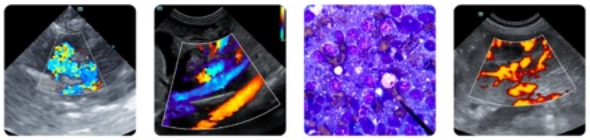


PATIENT

Hunter Potter

SPECIES

Canine

BREED

Miniature Pinscher Mix

SEX

Neutered male

AGE

11 years

WEIGHT

25.9 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Andi Eways

HOSPITAL NAME

TotalBond VH Paw Creek

REFERRING VET

Dr. Eways

INVOICE

71064

DATE

1/29/26

PRESENTING CLINICAL SIGNS

- Pt presented on 1/15 for acute vomiting and diarrhea. Treated for acute pancreatitis with outpatient care including fluid therapy, panoquel, cerenia, metronidazole, and probiotic. Pt had known elevated liver values since Sept 2025 and repeated labs showed significant elevation since then. Pt improved with outpatient care. Recommended abdominal ultrasound for further liver enzyme workup.
- CBC: Normal low RBC (5.77), normal white blood cells, mild platelet variation (491), HCT 38.5% - Chemistry panel: Confirmed pancreatitis - lipase 2600 and cPLI over 800, severely elevated liver enzymes (ALKP 1167 doubled since September- 606), ALT 148 H, BUN 33

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is mildly underdistended. The urinary bladder wall measures 2.2 mm and appears smooth; due to underdistension, wall thickness may be overestimated. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 5.26×2.88 cm. Cortical thickness is 0.67 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. No pyelectasia, nephroliths, or hydronephrosis are identified.

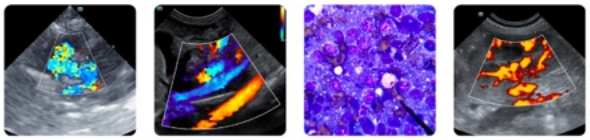
The right kidney is normal in shape and size, measuring 5.18×2.71 cm. Cortical thickness could not be reliably measured. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. No pyelectasia, nephroliths, or hydronephrosis are identified.

Adrenal Glands

Both adrenal glands have a normal shape and echogenicity. The left adrenal gland is incompletely visualized and appears mildly indistinct; it measures approximately 0.43 cm at the cranial pole and 0.54 cm at the caudal pole. The right adrenal gland measures 0.52 cm at the cranial pole and 0.53 cm at the caudal pole.

Spleen

Splenic thickness measures 1.25 cm. The splenic parenchyma has a normal echogenicity and fine homogeneous echotexture, with a few small hyperechoic foci measuring up to 0.5 cm. The splenic capsule is smooth and regular.



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Liver

The liver is subjectively increased in size, with sharp margins and a regular contour. Hepatic parenchyma is homogeneous and isoechoic relative to falciform fat, with a normal echotexture. No hepatic lymphadenopathy is identified.

The gallbladder lumen is moderately distended. Subtle hypoechoic mural undulations are present along the gallbladder wall, which may represent mucosal or mucinous gland hyperplasia in the context of early gallbladder mucocele formation. The gallbladder contains markedly echogenic, organized, non-dependent material, most consistent with inspissated bile or an early-stage gallbladder mucocele (grade 1–2). A classic “kiwi sign” is not identified. There is no ultrasonographic evidence of gallbladder rupture or biliary peritonitis.

Gastrointestinal

The stomach is empty and moderately folded, with preserved wall layering and a mural thickness of 2.73 mm. The pylorus measures 3.46 mm.

Duodenal wall thickness measures 3.04 mm. Jejunal wall thickness measures 2.84 mm. Ileal wall thickness measures 2.13 mm. Wall layering is preserved throughout. The ileocecal junction is not visualized. No ultrasonographic evidence of mural inflammation, ileus, or foreign material is identified.

The colonic wall measures 1.01 mm and is largely empty.

Pancreas

The left pancreatic limb does not demonstrate ultrasonographic evidence of active inflammation. The right pancreatic limb appears mildly heterogeneous, without enlargement, focal peripancreatic fluid, or increased echogenicity of the surrounding fat. These findings are more compatible with prior or chronic pancreatic changes rather than active pancreatitis, based on the provided images.

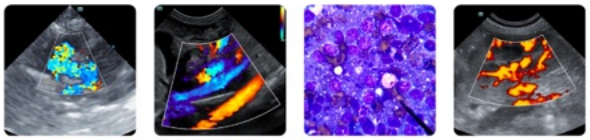
Peritoneal Cavity

No abdominal effusion or ultrasonographic evidence of peritonitis is observed. Abdominal lymph nodes are not visualized, and the surrounding regions appear unremarkable. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Subtle gallbladder wall irregularities suggestive of mucosal or mucinous gland hyperplasia.
- Markedly echogenic, organized, non-dependent gallbladder contents consistent with early gallbladder mucocele (grade 1–2).



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- Mild heterogeneity of the right pancreatic limb, compatible with prior or chronic pancreatitis.

SECONDARY FINDINGS

- Few small hyperechoic splenic foci, likely incidental

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography identifies early gallbladder pathology, most consistent with inspissated bile or an early-stage gallbladder mucocele (grade 1–2), characterized by non-dependent, organized echogenic intraluminal material and subtle gallbladder wall irregularities. There is no evidence of gallbladder rupture, biliary obstruction, or biliary peritonitis at this time. In the context of markedly elevated and progressive liver enzyme activity, subjective hepatomegaly with preserved echogenicity is most consistent with a reactive or functional hepatopathy, rather than a primary infiltrative or obstructive hepatic disorder.

Given the history of confirmed acute pancreatitis with clinical improvement, the mild heterogeneity of the right pancreatic limb without peripancreatic fat reaction or fluid is most compatible with resolving or chronic pancreatic change, rather than ongoing active pancreatitis.

Splenic findings, consisting of a few small hyperechoic foci, are nonspecific and most consistent with benign changes such as fibrosis, myelolipomas, or nodular hyperplasia.

Overall, the ultrasonographic findings support a multifactorial hepatobiliary process, with early gallbladder mucocele formation representing the most clinically relevant abnormality in the context of recurrent pancreatitis and progressive cholestatic enzyme elevation.

Recommendations

- Medical management with ursodeoxycholic acid may be considered in this early-stage gallbladder mucocele, provided close clinical and ultrasonographic monitoring is performed to assess for progression.
- Adjunctive hepatoprotective therapy is recommended to support hepatocellular function and mitigate ongoing enzyme elevation.
- Dietary fat restriction is strongly recommended, as this is a critical component of management in patients with gallbladder disease and a history of pancreatitis.
- Serial liver enzyme monitoring to assess response to therapy.
- Repeat abdominal ultrasound to evaluate gallbladder contents and wall integrity
- Immediate reassessment if vomiting, abdominal pain, lethargy, or icterus develops.

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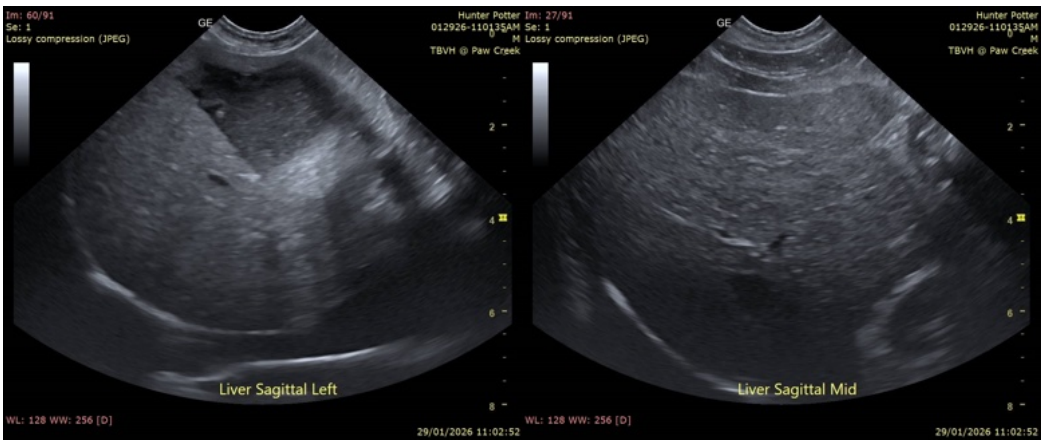

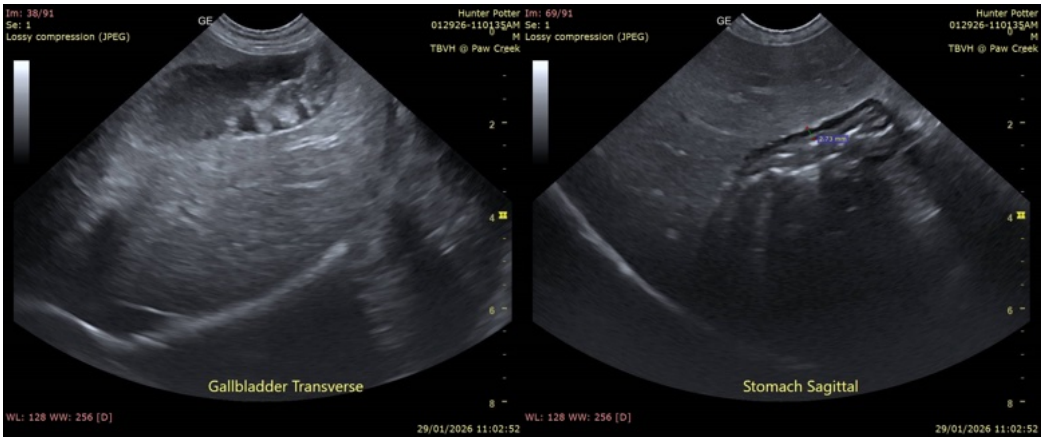

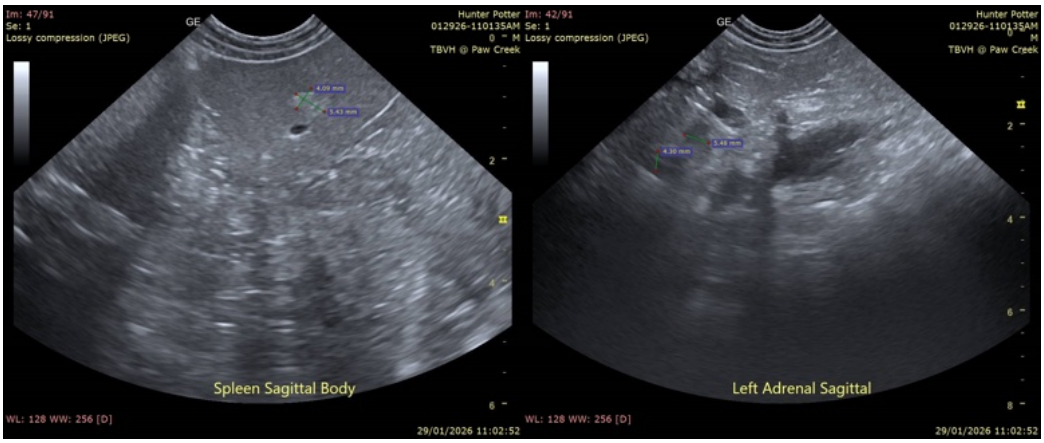

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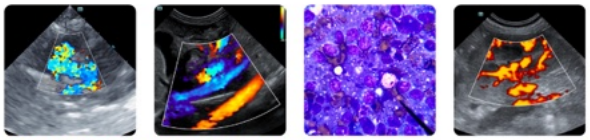

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SonoPath.com info@sonopath.com 1.800.838.4268

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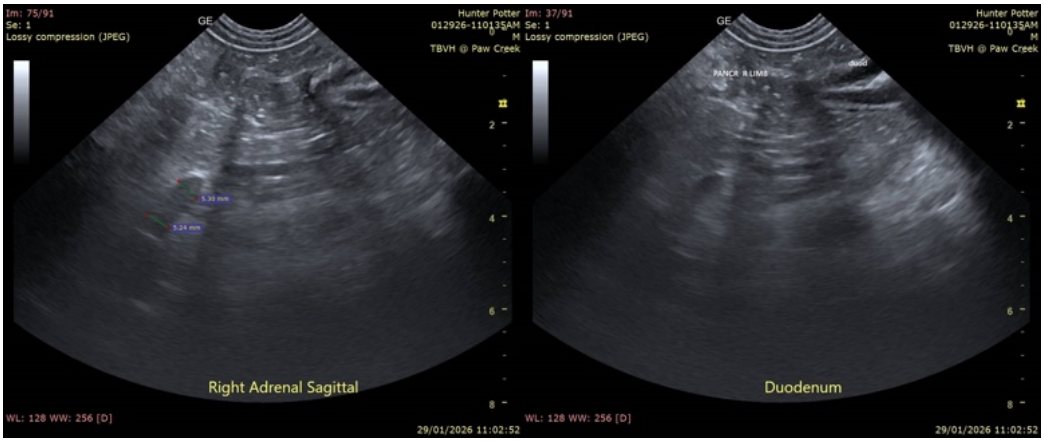

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com