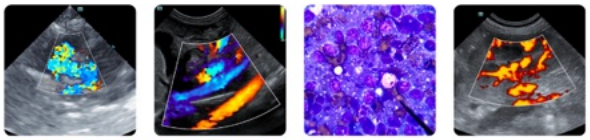


PATIENT

Pip Jackson

SPECIES

Canine

BREED

Chihuahua

SEX

Neutered male

AGE

13 years

WEIGHT

7.3 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Brandi Barry

HOSPITAL NAME

Bluegrass AH

REFERRING VET

Dr. Disney

INVOICE

73910

DATE

3/30/26

PRESENTING CLINICAL SIGNS

- Patient presents for abdominal ultrasound for further evaluation of gas distension of abdomen and discomfort after eating. Owner reports that these episodes have been noted at home on and off for about a year. Patient eats dry food with water added in. Episodes normally noted for 1-2 weeks at a time, mostly after dinner. Owner has tried feeding smaller meal in PM. Abdomen feels firm on palpation and persists until patient walks around more or burps to release gas.
- History of chronic cough, Stage B1/2 myxomatous valvular disease, and PLN.
- Current meds include famotidine, Vetmedin, telmisartan, and clopidrogrel.
- Grade 3-4/6 heart murmur. Iris atrophy OU. Corneal deposit/dystrophy OD. Moderate dental calculus. Labs last performed 9/2025: RETIC 136.4 (H) PLT 502 (H) ALT 511 (H) AMYL 1778 (H)

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 appear normal. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size (3.43×1.83 cm), with a cortical thickness of 0.30 cm in the sagittal plane. Mild pyelectasia is present (1.21 mm).

The right kidney measures 2.91×1.84 cm. Cortical thickness is 0.27 cm.

Both kidneys: The cortex is increased in echogenicity compared to the liver parenchyma. Several small cortical cysts are present, the largest measuring 1.5×2.7 mm. The corticomedullary ratio is within normal limits, although corticomedullary definition is mildly decreased. There is no evidence of nephrolithiasis or hydronephrosis. Doppler color evaluation shows a normal perfusion pattern.

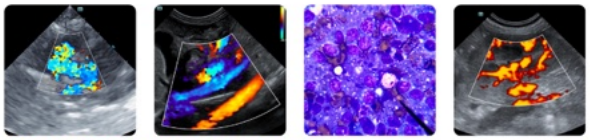
Adrenal Glands

Both adrenal glands have normal shape and echogenicity.

The left adrenal gland measures 0.51 cm (cranial pole) and 0.53 cm (caudal pole). The right adrenal gland measures 0.64 cm (cranial pole) and 0.58 cm (caudal pole).

Spleen

Splenic thickness is 0.93 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal abnormalities. The splenic capsule is smooth and regular.



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Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The parenchyma is diffusely hyperechoic relative to the falciform fat and contains several small hypoechoic foci, the largest measuring 3.6×5.46 mm. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended. The wall is thin, and it contains a mild to 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 wall thickness ranging from 2.09–2.20 mm and preserved layering.

The pylorus measures 4.75–5.72 mm. Duodenum: 3.40 mm. Jejunum: 3.92 mm, with preserved wall layering. The ileocecal junction is not visualized. No evidence of inflammation, ileus, or foreign material is identified.

Colon: 0.90–1.08 mm, with minimal content throughout.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Increased cortical echogenicity and mild decreased corticomedullary definition. Small cortical renal cysts
- Mild pyelectasia (1.21 mm, left kidney)
- Diffusely hyperechoic liver with multiple small hypoechoic hepatic foci (largest 3.6×5.46 mm)
- Mild biliary sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No ultrasonographic evidence of structural gastrointestinal abnormality is identified. Gastric and small intestinal wall thickness and layering are within accepted reference ranges for a dog of this size, and there are no findings to support obstruction, inflammatory enteropathy, or infiltrative disease.
Given the chronic, intermittent, postprandial abdominal distension that improves with movement or eructation, in the absence of structural abnormalities, the clinical presentation is most consistent with a

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functional gastric motility disorder (functional dyspepsia-like syndrome), resulting in delayed gastric emptying and secondary gas retention. Functional gastric disorders of this type are increasingly recognized in small breed dogs and are thought to reflect altered gastric motility and coordination rather than primary structural disease.

The liver is diffusely hyperechoic, with multiple small hypoechoic foci. This pattern is most consistent with vacuolar hepatopathy and/or benign nodular hyperplasia, particularly in an older patient and in the context of elevated ALT. The gallbladder contains a small amount of sludge, consistent with mild biliary stasis.

The kidneys show increased cortical echogenicity with mildly decreased corticomedullary definition, small cortical cysts, and minimal left pyelectasia (1.21 mm). These findings are consistent with chronic renal change, which may correlate with the history of protein-losing nephropathy.

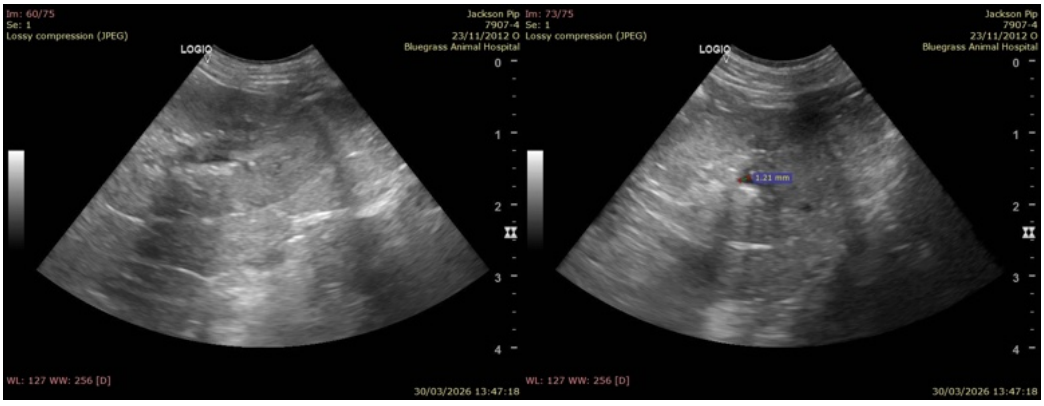
The right adrenal gland is mildly larger than the left but remains within acceptable variation, with no morphological abnormalities, and is considered clinically insignificant in the absence of compatible clinical signs or supportive biochemical abnormalities (ALP elevation).

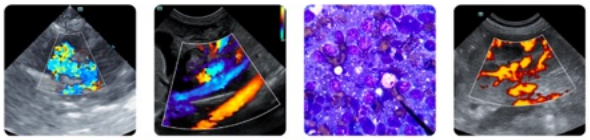
Recommendations
Consider management for suspected gastric dysmotility, including:

- Feeding smaller, more frequent meals.
- Evaluating diet composition (highly digestible diet; consider reducing expansion of dry kibble).
- Encouraging slower feeding if appropriate.

A prokinetic trial may be considered to improve gastric emptying and assess clinical response.
Continue acid suppression as clinically indicated, although this is unlikely to address the primary mechanism.
If clinical signs persist or worsen, further evaluation of gastric function may be considered.

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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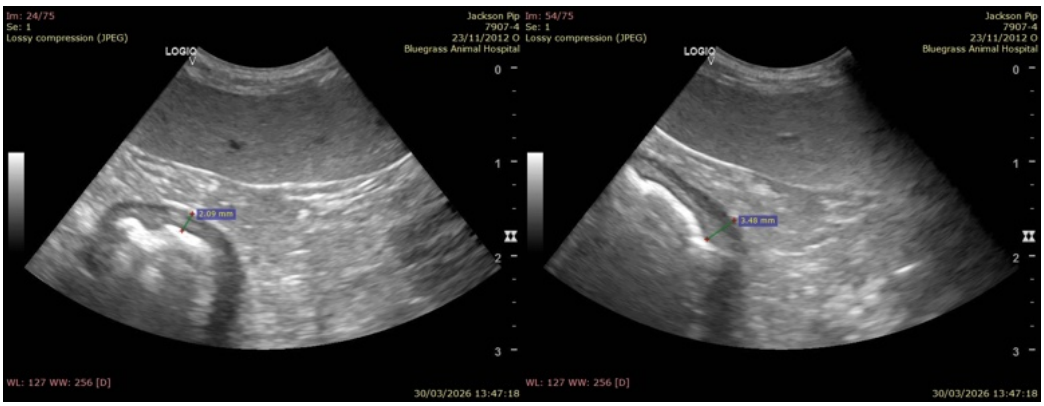

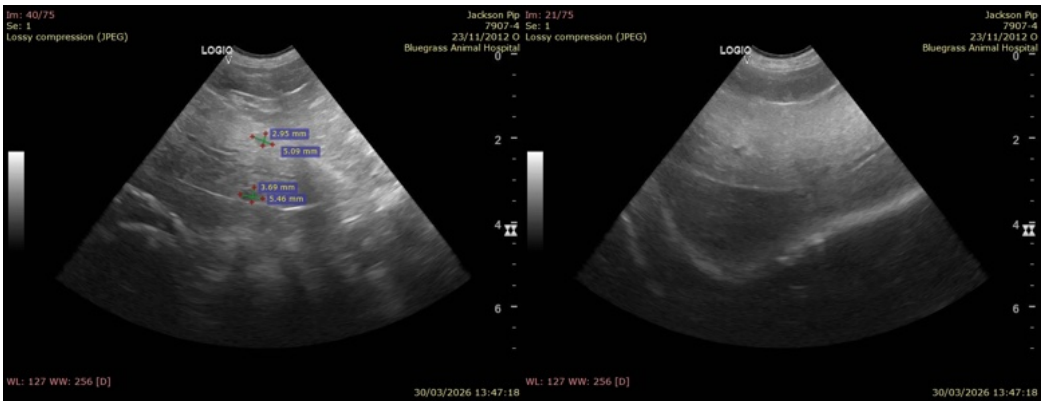

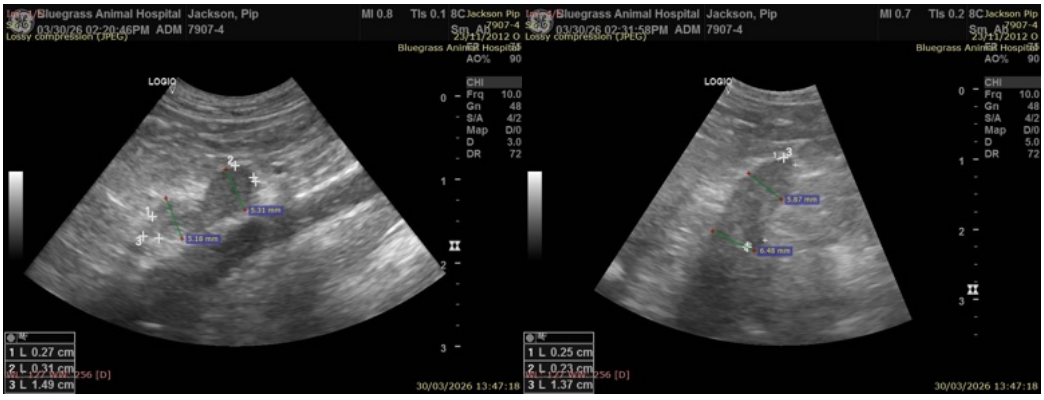

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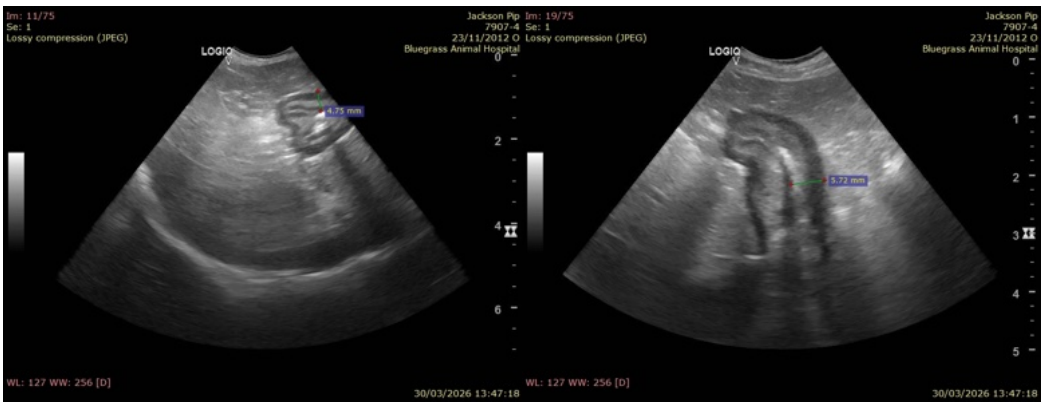

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com