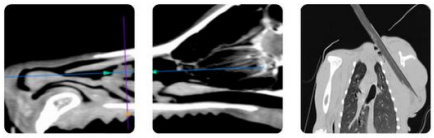


PATIENT

Oakley Springer

SPECIES

Canine

BREED

Bernese Mountain Dog

SEX

F

AGE

5Y, 9M

WEIGHT

99lbs

INTERPRETED BY

Tilde Rodrigues Froes, DMV, MSc., Dr. Med Vet., Dipl. CBraRVet

IMAGING PERFORMED BY

Tina Lynn, CVT/George Eales,DVM

HOSPITAL NAME

Green Prairie Animal Hospital

REFERRING VET

Dr. George Eales

INVOICE

74899

DATE

5-5-26

PRESENTING CLINICAL SIGNS

Oakley is a 5.5-year-old female Bernese Mountain Dog presenting for lethargy, trembling, vomiting, and inappetence. These signs developed a few hours after receiving an Interceptor Plus tablet and Advantage II (topically) the previous Saturday and have since worsened. The patient is also panting, lip-licking, and yawning. Vomited dinner last night but has not vomited since. A similar, more severe episode occurred approximately 1.5 months ago following administration of the preventative Simparica Trio, which resulted in a diagnosis of severe hepatitis with liver enzymes greater than 2000 U/L. The previous episode also involved vomiting, lethargy, inappetence, slight dehydration, and an elevated temperature. Past diagnostics at the U of I included X-rays and multiple ultrasounds that were inconclusive for liver cancer or a bileduct obstruction, and a CT scan was recommended but not performed at that time. currently on ursodiol and was on Denamarin The owner suspects a correlation between the heartworm prevention and the patient's illness.
Abnormal PE/Chem/CBC/UA Results: ALT-3599 ALKP-787

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX AND ABDOMEN

A pre- and post-contrast CT study of the thorax and abdomen is provided for review totaling 3 series. One pre-contrast series of the abdomen (soft tissue algorithm). One post-contrast series of the abdomen (soft tissue algorithm). One post-contrast series of the thorax (soft tissue algorithm).

COMPUTED TOMOGRAPHIC FINDINGS

ABDOMEN

The liver is markedly reduced in size, with overall regular contours. Hepatic attenuation and contrast enhancement are within normal limits.

There is marked distension of the gallbladder, filled predominantly with hypoattenuating fluid material. However, within the gallbladder neck, there is dependent aggregated more dense material. Mild focal gallbladder wall thickening is noted adjacent to this material.

The cystic duct is dilated, measuring approximately 1.5 cm in diameter. The common bile duct is mild to moderately dilated throughout its course, measuring up to approximately 0.9 cm adjacent to the duodenal papilla. No intraluminal mineral attenuating calculus is identified. No obstructive duodenal wall mass effect is observed.

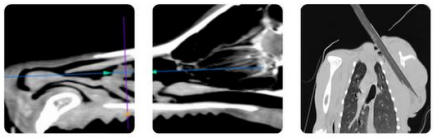
The pancreas is within normal limits.

The portal vein and associated vasculature are within normal limits. No enlarged periportal lymph nodes are identified.

The stomach is moderately distended with fluid and gas. The small and large intestines demonstrate mild to moderate diffuse fluid and gas distension, without evidence of mural thickening or obstructive mass effect. Gastrointestinal distribution is preserved.

The spleen is within normal limits. A small accessory spleen is present adjacent to the splenic head, considered an incidental finding.

The kidneys are normal in size, shape, contour, attenuation, and contrast enhancement. The renal pelves and ureters are within normal limits.



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The urinary bladder is moderately distended with hypoattenuating fluid and contrast material. The urinary bladder wall is within normal limits.

The uterine body is visible and measures approximately 0.9 cm in diameter. Both uterine horns are mildly distended, measuring approximately 1.2 to 1.4 cm in diameter, and contain homogeneous hypoattenuating fluid material. Both ovaries are identified, mildly enlarged, and measure approximately 1.3–1.6 cm in diameter.

The abdominal lymph nodes and adrenal glands are within normal limits.

The mesenteric and serosal fat demonstrate normal attenuation.

Multifocal complete and incomplete bridging spondylosis deformans is present within the lumbar and lumbosacral spine.

There is bilateral coxofemoral joint incongruity, associated with mild periarticular osteophyte formation on the right side, consistent with mild right coxofemoral osteoarthrosis.

THORAX

The trachea and main bronchi are within normal limits.

The sternal, cranial mediastinal, and tracheobronchial lymph nodes are unremarkable.

The pulmonary parenchyma shows normal attenuation with no evidence of micronodules, nodules, or masses.

The bronchial tree exhibits normal branching and tapering. Bronchial walls are thin and smooth, with a normal bronchus-to-artery ratio.

The cardiac silhouette and pulmonary vessels are normal, and post-contrast opacification is adequate.

The pleural space, diaphragm, and thoracic wall are unremarkable.

The thoracic esophagus is unremarkable.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Marked reduction in hepatic size (microhepatia), with otherwise preserved hepatic attenuation and contrast enhancement. Differential diagnoses include chronic hepatopathy and hepatic fibrosis/cirrhosis.
- Marked gallbladder distension containing dependent more dense intraluminal material within the gallbladder neck, associated with cystic duct dilation and mild dilation of the common bile duct. Differential diagnoses include cholangiectasis secondary to inspissated bile/biliary sludge, concurrent gallbladder mucocele formation (Grade II), and partial biliary obstruction secondary to inspissated bile.
- No evidence of obstructive mineralized calculus or duodenal mass is identified.
- Mild fluid distension of the uterine horns. Differential diagnoses include hormonally mediated uterine fluid accumulation, early mucometra/hydrometra, or less likely pyometra, depending on the clinical status.
- Incidental accessory spleen.
- Multifocal lumbar and lumbosacral spondylosis deformans.

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- Bilateral coxofemoral incongruency and right coxofemoral osteoarthrosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The tomographic findings reveal marked reduction in hepatic size (microhepatia), while hepatic attenuation and contrast enhancement remain relatively preserved. Considering the markedly elevated hepatic enzyme activities and the patient's clinical history of recurrent hepatopathy, these findings are suggestive of chronic liver disease, including chronic hepatitis and/or hepatic fibrosis/cirrhosis. Correlation with hepatic functional assessment, including bile acids and coagulation profile, is recommended. If clinically indicated and coagulation status permits, hepatic biopsy should be considered for definitive diagnosis and histopathological characterization.

Additionally, marked gallbladder distension containing more dense dependent intraluminal material within the gallbladder neck, associated with cystic duct dilation and mild dilation of the common bile duct. These findings are most consistent with cholangiectasis secondary to inspissated bile/biliary sludge, with possible concurrent early gallbladder mucocele formation (Grade II). Partial extrahepatic biliary obstruction secondary to inspissated bile is also considered. However, no evidence of obstructive mineralized cholelithiasis or duodenal mass effect is identified on the present examination.

Continued hepatobiliary monitoring and follow-up abdominal ultrasonography are recommended to assess progression of the biliary abnormalities and gallbladder contents.

Mild fluid distension of the uterine horns is present and may represent hormonally mediated uterine fluid accumulation or early mucometra/hydrometra. Early pyometra is considered less likely but cannot be completely excluded depending on the clinical presentation.

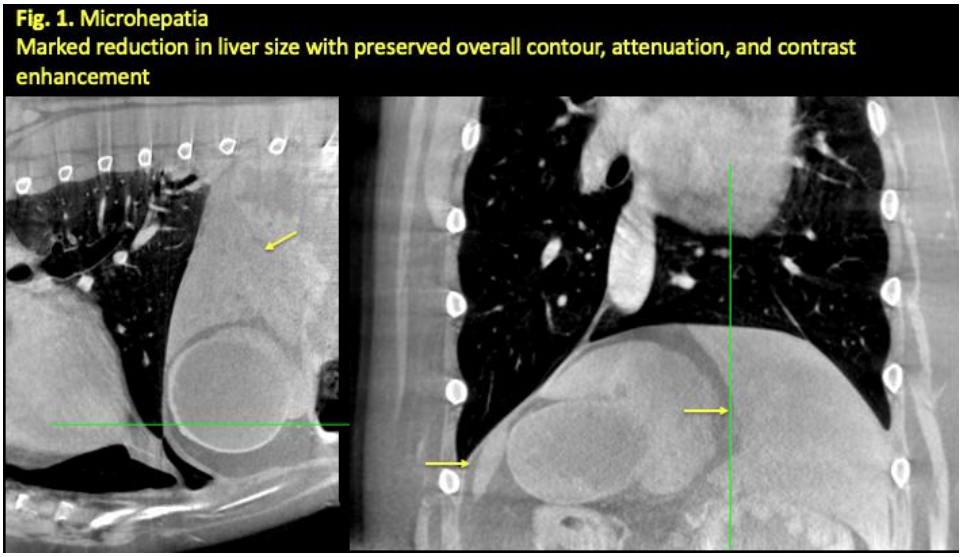

Fig. 1. Microhepatia
Marked reduction in liver size with preserved overall contour, attenuation, and contrast enhancement

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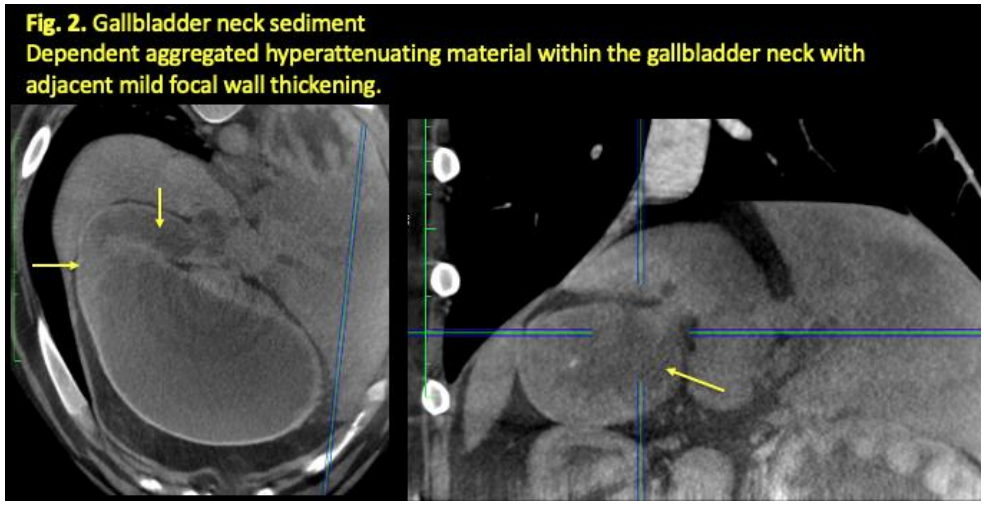

Fig. 2. Gallbladder neck sediment
Dependent aggregated hyperattenuating material within the gallbladder neck with adjacent mild focal wall thickening.

Fig. 3 Biliary ductal dilatation
Dilation of the cystic duct and common bile duct without identifiable mineral attenuating obstructive calculus

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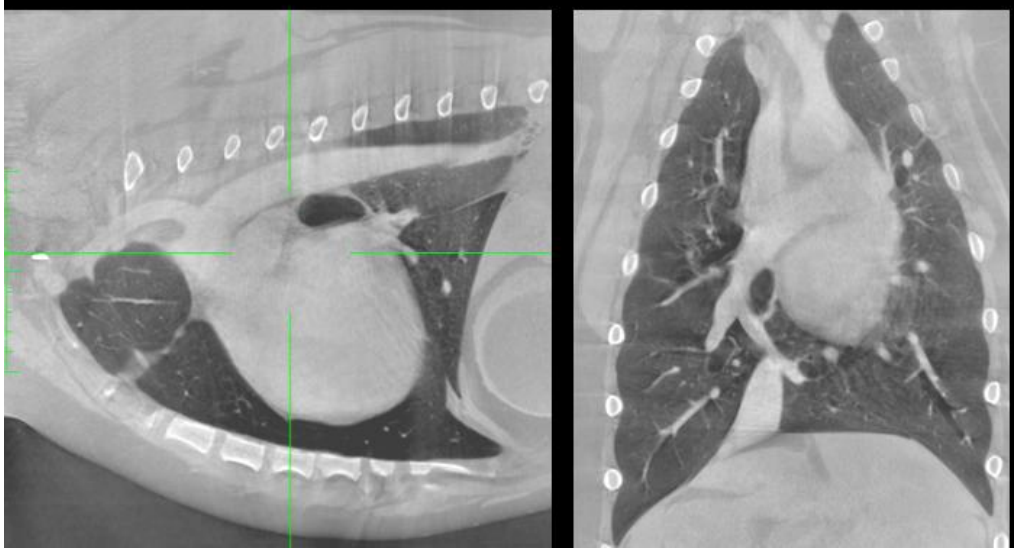
Fig. 4. Normal thorax



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.

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.

Tilde Rodrigues Froes, DMV, MSc., Dr. Med.Vet., Dipl.CBraRVet
info@sonopath.com