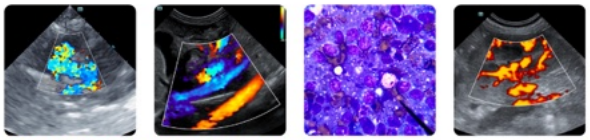


PATIENT

Becca Leonard

SPECIES

Canine

BREED

Corgi Mix

SEX

Spayed female

AGE

10 years

WEIGHT

23 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Anshu Gupta

HOSPITAL NAME

Liverpool Village AH

REFERRING VET

Dr. Gupta

INVOICE

77599

DATE

5/15/26

PRESENTING CLINICAL SIGNS

History: - elevated liver values on bloodwork
- at presentation for pre-operative bloodwork for dental procedure, found elevated liver values, worsened with metronidazole, Denamarin
- patient is otherwise asymptomatic
Abnormal PE/Chem/CBC/UA Results: PE: overweight, periodontal disease stage 4 CBC: NSF Chem: 1) 3/25- ALP 263, ALT 389, TBIL 0.8, 2) 4/29- ALP 313, ALT 574, GGT 37, TBIL 0.7

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is moderately distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal ultrasonographic appearance. No calculi are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic mural disease.

The left kidney is normal in shape and size, measuring 4.57×2.76 cm, with a cortical thickness of 0.41 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.56×2.48 cm, with a cortical thickness of 0.42 cm in the sagittal plane. Both kidneys: The renal cortices are isoechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

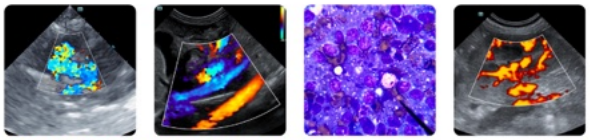
Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.63 cm at the cranial pole and 0.76 cm at the caudal pole. The right adrenal gland measures 0.68 cm at the cranial pole and 0.69 cm at the caudal pole.

Spleen

Splenic thickness is 1.42 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture, with a few small hyperechoic focal parenchymal nodules compatible with benign myelolipoma-like lesions. The largest lesion measures approximately 1.02×1.30 cm within the ventral aspect of the spleen. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat, with a normal echotexture. No focal hepatic lesions or hepatic lymphadenopathy are identified.



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The gallbladder lumen is markedly distended. The gallbladder wall is thin. A small amount of non-shadowing biliary sludge is present within the lumen. The cystic duct and common bile duct are not confidently identified in the submitted video clips.

Gastrointestinal

The stomach contains a small amount of ingesta, with preserved wall layering and mural thickness measuring approximately 2.56 mm. The pylorus measures 5.71 mm. The duodenum measures 2.98 mm. The jejunum measures 2.88 mm with preserved wall layering. No ultrasonographic evidence of gastrointestinal inflammation, obstructive disease, ileus, or foreign material is identified. The colon measures 1.43 mm and contains formed fecal material within the descending colon.

Pancreas

The pancreas measures approximately 1.01 cm in thickness. The pancreatic parenchyma is mildly hyperechoic relative to the adjacent omental fat. No peripancreatic fat inflammation, free fluid, or focal pancreatic mass lesion is identified.

Free Abdomen

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

PRIMARY FINDINGS

- Mild bilateral adrenal enlargement
- Marked gallbladder distension with mild biliary sludge

SECONDARY FINDINGS

- Mild diffuse pancreatic hyperechogenicity
- Small benign-appearing splenic myelolipoma-like nodules

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild bilateral adrenal enlargement is present, most notably involving the caudal pole of the left adrenal gland. In a dog of this size, these measurements are mildly above expected reference limits and may reflect mild adrenal hyperplasia or chronic endocrine stimulation. Although hyperadrenocorticism remains a differential consideration, the adrenal changes are subtle and nonspecific, and the current ultrasonographic appearance would be more compatible with early pituitary-dependent hyperadrenocorticism rather than adrenal-dependent disease if clinically present.

The liver demonstrates a relatively normal ultrasonographic appearance despite the biochemical hepatopathy. The combination of obesity, mild biliary sludge, mild diffuse pancreatic hyperechogenicity, and relatively limited structural hepatic abnormalities favors a metabolic/vacuolar hepatopathy

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pattern. Underlying hyperlipidemia or metabolic/endocrine-associated hepatopathy should therefore be considered clinically.

Marked gallbladder distension with mild biliary sludge is present without ultrasonographic evidence of cholecystitis, biliary obstruction, or advanced gallbladder mucocele formation. These findings may reflect biliary stasis and could be associated with underlying metabolic or endocrine dysfunction.

Mild diffuse pancreatic hyperechogenicity without surrounding inflammatory change is most compatible with pancreatic lipomatosis/lipid infiltration or chronic age-related pancreatic change. No convincing ultrasonographic evidence of active pancreatitis is identified.

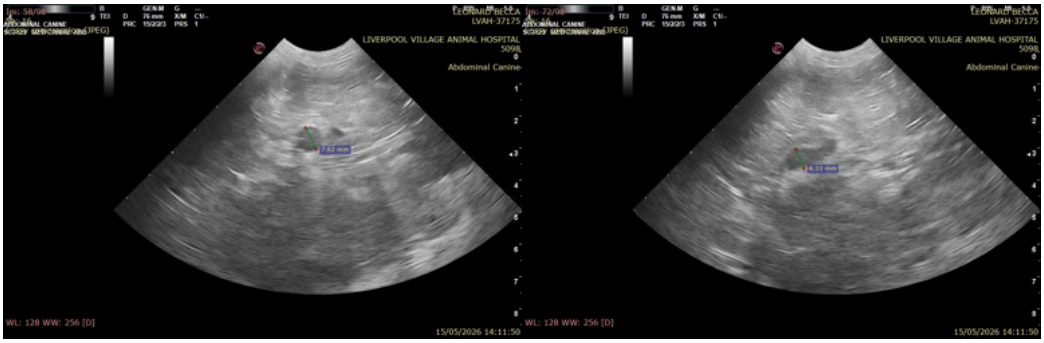
The small splenic hyperechoic nodules are most compatible with incidental benign myelolipoma-like lesions, which are common in older dogs.

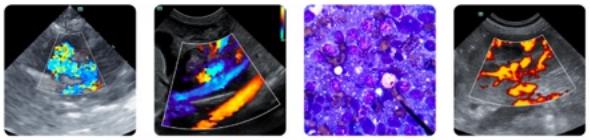
Overall, the ultrasonographic findings are relatively mild compared to the degree of liver enzyme elevation and favor a chronic metabolic/endocrine hepatopathy pattern over severe primary structural hepatobiliary disease.

Recommendations

- Correlation with a fasting lipid panel (cholesterol/triglycerides) may be clinically useful, as underlying hyperlipidemia or metabolic syndrome could contribute to the biochemical hepatopathy, biliary sludge, and mild pancreatic hyperechogenicity identified on this examination.
- Hepatoprotective and choleretic therapy may be considered at the discretion of the attending veterinarian.
- Continued monitoring of liver enzyme activity and bilirubin is recommended.
- Correlation with endocrine testing for hyperadrenocorticism could be considered, particularly if compatible clinical signs develop or liver enzyme elevations continue to progress.
- Periodic ultrasonographic monitoring of the gallbladder is reasonable given the marked distension and biliary sludge.

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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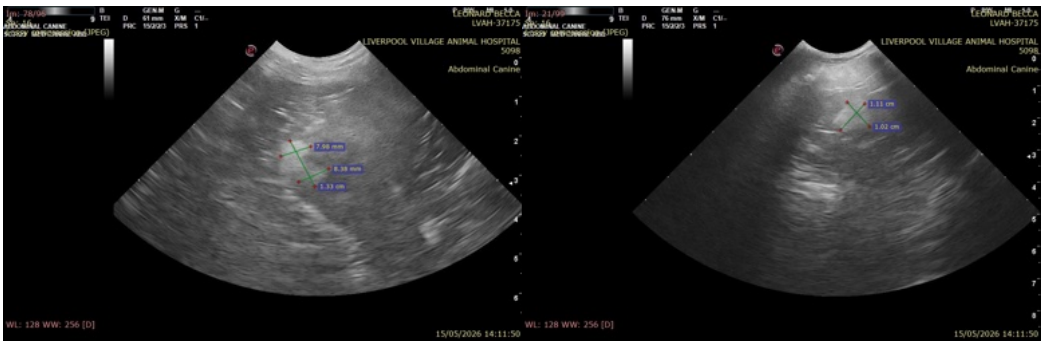
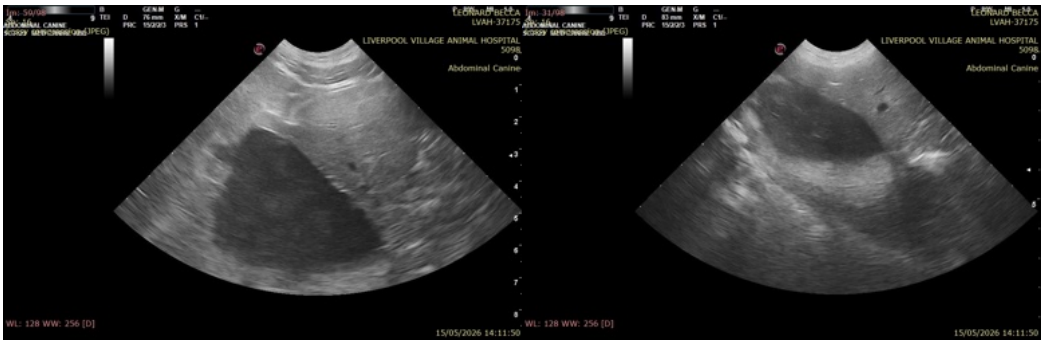
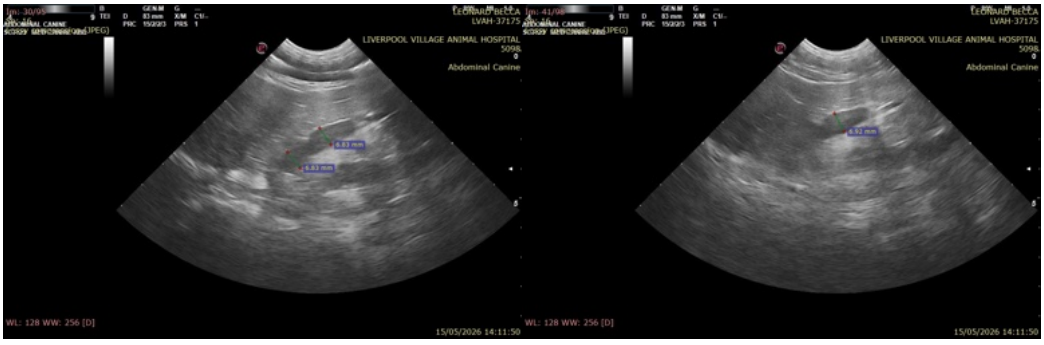
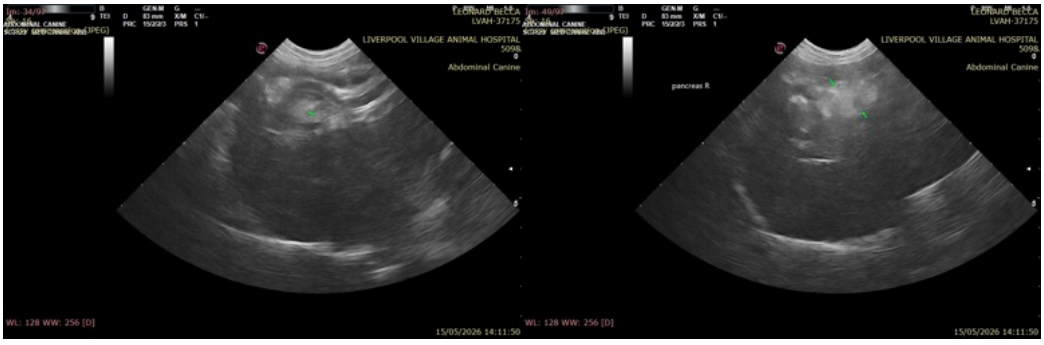


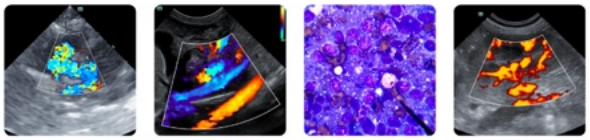






The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance please contact me.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com