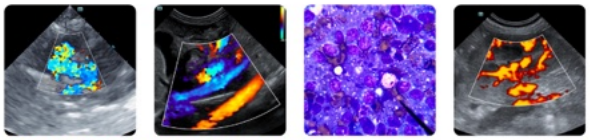


PATIENT

Ronin Nguyen

SPECIES

Canine

BREED

Pitbull

SEX

Intact male

AGE

8 years

WEIGHT

32 kg

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Catherine Alexander, LVT

HOSPITAL NAME

NorthStar VS, PLLC

REFERRING VET

Dr. Sethi

INVOICE

75382

DATE

5/12/26

PRESENTING CLINICAL SIGNS

History: Persistently elevated liver enzymes identified on recent April 2026 bloodwork. Owner reports no current vomiting, diarrhea, coughing, or nausea. History is significant for chronic gastrointestinal sensitivity/inflammatory GI disease, including historical vomiting episodes, hemorrhagic gastroenteritis/severe gastritis, food hypersensitivity concerns, and stress/anxiety-associated GI flares. In 2020, the patient underwent abdominal ultrasound, endoscopy, GI biopsies, and GI bloodwork through an internal medicine referral after chronic vomiting and GI signs. Previous diagnostics reportedly identified thickened gastric rugal folds and inflammatory changes in the small intestine, considered potentially secondary to food hypersensitivity/chronic inflammatory enteropathy. The patient reportedly improved previously while on a hydrolyzed protein diet. history of hypothyroidism and is currently maintained on NP Thyroid and T2 supplementation. Previous records documented low thyroid values prior to supplementation. Current supplements reported by the owner include digestive enzymes, probiotics, omega supplementation, liver/GI support products, and multiple integrative nutraceuticals.
Abnormal PE/Chem/CBC/UA Results: ALT 163 U/L (RI 10–125; previously 169 U/L) and AST 70 U/L (RI 11–50). Mild elevation in BUN 43 mg/dL (RI 7–27) was present with creatinine 1.4 mg/dL (RI 0.5–1.8). SDMA remained within normal reference range at 11 µg/dL (RI 0–14). Urinalysis demonstrated hyposthenuria/poor urine-concentrating ability with a low urine specific gravity (USG 1.006). Mild amylase elevation was present at 1,774 U/L (RI 500–1,500). CBC was largely unremarkable aside from mild thrombocytosis at 427 K/uL (RI 148–484). Previous specialty GI testing additionally identified elevated Vitamin D at 175.2 (RI 100–120) and low magnesium at 1.3 mg/dL (RI 1.8–2.4). Mildly decreased albumin 2.9 g/dL (RI 3.1–4.0), globulin 2.1 g/dL (RI 2.3–4.0), and total protein 5.0 g/dL (RI 5.2–7.8) were also noted on specialty testing.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a normal thickness and smooth appearance of the wall. A small amount of dependent, hyperechogenic sediment.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

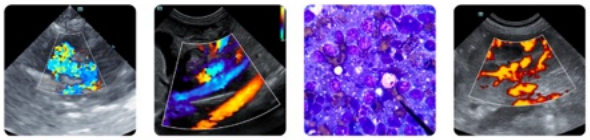
Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 8.1 cm, right measured 6.1 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

Normal size and appearance of the prostate with regular curvilinear capsule. The prostate measures 3.0 x 3.0 cm in size.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.53 cm in width. The right adrenal gland measured 0.57 cm and 0.65 cm in width.



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Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. Small, focal, non-vascularized, hypoechogenic parenchymal nodule in the body of the spleen measuring 0.6 cm in size. The spleen measures 2.8 cm in width.

Liver

Normal size with a mild, patchy increase in echogenic appearance, normal portal markings, and regular curvilinear capsule. No nodules or masses evident. Normal appearance of the hepatic and portal vasculature.

Gallbladder

The gallbladder is full containing a small amount of non-adhered, hyperechogenic sediment. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Normal appearance of the stomach, duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen.

Pancreas

The visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy.
- Splenic nodule.
- Gallbladder sediment.
- Urinary bladder sediment.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies of the hepatopathy would be reactive hyperplasia, early nodular hyperplasia, vacuolar and metabolic with hepatitis and infiltrative neoplasia an unlikely differential diagnosis.

The most likely etiology for the splenic nodule would be incidental reactive hyperplasia/extramedullary hemopoiesis with hematoma and granuloma, possible differential diagnosis and emerging neoplasia a less likely differential diagnosis.

The gallbladder sediment can be considered an incidental finding.

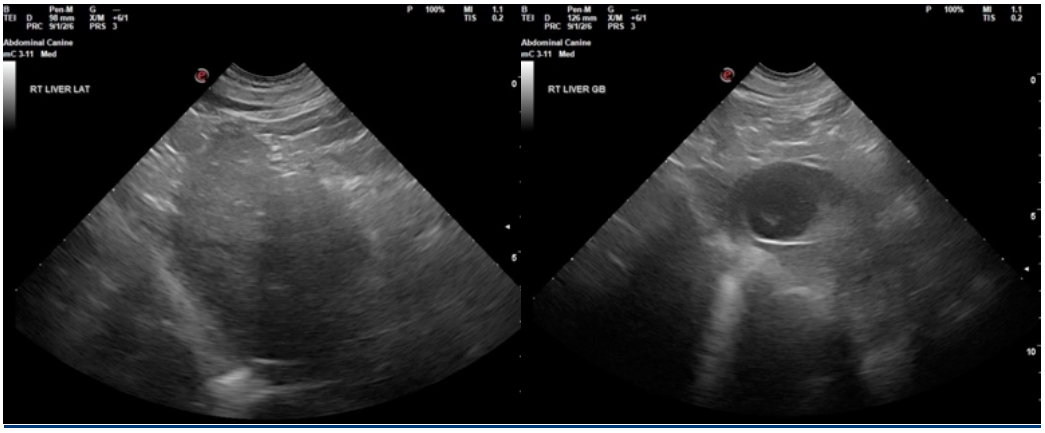
Etiologies for the urinary bladder sediment would be incidental debris and crystalluria.

Further assessment would be urinalysis and possibly FNA cytology of the liver. However, a tru cut or wedge biopsy may be required for a final etiological diagnosis.

Ultrasound monitoring of the splenic nodule would be recommended and if there is any progressive enlargement or bulging of the overlying capsule noted, then splenectomy should be considered.

Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management that could be considered for the hepatopathy would be the use of Ursodiol with regular monitoring of liver enzyme activity.



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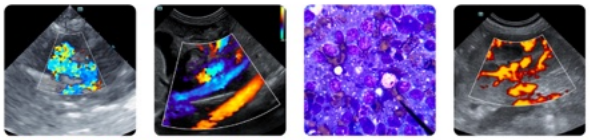

Clinical Sonography & Telecytology
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SonoPath.com info@sonopath.com 1.800.838.4268

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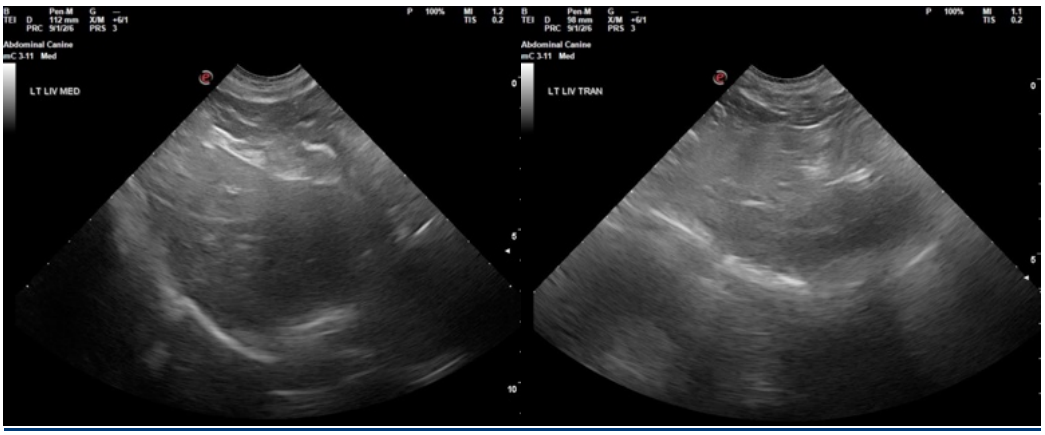

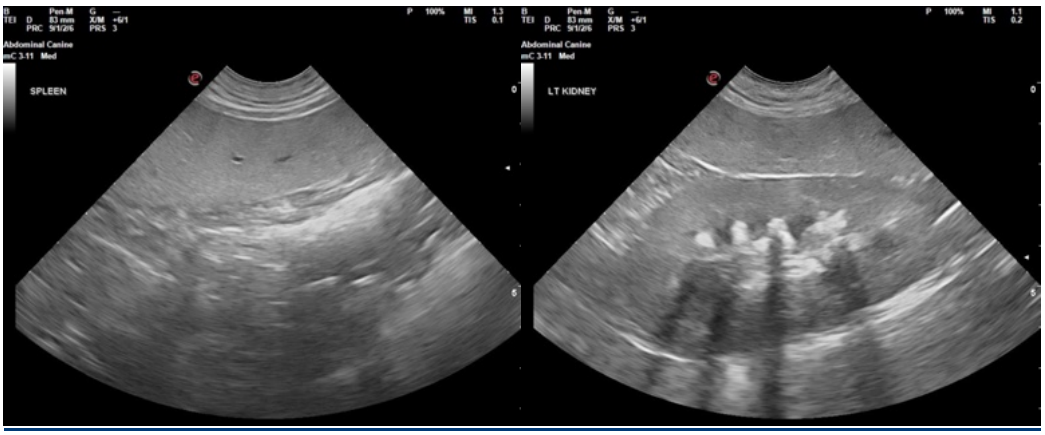

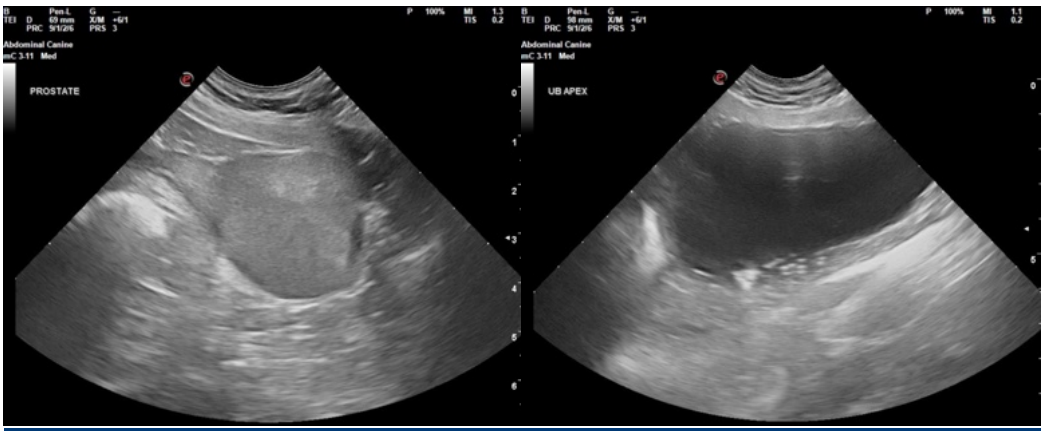

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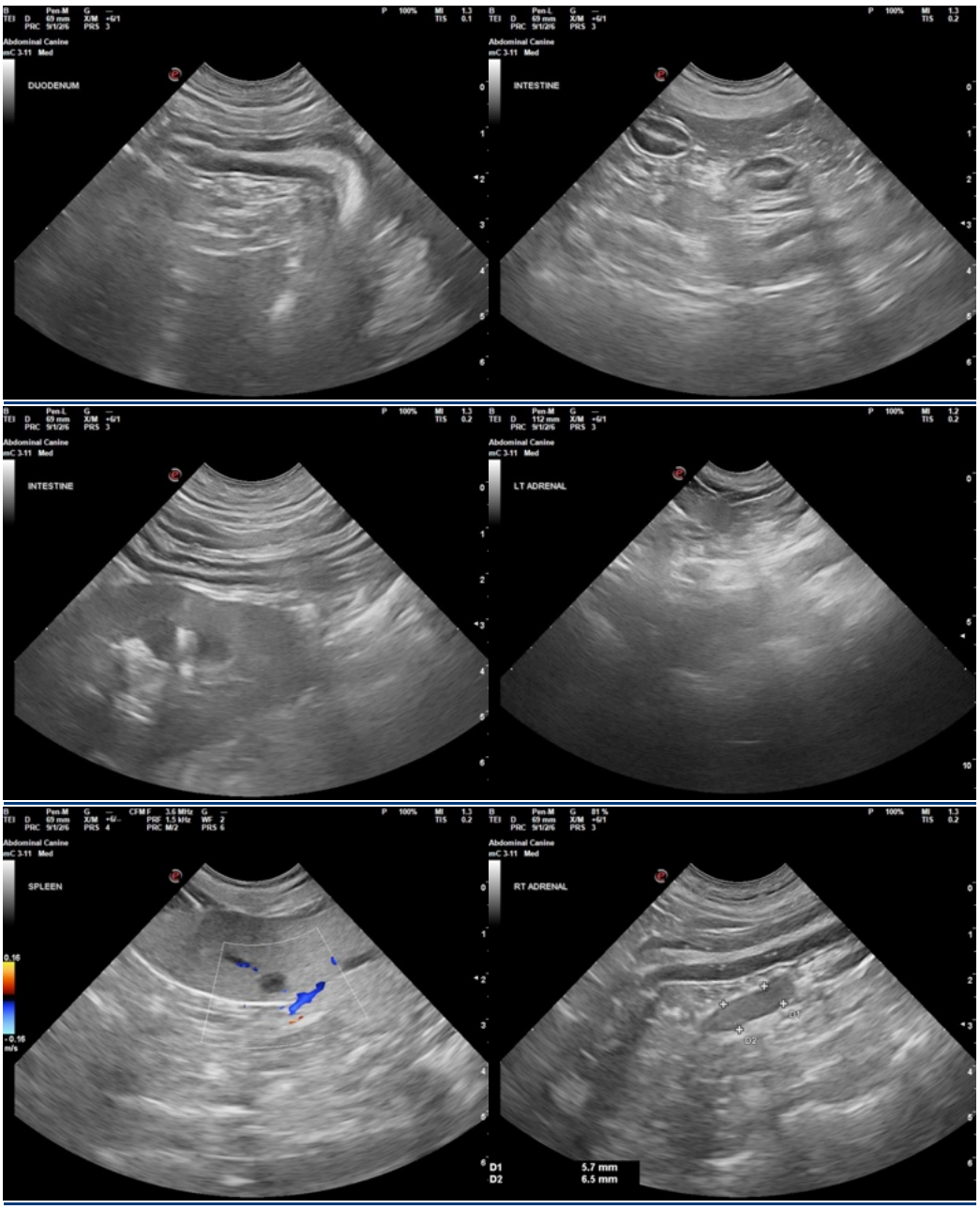

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

info@sonopath.com