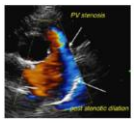
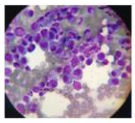
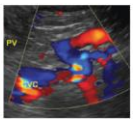




PATIENT

Ahsoka St. Claire

SPECIES

Canine

BREED

Welsh Corgi Pembroke

SEX

SF

AGE

6 years

WEIGHT

Welsh Corgi Pembroke

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Jeremy R. Joy

INVOICE

15760

DATE

12/29/22

PRESENTING CLINICAL SIGNS

Yellow skin and eyes. Owner reports this has been present since they got her about 2 weeks ago from a shelter. She does not seem to have any other symptoms.

Abnormal PE/Chem/CBC/UA Results: Pt seems to be in overall good health, but is severely jaundiced. BW suspicious for liver dz, hypoalbuminemia (lymphangiectasia?), PLE, shunt, and multiple others. The cPL was normal during the visit. WBC 18.5, neut 12.9, retic 286, ALB 2.0, ALK 260, ALT 319, AMLY 331, BUN/UREA 4, Ca 7.5, Chloride 106, Chol 24, TBIL 7.1

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 calculi 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 area of the uterine remnant appeared to be overtly normal.

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 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 5.8 cm in length. The right kidney measured 5.8 cm in length.

Adrenal Glands

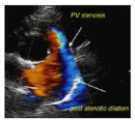
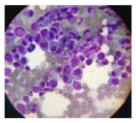
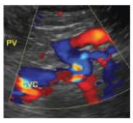
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.54 cm width at the caudal pole and 0.48 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.42 cm width at the caudal pole and 0.44 cm width at the cranial 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 subjective mild enlargement. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. Overtly normal to adequate hepatic vascular volume was noted. No obvious evidence of a

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portosystemic shunt. The gallbladder was distended in size with generalized mild gallbladder wall edema. The gallbladder wall width measured 0.32 cm. The gallbladder contained primarily anechoic content with moderate, congealed yet nonorganized, uniformly echogenic, sludge. The common bile ducts was not definitively visualized without obvious evidence of common bile duct stasis, obstruction, or dilation.

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 ileus, obstruction, or foreign material.

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

Pancreas

The generalized pancreas exhibited prominent to mild enlargement, capsule asymmetry, and nonhomogeneously hypoechoic to mixed echogenic pancreatic parenchyma including possible indistinct hypoechoic parenchymal striations. No evidence of pancreatic masses or parenchymal mineralization.

Free Abdomen

Mild to moderate volume anechoic peritoneal free fluid was present. Generalized mild hyperechoic mesentery was noted. No evidence of significant lymphadenopathy or omental masses.

Rapid view of the heart revealed no evidence of pericardial masses or effusion in the visible window. No evidence of right cardiomyopathy.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy exhibiting uniform parenchyma hyperechogenicity - nonspecific, vacuolar hepatopathy, lipidosis, cholestasis, inflammatory / immune-mediated disease, occult neoplasia are all potentials
- Distended gallbladder with moderate nondependent sludge and wall edema
- Generalized prominent to enlarged nonhomogeneous pancreas - inflammation, pancreatitis edema possible
- Sonographically unremarkable gastrointestinal tract
- Moderate volume noncardiogenic peritoneal effusion

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, hepatic parenchyma FNA cytology using a 25-gauge needle with potential vitamin K pretreatment, as well as effusion analysis, cytology +/- C/S are suggested for further assessment.

Atypical gallbladder mucocele or cholecystitis is possible with the less likely potential for anaphylaxis.

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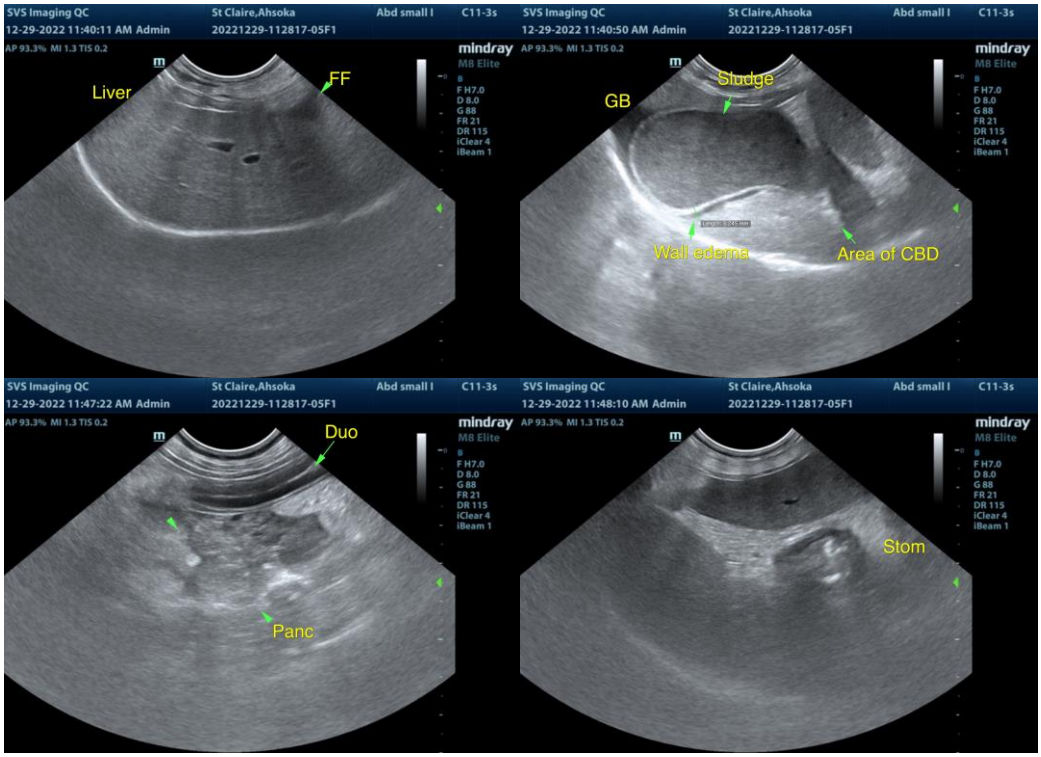
Given the current reported albumin levels, effusion and gallbladder wall edema secondary to hypoalbuminemia may be considered less likely unless albumin levels have decreased. Recheck or monitoring of Spec cPL could be considered if clinically indicated.

Empirical therapy for hepatobiliary inflammation with some or all of the following protocol may be considered with close monitoring. Possible cholecystectomy with hepatopancreatic biopsies may be indicated if progressive clinical signs and hepatic enzyme elevations are noted. Leptospirosis titers / PCR are warranted.

Enrofloxacin 5 mg/kg SID PO & **Metronidazole** (10-20 mg/kg po bid) over 3 weeks, **Ursodiol (**10-15 mg/kg p.o. q24h) over 8 weeks and recheck sonogram. Monitor rapid rise in ALT, SAP, Bilirubin, bilirubinuria, leukocytosis, focal cranial abdominal subxyphoid discomfort or progressive anorexia. More information regarding clinical emerging mucocele issues may be found with our article and research at http://sonopath.com/resources/articles, ***Defining a GB Mucocele*** and ***Clinical Parameters in Dogs with Sonographically Diagnosed Surgical Biliary Disease*** from ECVIM 2009.



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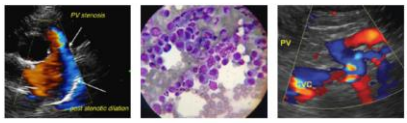

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Clinical Sonography & Telecytology

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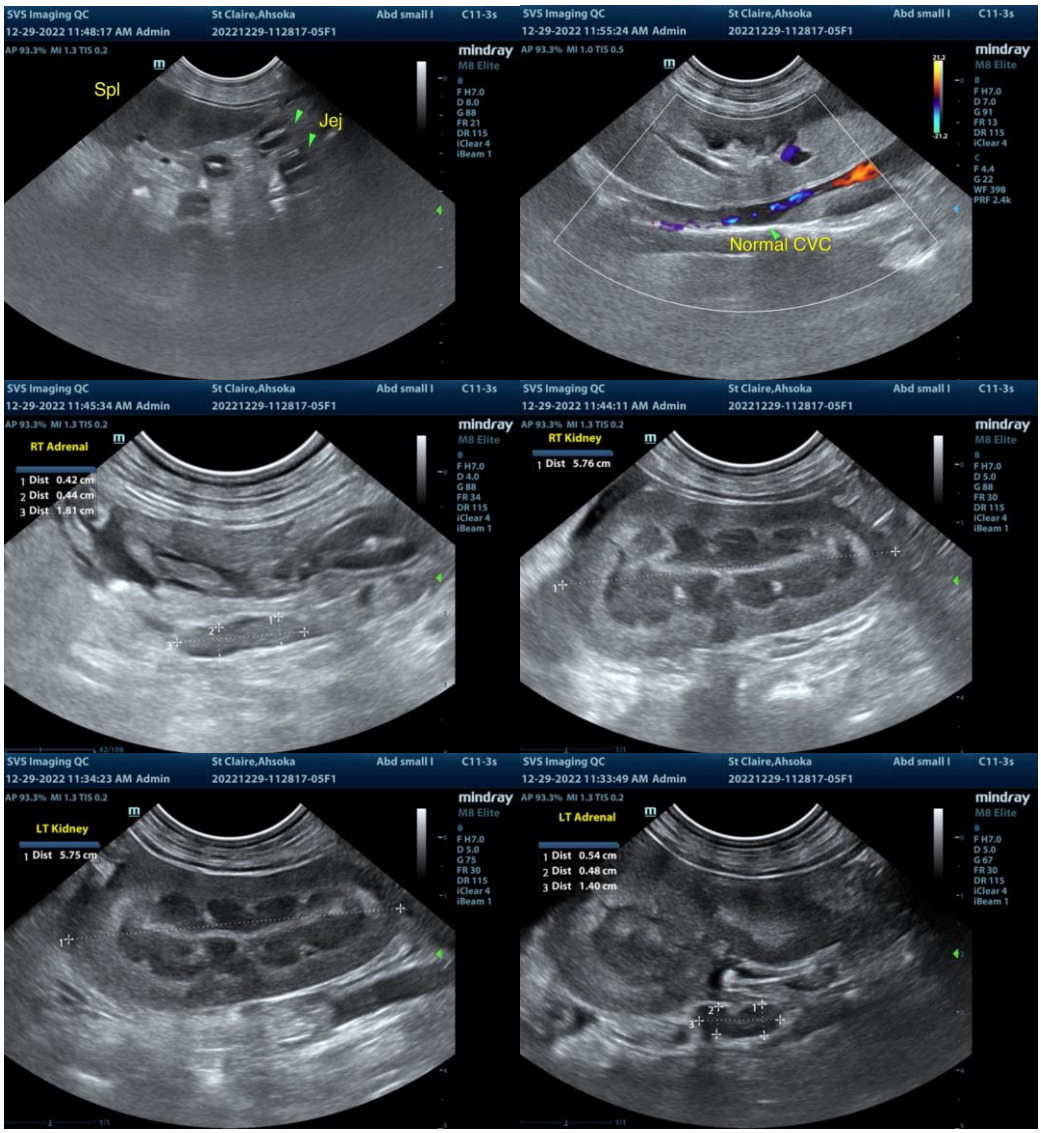

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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