

PATIENT

Max Broadbear

SPECIES

Canine

BREED

Lab X

SEX

Neutered Male

AGE

9 years

WEIGHT

45 kg

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP

IMAGING

PERFORMED BY

Kelly Reshny, RVT

HOSPITAL NAME

Beattie Pet Hospital
Stoney Creek

REFERRING VET

Dr. Baskin

INVOICE

12368

DATE

10/18/21

PRESENTING CLINICAL SIGNS

- P had blood work done at rDVM over the summer and everything was WNL. - P was not eating for a couple days, came to our hospital and blood work was done. - BW showed an increase in ALKP - Clinically P is doing better

Abnormal PE/Chem/CBC/UA Results: CBC: - Retic-HGB is mildly decreased - Mild increase in Monocytes Chemistry: - Creatinine is increased at 190umol/L (44/159) - ALT increased at 165U/L (10-125) - ALKP increased at 1164 U/L (23-212) Urinalysis: - Proteins 30mg/dL - UBG 4mg/dL - Blood 50 Ery/uL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The residual prostate was sonographically unremarkable.

The area of the aortic trifurcation was free of pathology.

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 8.0 cm in length. The right kidney measured 8.1 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 2.8 cm length x 0.72 cm width at the caudal pole. The right adrenal gland was without overt pathology, subjectively measuring 3.0 cm length x 1.2 cm width at the caudal pole. No evidence of adrenal tumors was noted.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to



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benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with mild gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild gastric distension with minor retained anechoic fluid was present.

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 ileus, obstruction, or foreign material.

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

Pancreas

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Hepatopathy
- Mild gallbladder debris (non-mucocele)
- Suspect gastritis and potential minor gastric hypomotility

Secondary Findings

- Mild age-related kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Baseline renal staging to include urine culture and sensitivity and urine protein: creatinine ratio on a sterile urine sample may be considered given the mild hematuria and proteinuria.

The liver exhibited characteristics of both acute and chronic hepatopathy. Considerations may include vacuolar hepatopathy and cholestasis, given the primarily elevated ALP with potential for inflammatory hepatopathy or hepatobiliary disease (infectious, immune-mediated, toxin, or other), given the mild ALT elevation. No overt evidence of hepatic or hepatobiliary neoplasia, which is considered a less likely differential diagnosis.

Further assessment may include hepatic FNA for screening cytology, assuming normal clotting status and Leptospirosis titer/ PCR.



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Hepatosupportive medications +/- appropriate antibiotic trial initially for two weeks with a reassessment of hepatic enzymes, may prove beneficial. If antibiotics are elected, discontinuation of antibiotics is recommended if no improvement is noted after the initial two-week trial. Continued as-needed gastrointestinal support is suggested.

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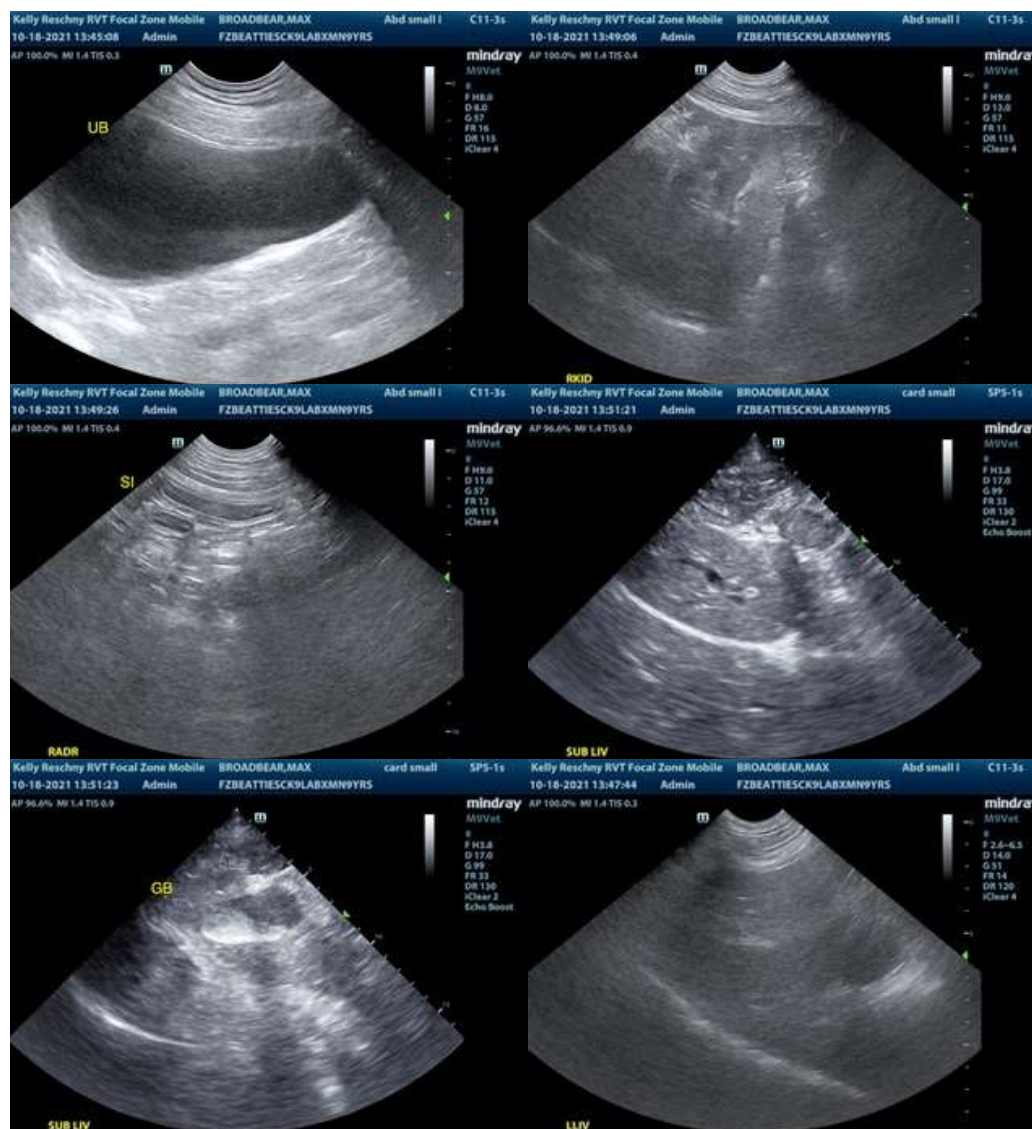
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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