

PATIENT

Miley Monrreal

SPECIES

Canine

BREED

Brussels Griffon

SEX

Female

AGE

12 years

WEIGHT

18 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Amanda Favis

HOSPITAL NAME

Ruidoso AC

REFERRING VET

Dr. Favis

INVOICE

73909

DATE

3/30/26

PRESENTING CLINICAL SIGNS

- Hx of Vomiting/diarrhea
- Currently on meds from rDVM - Cobalequin SID, Clavamox 125mg BID, prednisone 5mg SID, carprofen 18.75mg SID and aspirin (unknown dose)
- Concern for hypoalbuminemia - most recent BW - albumin 1.9, BUN/Creatinine wnl, SDMA 17.3; CBC - elevated WBC

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended, with a thin, smooth wall and anechoic content. The bladder neck and proximal urethra are unremarkable. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size (3.96×2.31 cm), with a cortical thickness of 0.36 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size (4.25×2.22 cm), with a cortical thickness of 0.40 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

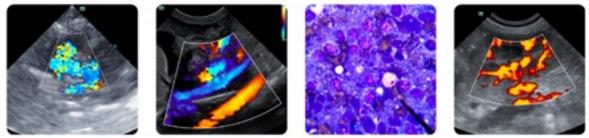
Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.53 cm at the cranial pole and 0.54 cm at the caudal pole. The right adrenal gland measures 0.71 cm at the cranial pole and 0.92 cm at the caudal pole.

Spleen

Splenic thickness is 0.69 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively mildly increased in size, with sharp edges and a regular contour. The parenchyma is uniform and isoechoic compared to the falciform fat, with otherwise normal echotexture. Few hypoechoic focus are identified, the largest 4.91×6.53 mm. No hepatic lymphadenopathy is observed.



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The gallbladder is normally distended. The wall is thin, and the contents include a moderate amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with gas content, a wall thickness of 2.31 mm, and preserved layering. The pylorus is not clearly visualized.

Duodenum: 5.37 mm, with multiple hyperechoic mucosal striations. Jejunum: 4.45 mm, with preserved wall layering.

Colon: 0.90–1.28 mm, with formed feces in the descending segment.

Pancreas

Pancreatic thickness is 8.52 mm. The parenchyma is isoechoic relative to adjacent omental fat. No peripancreatic fat changes are identified.

Free Abdomen

A very small volume of abdominal effusion is present. No sonographic evidence of peritonitis or lymphadenomegaly is identified. The iliac trifurcation appears normal.

PRIMARY FINDINGS

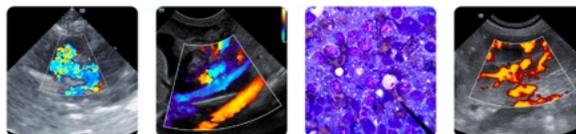
- Mild hepatomegaly.
- Several small hypoechoic hepatic foci (largest 4.91×6.53 mm).
- Moderate biliary sludge.
- Duodenal thickening with hyperechoic mucosal striations.
- Mild jejunal thickening

SECONDARY FINDINGS

- Small volume abdominal effusion
- Right adrenal gland enlargement (up to 0.92 cm).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The duodenum and jejunum are thickened relative to expected values, with preserved wall layering and the presence of hyperechoic mucosal striations in the duodenum. These striations are associated with lacteal dilation, supporting a diagnosis of protein-losing enteropathy. In the context of marked hypoalbuminemia, these findings are highly consistent with an underlying chronic enteropathy, with differentials including inflammatory bowel disease, lymphangiectasia, or less likely low-grade lymphoma. Preservation of layering and absence of mass effect favor inflammatory or lymphangiectatic disease, although overlap exists and definitive differentiation requires histopathology.



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The very small volume of abdominal effusion is most consistent with hypoalbuminemia, given the lack of peritoneal inflammation.

The liver is mildly enlarged, with a few small hypoechoic foci. In an older patient, this pattern most likely represents benign nodular change (nodular hyperplasia) or mild hepatocellular vacuolar change.

The right adrenal gland is enlarged (up to 0.92 cm), exceeding expected reference ranges for a dog of this size (generally ≤ 0.54 – 0.60 cm), while the left adrenal gland is within normal limits. This asymmetry may reflect incidental adrenal hyperplasia or non-functional enlargement. In the absence of compatible clinical signs, this finding is of uncertain clinical significance. Ultrasonography does not assess adrenal function.

The stomach shows no evidence of ulceration or perigastric reaction despite concurrent corticosteroid, NSAID, and aspirin therapy, although the pylorus is not clearly visualized, representing a mild limitation. It should be noted that ultrasonography has limited sensitivity for the detection of gastric ulceration, and small or early lesions may not be identified.

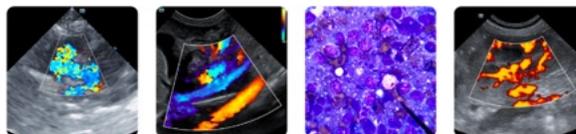
Overall, the findings are most consistent with protein-losing enteropathy as the cause of hypoalbuminemia, with incidental mild hepatopathy and adrenal enlargement.

Recommendations

- Further evaluation for protein-losing enteropathy is recommended:
 - Serum cobalamin/folate (if not already available)
 - Consider fecal α 1-proteinase inhibitor
 - Dietary trial and/or immunomodulatory therapy as clinically indicated
- Definitive differentiation requires intestinal biopsy if clinically warranted .
- Gastroprotective treatment (proton pump inhibitor \pm sucralfate) is recommended, along with reassessment of the current medication combination given the high risk of gastrointestinal ulceration.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient’s clinical status.





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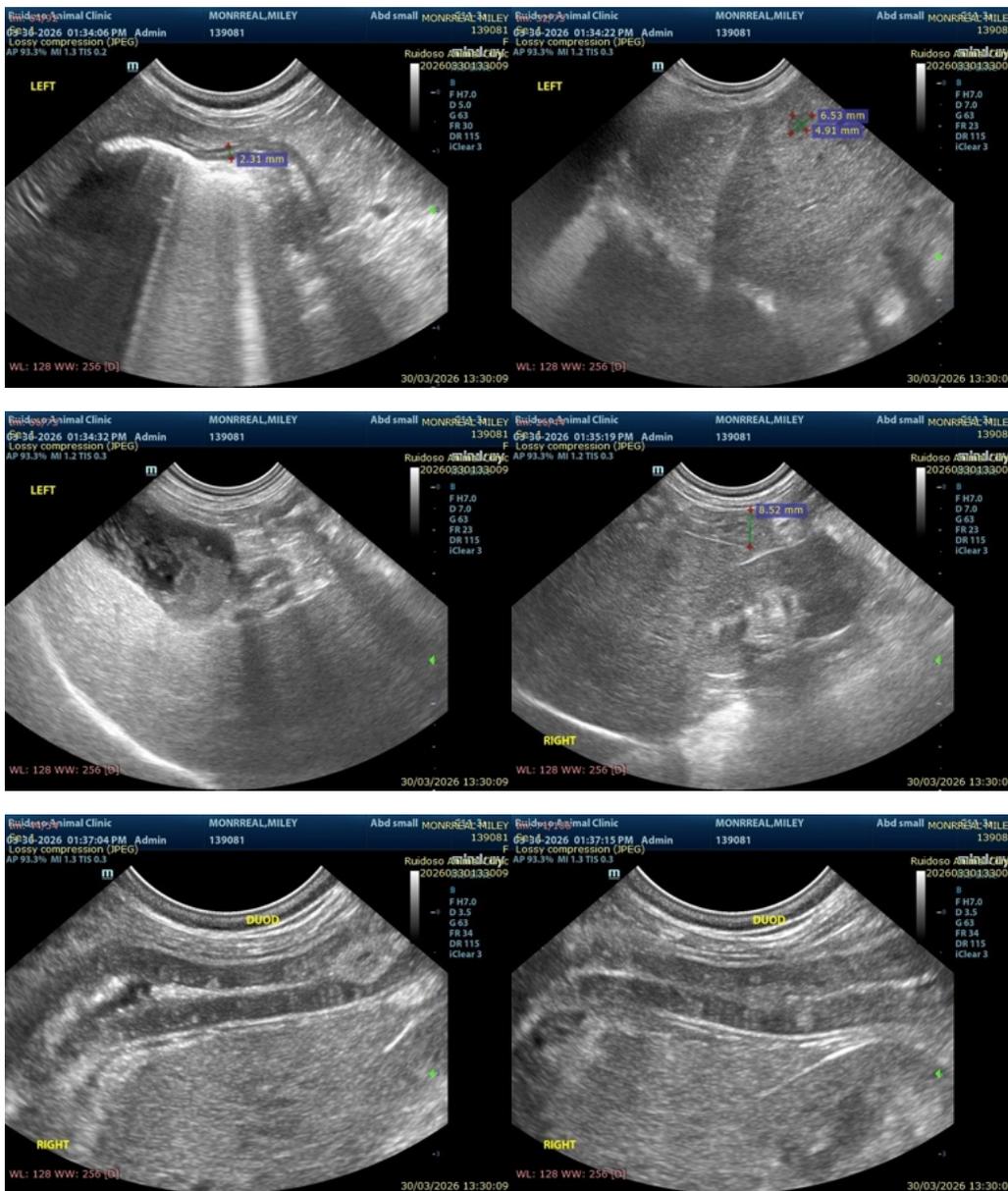
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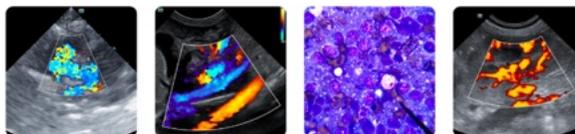
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

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