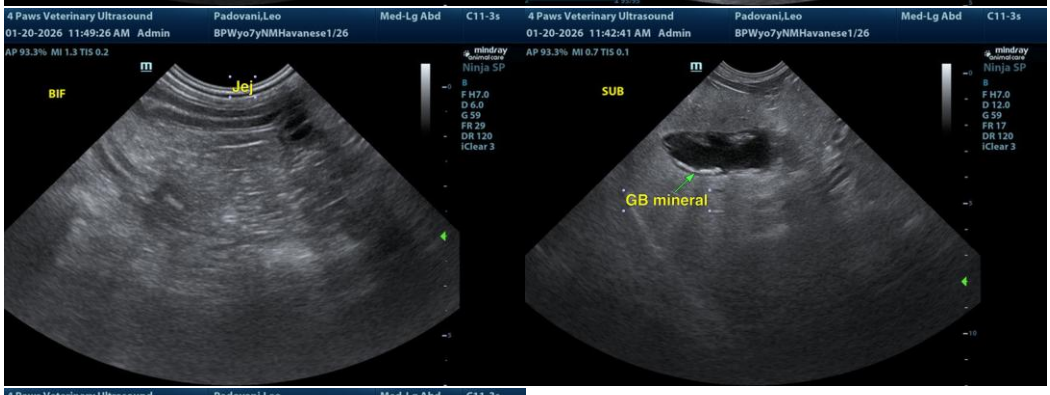

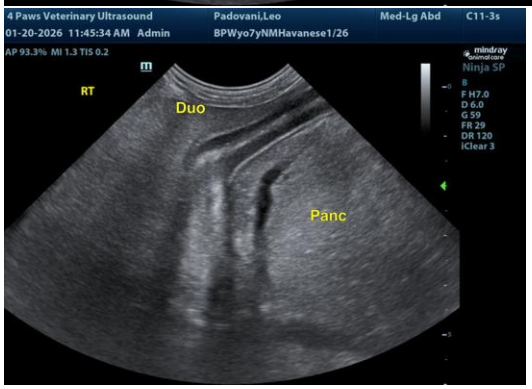

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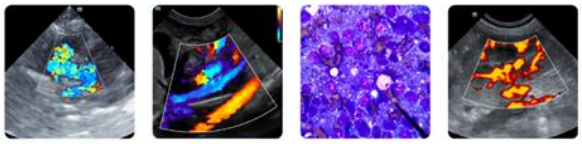

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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