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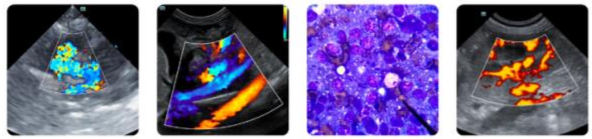


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Oskar Adams

SPECIES
Canine

BREED
Corgi Mix

SEX
Neutered Male

AGE
9 Years

WEIGHT
30.6 lbs

INTERPRETED BY
Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY
Kristen Velasco

HOSPITAL NAME
Bethany Family Pet Clinic

REFERRING VET
Dr. Pow

INVOICE
16466

DATE
05/22/26

PRESENTING CLINICAL SIGNS

P had an acanthomatous ameleoblastoma on 306/307 and was completely excised via left mandibulectomy Dec 2025. Prior to the mandibulectomy, abdominal ultrasound was performed as part of staging at the specialist. A gall bladder mucocele was found. P was placed on Usodial and a hydrolyzed protein low fat diet for management. This is the first recheck ultrasound previously recommended.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. No calculi or sonographic evidence of inflammatory or neoplastic mural changes are identified.

The left kidney is normal in shape and size, measuring 5.24×2.76 cm, with a cortical thickness of 0.46 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 5.15×2.82 cm, with a cortical thickness of 0.44 cm in the sagittal plane.

Both kidneys: Renal cortical echogenicity is within normal limits bilaterally. The corticomedullary ratio is normal, and corticomedullary definition is preserved. No evidence of pyelectasia, nephrolithiasis, ureteral dilation, or hydronephrosis is identified. Color Doppler interrogation demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland is normal in size and echogenicity, measuring 0.51 cm at the cranial pole and 0.52 cm at the caudal pole. The right adrenal gland is not confidently visualized on the current examination.

Spleen

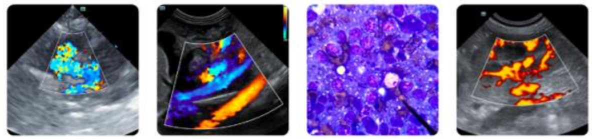
Splenic thickness is 1.04 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively mildly enlarged, with a regular contour. The hepatic parenchyma is mildly diffusely hyperechoic relative to the renal cortex, with a fine homogeneous echotexture. A cystic lesion measuring up to 2.23×1.12 cm is identified within the hepatic parenchyma. No hepatic lymphadenopathy is identified.

The gallbladder is normally distended. The gallbladder wall demonstrates mucosal/mucinous glandular hyperplastic change. A large amount of echogenic biliary sludge/inspissated bile is present within the lumen. No convincing dilation of the cystic duct or common bile duct is identified.

Gastrointestinal tract



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The stomach contains ingesta. Gastric wall thickness measures 2.08 mm, with preserved wall layering. The pyloric wall measures 5.13 mm.

The duodenal wall measures 3.17–4.08 mm. The jejunal wall measures 4.56 mm, with preserved wall layering throughout the evaluated small intestinal tract. No sonographic evidence of gastrointestinal obstruction, focal mural mass lesion, inflammatory corrugation, or foreign material is identified.

The colon measures 1.26 mm in wall thickness and contains formed fecal material within the descending colon.

Pancreas

The evaluated pancreatic regions 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 is normal.

PRIMARY FINDINGS

- Persistent gallbladder sludge/inspissated bile with mucosal hyperplastic change.
- Mild diffuse hyperechoic hepatopathy/hepatomegaly.
- Stable hepatic cystic lesion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

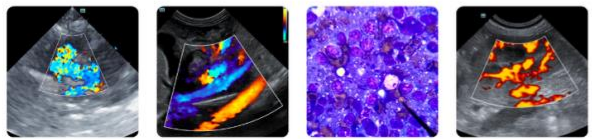
Compared with the prior abdominal ultrasound examination, the gallbladder abnormality persists and appears mildly progressive, now most consistent with early gallbladder mucocele-spectrum change characterized by mucosal hyperplasia and moderately organized inspissated biliary material/sludge accumulation. A classic advanced immobile stellate ("kiwi-like") mucocele pattern is not identified at this time.
There is currently no convincing sonographic evidence of extrahepatic biliary obstruction, gallbladder rupture, reactive peritonitis, gallbladder wall devitalization, or severe pericholecystic inflammatory change. The absence of biliary ductal dilation and lack of surrounding inflammatory reaction are reassuring features at this stage.

The mild diffuse hyperechoic hepatopathy and mild hepatomegaly remain most compatible with chronic vacuolar hepatopathy/reactive hepatocellular change and appear biologically similar to the previously described hepatic changes. The hepatic cystic lesion remains present without aggressive ultrasonographic characteristics and most likely represents a benign chronic cystic hepatic lesion.

Overall, the examination supports persistent chronic gallbladder disease with early mucocele-spectrum development, without current evidence of biliary obstruction or impending rupture. Continued medical management and close ultrasonographic monitoring appear reasonable provided the patient remains clinically stable and clinicopathologic parameters remain acceptable.

Recommendations

- Correlation with pending serum biochemistry, including liver enzymes, bilirubin, cholesterol, and triglycerides, is recommended.
- Continued ursodiol therapy and dietary management appear reasonable given the current



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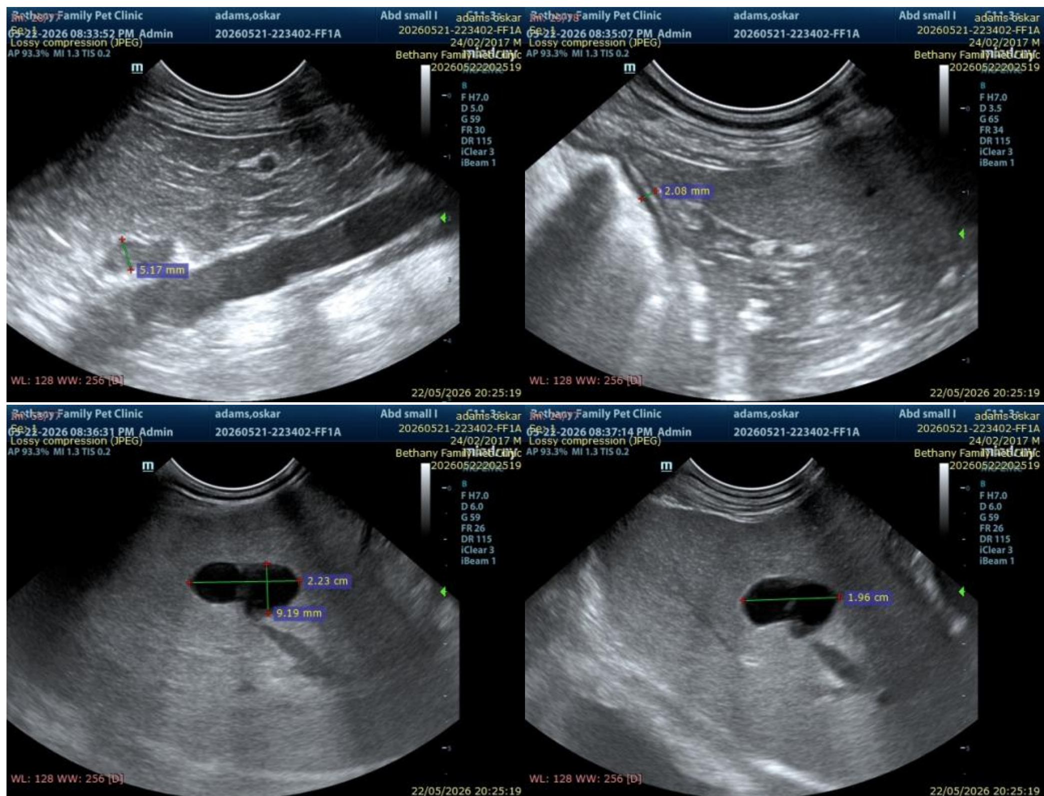
sonographic appearance and absence of obstructive biliary disease.

- Serial ultrasonographic monitoring of the gallbladder is recommended to assess for progression toward a more organized/advanced mucocele pattern, biliary obstruction, gallbladder wall devitalization, or pericholecystic inflammatory change.

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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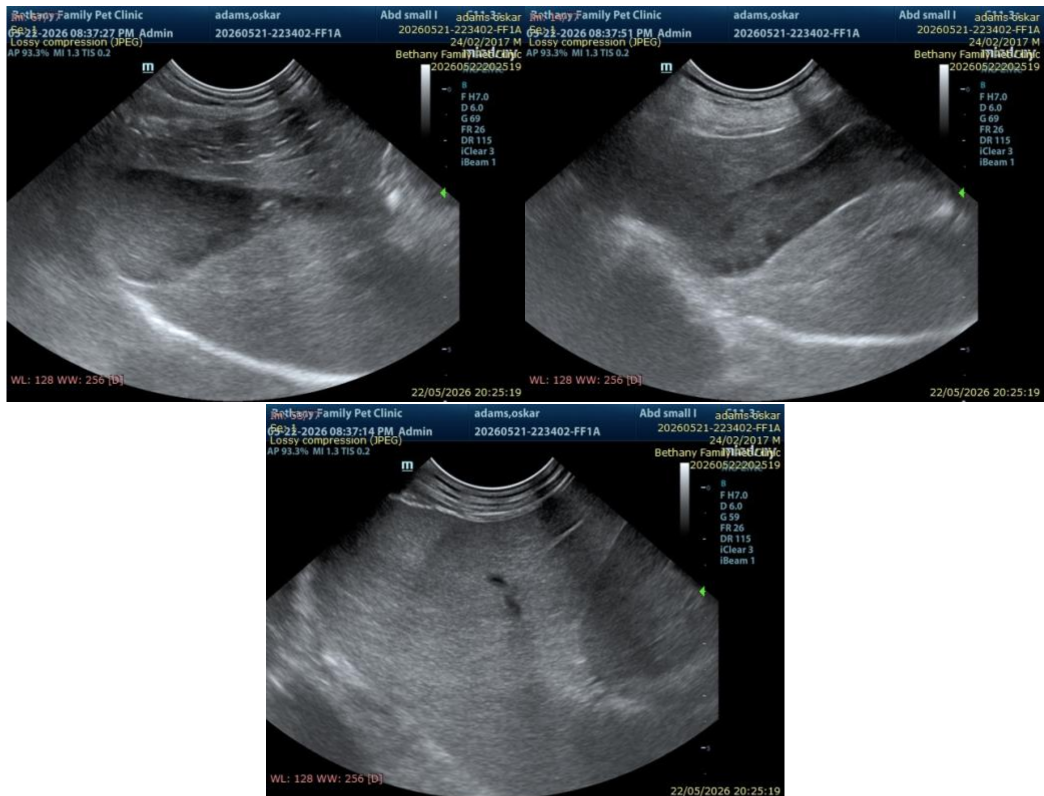

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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