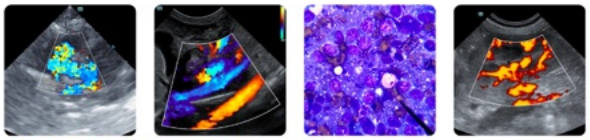


PATIENT

Chester Moylan

SPECIES

Ferret

BREED

Common Ferret

SEX

Male

AGE

4 years

WEIGHT

2.5 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Kim

HOSPITAL NAME

Ridgefield Park AH

REFERRING VET

Dr. Kim

INVOICE

74974

DATE

4/29/26

PRESENTING CLINICAL SIGNS

History: The patient presented to the hospital after being lethargic on Sunday and shaking, as well as vomiting several times. normal appetite and drinking.
normal fecal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 2.89×1.47 cm, with a cortical thickness of 0.26 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.33×1.56 cm, with a cortical thickness of 0.25 cm in the sagittal plane. In both kidneys, the cortex is isoechoic compared to the liver parenchyma. A small cortical cyst measuring 0.99×1.23 mm is noted in the right kidney. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.21 cm at the cranial pole and 0.29 cm at the caudal pole. The right adrenal gland measures 0.23 cm at the cranial pole and 0.25 cm at the caudal pole.

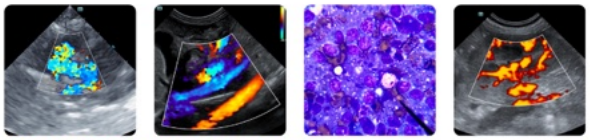
Spleen

Splenic thickness is 1.03 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 normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is moderately distended. The wall is thin. A small echogenic structure consistent with a cholelith is present. The remaining contents are predominantly anechoic. There is no evidence of dilation of the cystic duct or common bile duct.



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Gastrointestinal

The stomach is empty and folded, with a mural thickness of 0.93 mm and preserved wall layering.
The duodenum measures 2 mm, mildly distended with fluid. The jejunum measures 1.31–1.77 mm.
There is mildly increased peristalsis throughout the intestines, with a small amount of luminal fluid. No evidence of mural thickening, loss of layering, mechanical ileus, or foreign material is identified. The colon measures 0.55–0.64 mm and contains very soft fecal material.

Pancreas

The pancreas was not confidently identified in the available video clips. Although some still images were labeled as pancreas, the imaged structure could not be definitively distinguished from adjacent collapsed intestinal loops.

Free Abdomen

A very small amount of abdominal effusion is present between the hepatic lobes.
No sonographic evidence of lymphadenomegaly is identified in the study provided. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Mild diffuse intestinal fluid content with increased peristalsis
- Mild duodenal fluid distension
- Minimal abdominal effusion

SECONDARY FINDINGS

- Small cholelith (incidental)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ultrasonographic findings are mild and largely nonspecific, with no evidence of mechanical obstruction, focal gastrointestinal disease, or significant organ pathology.
The presence of mild diffuse intestinal fluid content with increased peristalsis, in the absence of mural abnormalities or ileus, is most consistent with a functional or inflammatory gastrointestinal process, such as acute gastroenteritis. This aligns well with the acute clinical presentation (vomiting, lethargy), and there is no sonographic evidence to support a foreign body or obstructive disease.

The minimal abdominal effusion is likely reactive and clinically insignificant in isolation.
The pancreas was not adequately visualized, which is a recognized limitation in ferrets due to size and anatomical constraints. Therefore, pancreatitis cannot be definitively assessed, although pancreatitis is considered very uncommon in ferrets, and based on imaging alone, it is not a leading differential here.

There are no ultrasonographic findings to explain the reported tremors/shaking. In a ferret of this age,

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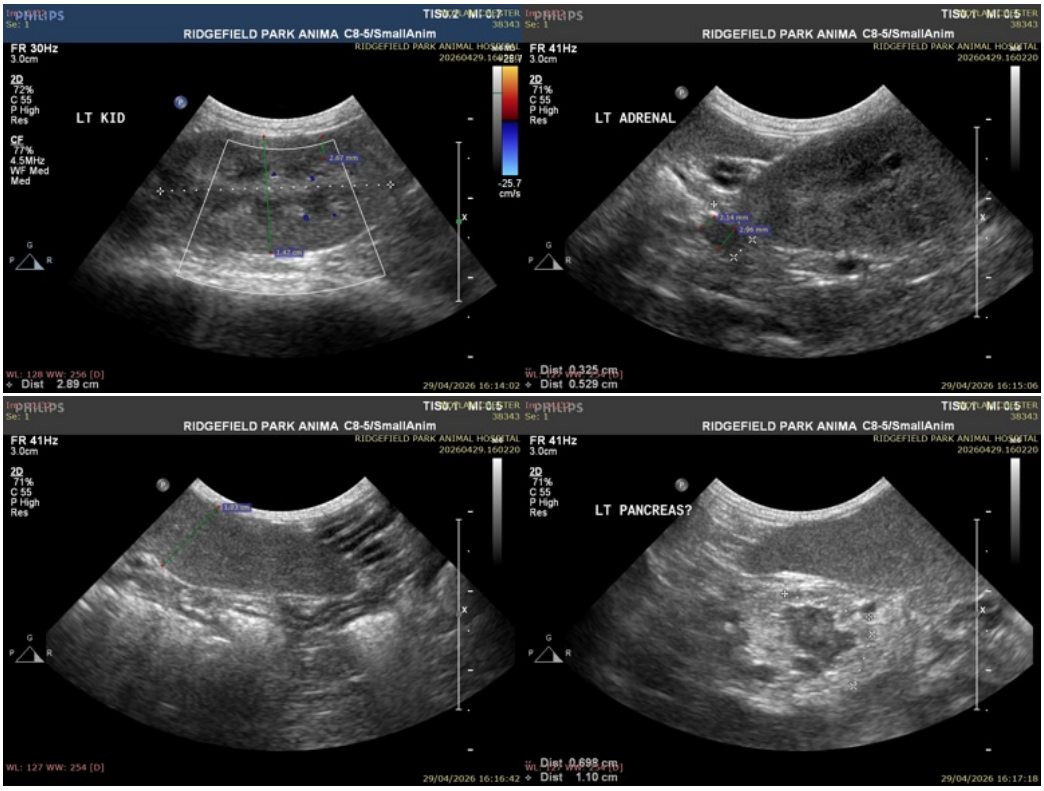
these signs are highly suggestive of hypoglycemia, and Insulinoma must be considered a primary differential diagnosis. Crucially, insulinomas in ferrets are often multifocal, small, and sonographically occult, meaning that a normal or non-visualized pancreas does not exclude the disease.
While transient hypoglycemia secondary to reduced intake or vomiting is theoretically possible, the described neurological signs (shaking/lethargy) are highly characteristic of insulinoma in this species, and this diagnosis should be actively pursued.

Overall, the imaging findings support a mild acute gastrointestinal process, but do not account for the full clinical picture. A concurrent or primary metabolic disorder (most notably insulinoma) remains a key concern.

Recommendations

- Blood glucose measurement (ideally repeated or serial), if not already performed, to assess for hypoglycemia.
- Provide supportive care for suspected acute gastroenteritis, including fluid therapy and antiemetics as clinically indicated.
- Monitor clinical response closely; if vomiting persists or worsens, repeat imaging or further diagnostics 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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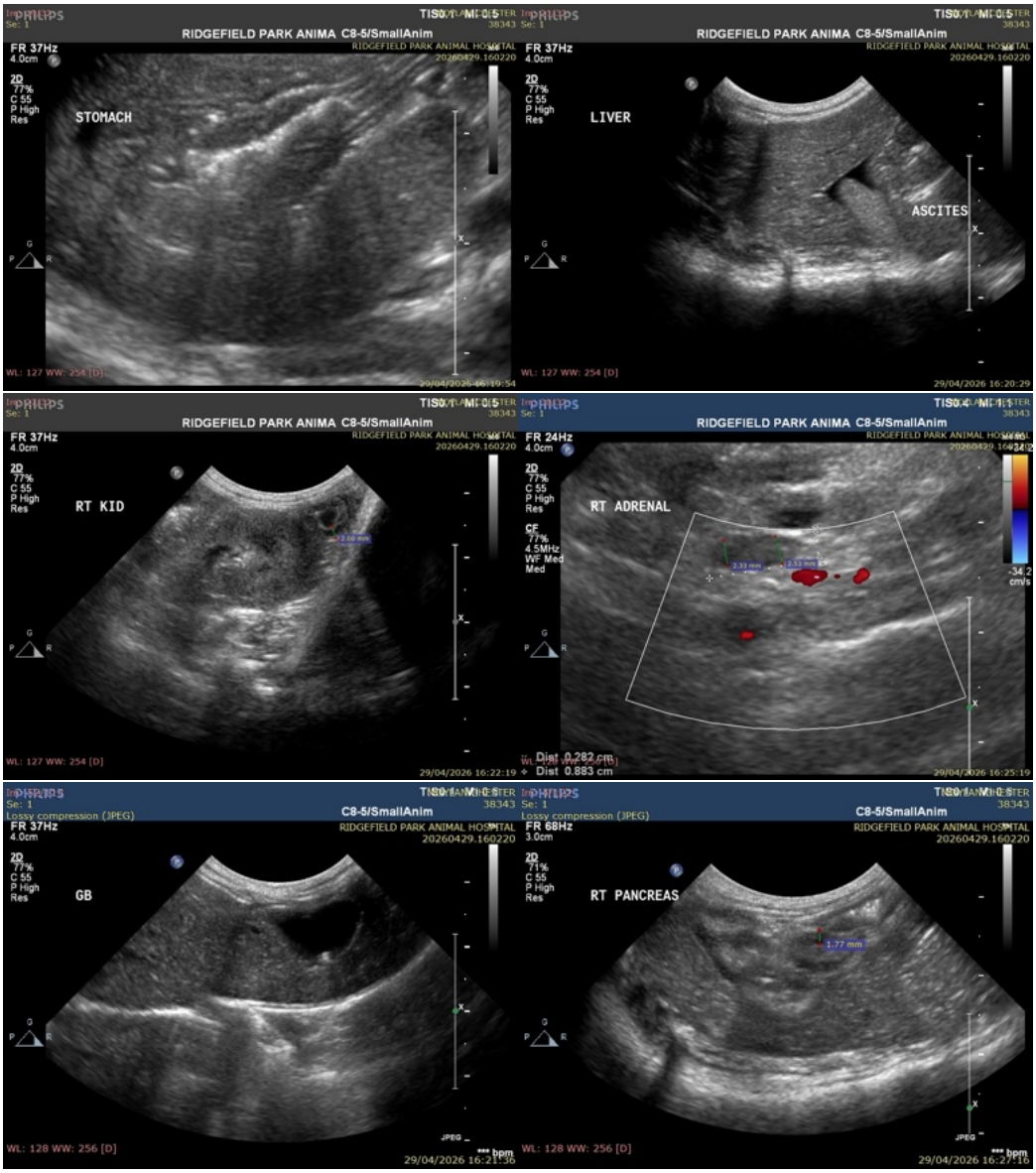

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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