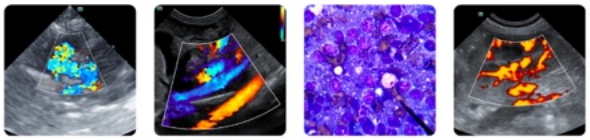


PATIENT

Sweet Pea Evans

SPECIES

Canine

BREED

Labrador Mix

SEX

Spayed female

AGE

8 years

WEIGHT

17.9 kg

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Dedden

HOSPITAL NAME

Brighton VC

REFERRING VET

Dr. Baker

INVOICE

69574

DATE

12/23/25

PRESENTING CLINICAL SIGNS

History: Sedation: 0.2mg/kg butorphanol and 0.01mg/kg medetomidine Thin deep chested dog. Was diagnosed with vestibular disease and facial paralysis in September 2025. Hypothyroid and elevation in liver values found on bloodwork as well as mild elevation in lipase and mild stress lymphopenia. Was started on 0.01mg/kg levothyroxine BID. Vestibular and facial nerve paralysis resolved. Discontinued thyroid meds December 17th as patient became PUPD and is still PUPD. Having occasional muscle spasms and weakness, loss of muscle mass and weight loss since vestibular episode. Decreased appetite.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 6.11×3.40 cm, and the cortical thickness is 0.46 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler shows a normal pattern.

The right kidney is normal in shape and size, measuring 5.87×2.98 cm, and the cortical thickness is 0.50 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler shows a normal pattern.

Adrenal Glands

The adrenal glands could not be visualized for evaluation in any of the provided video clips.

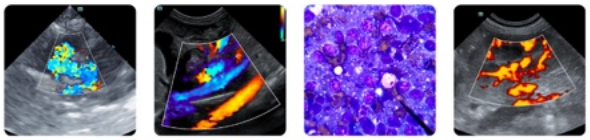
Spleen

Splenic thickness is 1.10 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma appears uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. Multiple intraluminal wall protrusions are observed, which do not demonstrate color Doppler signal and appear consistent with polypoid structures or possible



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adenomas. Additionally, there is intraluminal material that may represent organized biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.90 mm and preserved wall layering. The pylorus measures 4.74 mm. Duodenum measures 3.43–3.73 mm. Jejunum measures 3.39 mm, with normal wall layering. No signs of inflammation, ileus, or foreign material are identified. Colon wall thickness measures 1.11 mm, with formed feces present in the descending segment.

Pancreas

The visualized pancreatic regions do not show evident signs of inflammation.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes are not visualized, and the surrounding regions appear unremarkable. The iliac trifurcation is normal.

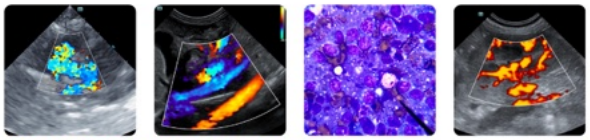
ULTRASONOGRAPHIC FINDINGS

- Multiple intraluminal gallbladder wall protrusions without detectable color Doppler signal, consistent with polypoid lesions or possible adenoma.
- Organized intraluminal echogenic material within the gallbladder, compatible with biliary sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography reveals a clinically significant gallbladder abnormality characterized by multiple intraluminal wall protrusions that do not demonstrate color Doppler signal. These structures are most consistent with gallbladder polyps or polypoid mucosal proliferations, with a gallbladder adenoma considered a differential diagnosis. In addition, organized intraluminal echogenic material is present, compatible with organized biliary sludge. There is no evidence of gallbladder wall thickening, pericholecystic reaction, or dilation of the cystic or common bile ducts, making biliary obstruction or cholecystitis unlikely at this time. These gallbladder findings may be associated with chronic biliary stasis or metabolic/endocrine disease.

The liver appears subjectively normal in size and echotexture, with no focal lesions or diffuse parenchymal changes detected. In this context, previously reported elevations in liver enzymes are unlikely to reflect primary hepatic disease and are more consistent with a secondary or metabolic process.



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The gastrointestinal tract demonstrates wall thickness and layering within normal limits for a medium-sized dog, with no evidence of inflammatory, infiltrative, or obstructive disease to explain the patient's decreased appetite or weight loss on ultrasound alone.

Based on the clinical presentation, laboratory abnormalities, treatment history, and the absence of significant structural disease on abdominal ultrasound, the following differential diagnoses should be considered and prioritized:

- Iatrogenic hypermetabolic state secondary to Levothyroxine supplementation: The development of polyuria/polydipsia, weight loss, muscle weakness, and decreased appetite following initiation of levothyroxine therapy raises concern for a functional hyperthyroid state, even if serum thyroid hormone levels were not markedly elevated. (Individual sensitivity to levothyroxine and potential misdiagnosis of primary hypothyroidism should be considered).
- Non-thyroidal illness (euthyroid sick syndrome) or concurrent systemic disease: The clinical signs are not typical of untreated hypothyroidism (particularly in a Labrador-type dog).
- Underlying metabolic or endocrine disease other than hypothyroidism:
  - Hyperadrenocorticism.
  - Diabetes mellitus (early or atypical).
  - Other metabolic or hormonal dysregulation contributing to muscle catabolism and weight loss.
- Chronic systemic or inflammatory disease (infectious, immune-mediated, or inflammatory) may explain weight loss, muscle wasting, and decreased appetite in the absence of overt abdominal structural changes.
- Neuromuscular or neurologic disease: Given the history of vestibular disease, facial nerve paralysis, muscle spasms, and weakness, a neurologic or neuromuscular disorder should be considered as a contributing or primary process.
- Early or occult neoplastic disease: Although no masses or lymphadenopathy are identified on ultrasound, early-stage or systemic neoplasia cannot be excluded and remains a consideration in an older dog with unexplained weight loss and anorexia.

Recommendations (in order of clinical priority):

- Repeat a complete thyroid panel after an appropriate washout period from levothyroxine, including total T4, free T4 (by equilibrium dialysis), and TSH, to confirm or refute true primary hypothyroidism and assess for prior oversupplementation.
- Perform baseline screening for hyperadrenocorticism, such as a low-dose dexamethasone suppression test or ACTH stimulation test, given the persistent polyuria/polydipsia, muscle wasting, and the inability to assess adrenal glands on ultrasound.
- If polyuria/polydipsia continues, obtain a fasting blood glucose and fructosamine, along with a repeat urinalysis with urine specific gravity, to evaluate diabetes mellitus or other causes of impaired urine concentration.
- Given ongoing muscle wasting, weakness, and spasms, consider serum CK, electrolytes (including ionized calcium), and neurologic or neuromuscular evaluation, with referral if abnormalities are identified.
- If weight loss and decreased appetite persist despite endocrine clarification, consider advanced systemic screening, including thoracic imaging and targeted inflammatory or neoplastic testing, to rule out occult disease not detectable in this abdominal ultrasound.

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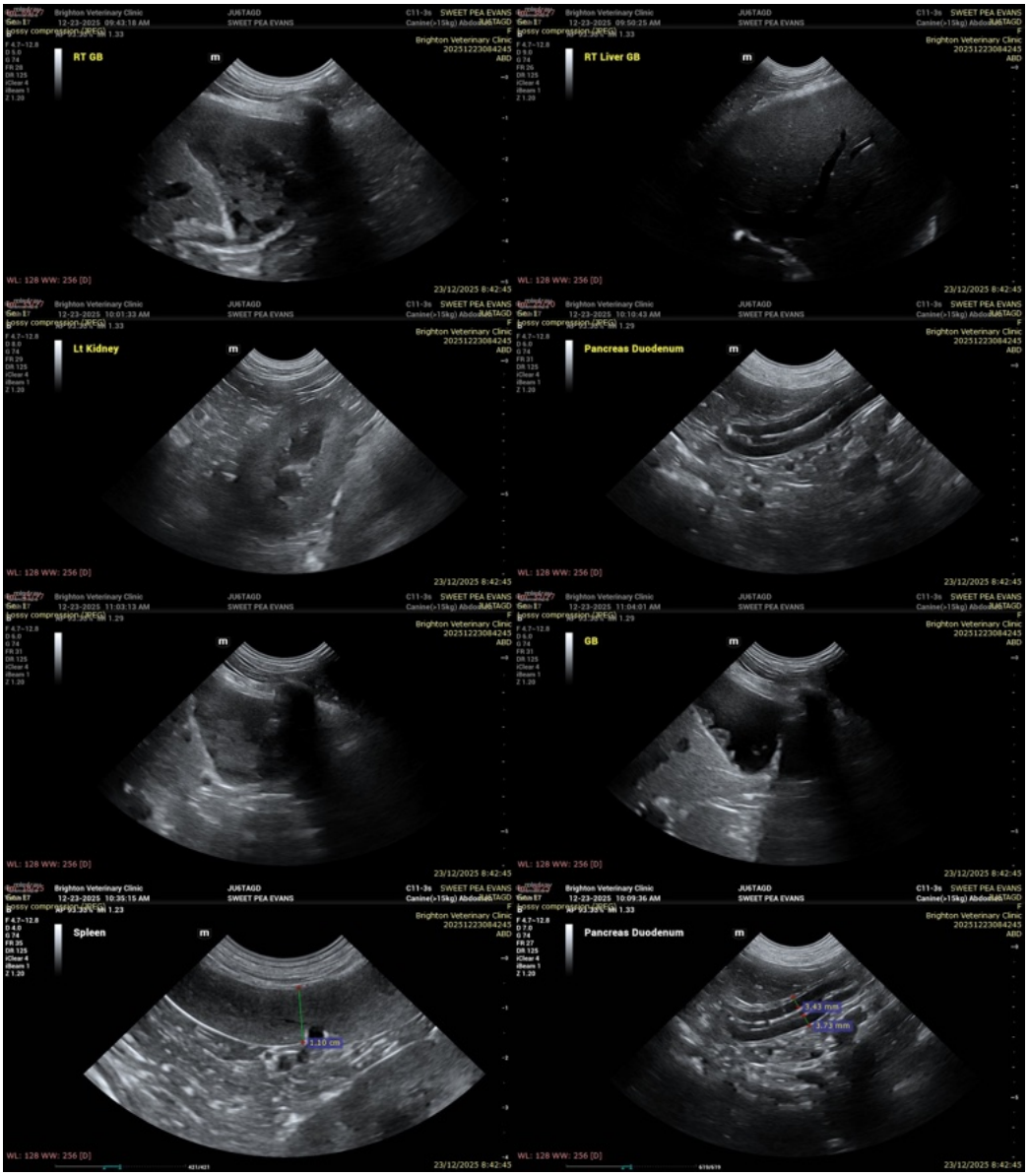

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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