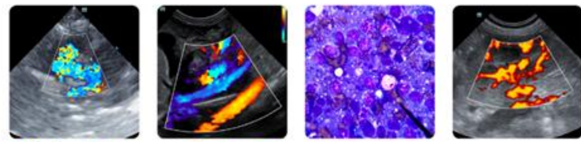


PATIENT

Shadow McCammon

SPECIES

Canine

BREED

Chihuahua

SEX

FS

AGE

10yr

WEIGHT

8.7kg

INTERPRETED BY

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

IMAGING PERFORMED BY

DVM Huntington

HOSPITAL NAME

Wilvet South

REFERRING VET

DVM Huntington

INVOICE
23049

DATE
11-25-25

PRESENTING CLINICAL SIGNS

The patient first became lethargic and anorexic approximately 2.5 weeks ago. Initial lab work with her regular veterinarian revealed elevated liver enzymes and a low white blood cell count. She was treated with Clavamox and her clinical signs resolved. The antibiotic course was completed 1 week ago. Vomiting began this past Wednesday. She was seen by her veterinarian on Friday; repeat labs showed improving liver enzymes, and an abdominal radiograph revealed a metallic foreign object of unknown duration or location, but no obvious cause for the vomiting was seen. She was given anti-nausea medication and subcutaneous fluids. Over the weekend, her appetite has been poor and selective (eating chicken but not rice, then eating some chicken and potato). She has not eaten this morning, aside from a small amount of toast. The owner reports the patient has been drinking water and urinating normally. She had a mucusy bowel movement yesterday. . General Appearance: Lethargic Hydration: Slightly dehydrated Eyes: Nuclear sclerosis, sclera - mild icterus Oral Cavity: Tartar moderate, mild icterus of mm Abdomen: Tense on palpation, not overtly painful Musculoskeletal: Normal musculature, good BCS Integument: Normal amount of shedding; skin looks normal; hair coat in good condition Lymph Nodes: Lymph nodes are all normal in size Urogenital: External genitalia appears normal; bladder palpates normally Neurologic: No apparent abnormalities

Abnormal PE/Chem/CBC/UA Results: 11/6 ALKP: 180 U/L (Reference Range: 5 - 160 U/L) ALT: 586 U/L (Reference Range: 18 - 121 U/L) CREA: 1.5 mg/dL (Reference Range: 0.5 - 1.0 mg/dL) GGT: 24 U/L 11/13 ALT: 450 U/L (Reference Range: 10 - 125 U/L) - Improved from 586 U/L GGT: 18 U/L (Reference Range: 0 - 11 U/L) - Improved from 24 U/L 11/21 ALT: 347 U/L (Reference Range: 10 - 125 U/L) - Improved from 450 U/L GGT: 17 U/L (Reference Range: 0 - 11 U/L) - Improved from 18 U/L 11/24 ALT: 2109 U/L (Reference Range: 10 - 125 U/L) - Significantly increased from 347 U/L ALP: 870 U/L (Reference Range: 23 - 212 U/L) GGT: 70 U/L (Reference Range: 0 - 11 U/L) - Significantly increased from 17 U/L TBILI: 3.7 mg/dL (Reference Range: 0.0 - 0.9 mg/dL)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

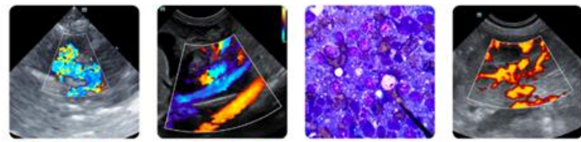
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. 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. No evidence of pelvic dilation was present. The left kidney measured 4.3 cm in length. The right kidney measured 4.5 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

Both adrenal glands were indistinctly visualized without overt pathology. The left adrenal gland subjectively measured 0.47 cm width at the caudal pole. The right adrenal gland subjectively measured 0.55 cm width at the caudal pole.



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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 was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with mildly prominent hyperechoic gallbladder wall and mild non-organized gallbladder debris. No evidence of peripheral gallbladder inflammation was present. The common bile duct was not visualized without overt evidence of dilation or post hepatic obstructive criteria.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild non-shadowing ingesta/chyme sonographically suggestive of food echogenicity 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 area of the pancreas was sonographically normal.

Free Abdomen

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

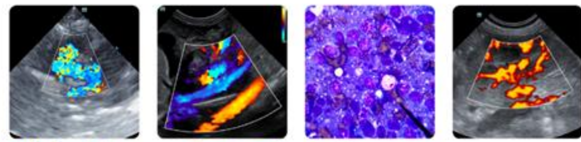
ULTRASONOGRAPHIC FINDINGS

Primary

- Hepatopathy
- Probable chronic cholecystitis with mild non-organized bile debris- not consistent with mature mucocele
- Normal gastrointestinal tract with mild non-shadowing gastric ingesta/ chyme
- Normal area of pancreas
- Age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although non-specific, the hepatopathy is consistent with benign criteria with inflammatory hepatobiliary disease, i.e. hepatitis / cholangiohepatitis and concurrent non-obstructive cholecystitis



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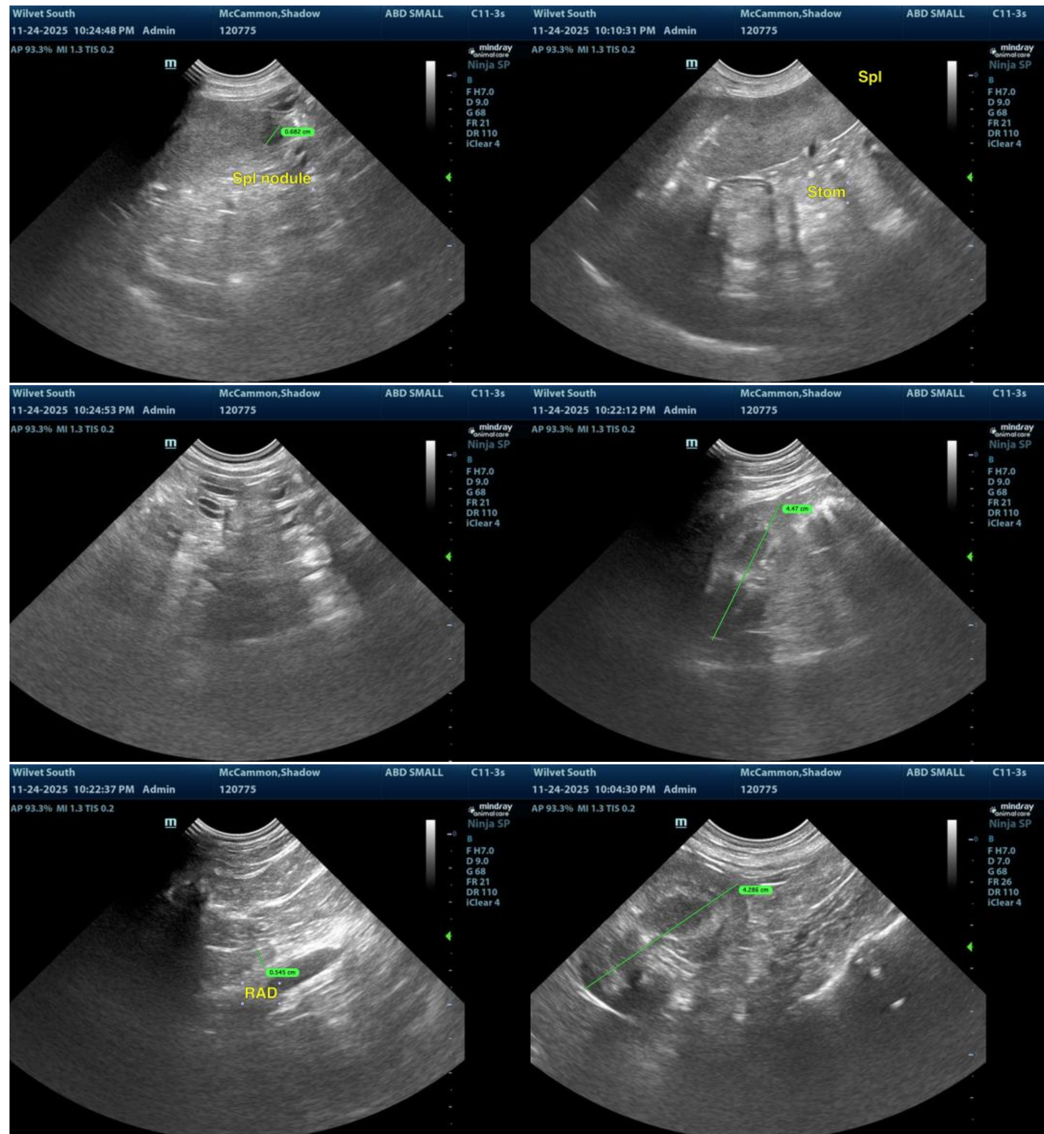
suspected.

Further assessment may include assuming normal clotting status, FNA cytology, primarily to assess for inflammatory cell type and leptospirosis titer /PCR. Hepatogastrointestinal support and clinical monitoring with sonographic reassessment if progressive hepatopathy or gastrointestinal signs is recommended. A spec cPL could be considered to assess for concurrent mild pancreatitis, which may present sonographically normal.



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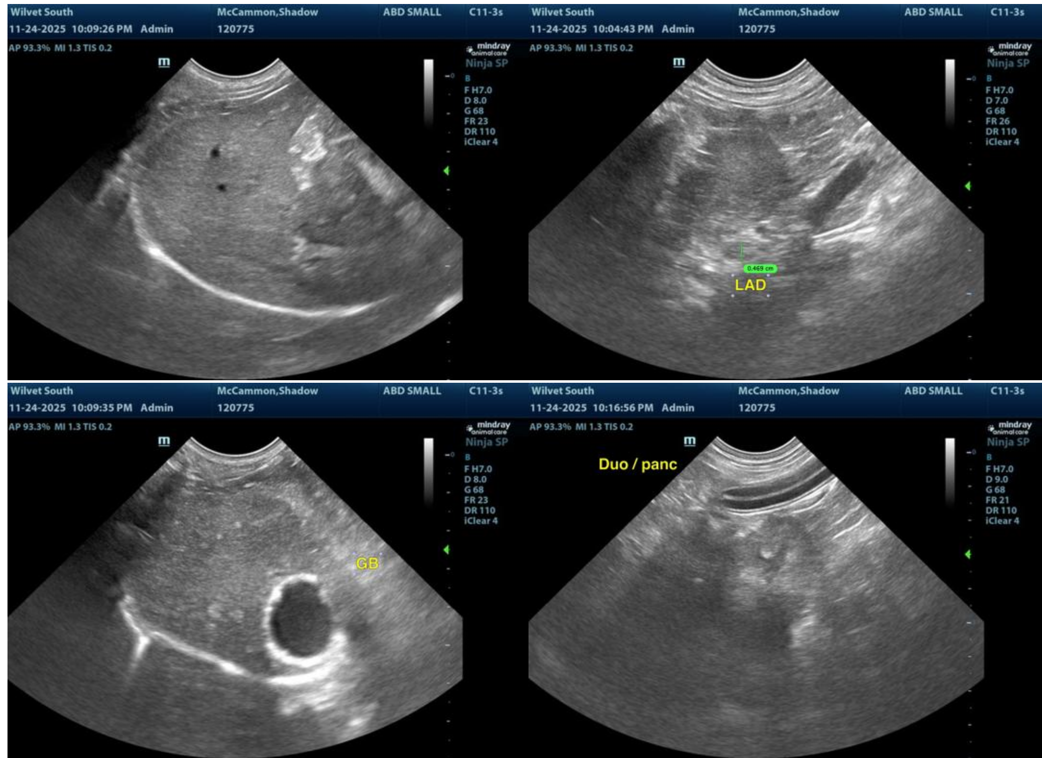

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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