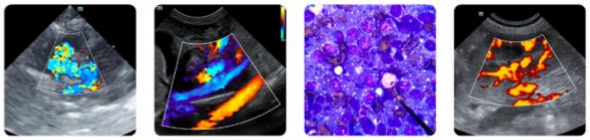


PATIENT

Millie Charlotte

SPECIES

Canine

BREED

Cavalier King Charles Spaniel

SEX

Spayed Female

AGE

8 Years

WEIGHT

13.6 pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Saum Hadi

HOSPITAL NAME

Nimbus Pet Hospital

REFERRING VET

Dr. Saum Hadi

INVOICE

12595

DATE

12/05/25

PRESENTING CLINICAL SIGNS

P presents for acute hyporexia, vomiting, diarrhea. BAR with NSF on exam. Possible Aleve (naproxen) ingestion per O. Labs showed normal kidney values, moderate increase in ALT/ALKP.

Abnormal PE/Chem/CBC/UA Results: ALT: 415 U/L ALKP: 339 U/L NSF on rest of labs (Chem 10, CBC, Lytes, SNAP cPL)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The left kidney is normal in shape and size: 4×2.19 cm, with a cortical thickness of 0.30 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

The right kidney is normal in shape and size: 3.68×1.99 cm, with a cortical thickness of 0.33 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

Adrenal Glands

The left adrenal gland measures 0.42 cm at the cranial pole and 0.46 cm at the caudal pole. The right adrenal gland was not visualized in any of the videos.

Spleen

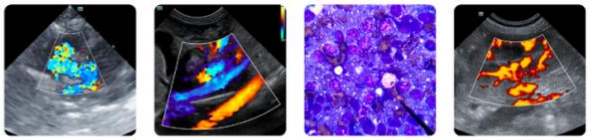
Splenic thickness is 0.74 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture, except for rounded structure that appears anechoic but does not show clear posterior acoustic enhancement. It is located at the ventral extremity of the spleen and protrudes outward, deforming the splenic capsule. It measures 0.61×0.95 cm (maximum dimensions from three measurements taken).

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. The wall is thin, and the contents are primarily anechoic with a small amount of biliary sludge. Several 3.2–3.7 mm hyperechoic nodules arise from the gallbladder wall; it is unclear whether these represent polyps or adenomas. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal



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The stomach is empty and folded, with mural thickness 2.64–2.98 mm and preserved wall layering. The mucosa measures 1.02 mm, with no visible ulcers. The pylorus measures 3.69 mm.
Duodenum: 3.81 mm.
Jejunum: 4.31 mm, mucosa: [measurement not provided], submucosa: [measurement not provided], muscularis propria: [measurement not provided].
Ileum: 1.72 mm, with normal wall layering.
There is significant gas in the stomach and intestines, although no signs of obstruction, ileus, or foreign material are identified.

Colon: 1.36 mm, with a small amount of fecal material in the descending segment.

Pancreas

The right limb measures 1.25 mm in thickness. The pancreatic parenchyma is isoechoic to the adjacent omental fat. No signs of active inflammation or neoplastic disease are evident.

Free Abdomen

No abdominal effusion or peritonitis is observed. Abdominal lymph nodes are not visualized, but the surrounding regions appear unremarkable.

The iliac trifurcation is normal.

PRIMARY FINDINGS

- Splenic capsular nodule.
- Gallbladder wall polyps/adenomas.
- Mild biliary sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A small, well-demarcated splenic capsular nodule, markedly hypoechoic and protruding beyond the ventral capsule, is identified. Its homogeneous, fluid-like appearance without posterior acoustic enhancement is most consistent with a splenic cyst or pseudocyst, although a small focal inflammatory nodule or early neoplastic focus (focal lymphoma or early hemangiosarcoma) cannot be fully excluded due to its subcapsular location. No splenic enlargement or adjacent effusion is present.

Small hyperechoic gallbladder wall nodules are also observed, which may represent benign polyps or cholesterol adenomas. The gallbladder contains a small amount of non-obstructive sludge without biliary tract dilation. No evidence of pancreatitis, intestinal ulceration, obstruction, or free abdominal fluid is present.

The liver appears structurally normal despite the moderate hepatocellular enzyme elevation, making reactive hepatopathy secondary to systemic illness, recent gastrointestinal upset, or possible NSAID exposure more likely than primary hepatobiliary disease.

No ultrasonographic signs consistent with NSAID-induced gastrointestinal ulceration (thickened, hypoechoic mucosa, crater defects) are observed. The gastrointestinal tract shows preserved wall layering and normal thickness, with gas-related artifacts but no mechanical or functional obstruction.

Recommendations

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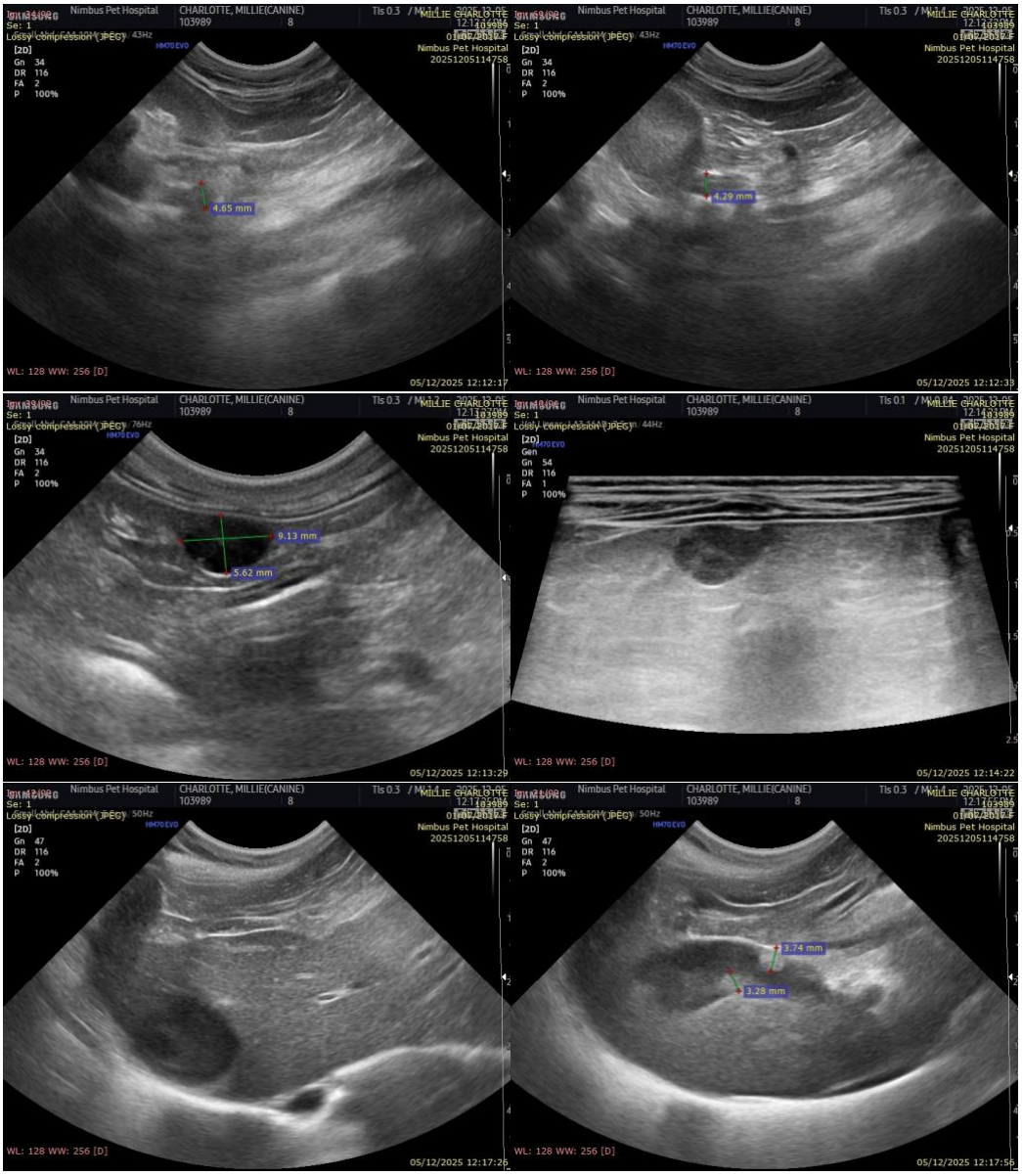
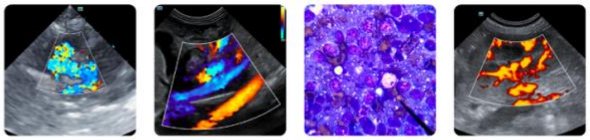
- Short-term monitoring of the splenic lesion: Repeat abdominal ultrasound in 6–8 weeks to assess for growth or changes in echogenicity (a >20–25% increase in size would be clinically significant).
- Fine-needle aspiration (optional).
- Follow-up for hepatobiliary changes.



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



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can be of any further assistance please contact me.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com