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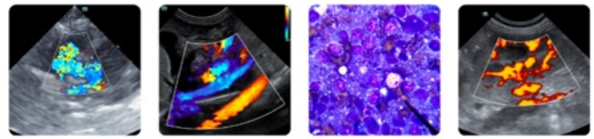


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Bowie Oso Bonilla

SPECIES

Canine

BREED

Chihuahua

SEX

Neutered male

AGE

4 years

WEIGHT

7.05 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Julia Wiederholt

HOSPITAL NAME

Dreaming Summit AH

REFERRING VET

Dr. Wiederholt

INVOICE

78027

DATE

5/27/26

PRESENTING CLINICAL SIGNS

History of acute onset vomiting in early February 2026 with elevated ALT, GGT. Debris within GB noted as possible emerging mucocele. Cholecystectomy discussed but as patient responded well to medical management, monitoring labs and US opted instead. Currently on 60mg Urodiol once daily as well as Denamarin. Clinically doing great - eating/drinking normally, no vomiting/diarrhea.
Abnormal PE/Chem/CBC/UA Results: 2/11 ALT >1000. 2/18 ALT 608. *Chem21 w/ SDMA pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the urinary bladder wall measures approximately 1.93 mm in thickness and appears smooth. Given the degree of bladder distension, mild overestimation of wall thickness is possible. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no ultrasonographic evidence of inflammatory or neoplastic change.

The left kidney is normal in shape and size, measuring 3.62×2.00 cm, with cortical thickness measuring 0.28 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates a subjectively normal vascular pattern.

The right kidney is normal in shape and size, measuring 3.39×1.94 cm, with cortical thickness measuring 0.30 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates a subjectively normal vascular pattern.

Adrenal Glands

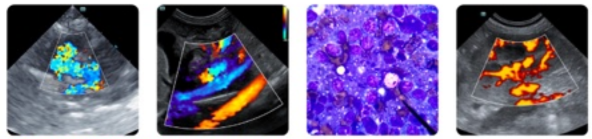
Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.44 cm at the cranial pole and 0.47 cm at the caudal pole. The right adrenal gland measures 0.45 cm at the cranial pole and 0.40 cm at the caudal pole.

Spleen

Splenic thickness is 1.12 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. Within what appears to represent the region of the left hepatic lobes, adjacent to the diaphragmatic hepatic margin,



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a focal well-defined heterogeneous parenchymal lesion measuring approximately 2.44 ×1.46 cm is identified. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended. The gallbladder wall measures approximately 1.17 mm in thickness. A moderate amount of biliary sludge occupies approximately 50% or slightly more of the gallbladder lumen. Part of the sediment is mobile and gravity-dependent, while additional portions appear more organized and mildly heterogeneous with multifocal rounded hypoechoic mucoid-type aggregates/sludge concretions. No convincing cystic duct or common bile duct dilation is identified.

Gastrointestinal tract

The stomach is empty and folded, with wall thickness measuring approximately 2.59 mm and preserved wall layering. The pylorus measures 3.22 mm in wall thickness. The duodenum measures 3.01 mm in wall thickness. The jejunum measures approximately 2.13-2.61 mm in wall thickness with preserved mural layering. No intestinal inflammatory change, obstructive pattern, ileus, or foreign material is identified. The colon measures approximately 0.76-0.99 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.

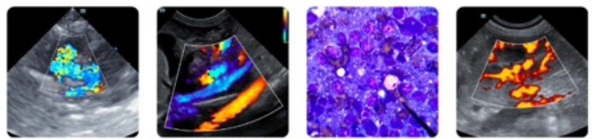
PRIMARY FINDINGS

- Moderate biliary sludge accumulation with partially organized/mucoid-appearing intraluminal sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Compared with the previously described marked hepatobiliary episode associated with severe ALT elevation and suspected early gallbladder disease, the current examination demonstrates persistent moderate biliary sludge accumulation with partially organized/mucoid intraluminal material. Portions of the sediment remain mobile and gravity-dependent, while other regions demonstrate a more structured heterogeneous appearance suggestive of early mucoid organization/biliary inspissation.

At this time, there is no convincing ultrasonographic evidence of complete gallbladder mucocele formation, extrahepatic biliary obstruction, gallbladder rupture, or secondary pancreatitis. The lack of progressive biliary duct dilation, preserved gallbladder wall appearance, improving clinical status, and improving liver enzyme trends are reassuring.



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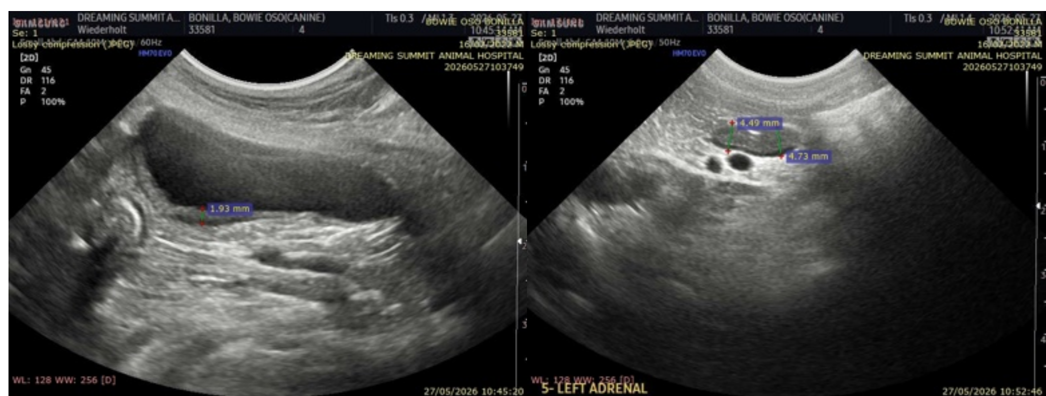
However, given the patient's prior severe hepatobiliary enzyme elevation and the partially organized appearance of portions of the gallbladder contents, evolving gallbladder mucocele spectrum disease or chronic biliary dysmotility/cholestatic disease remains a realistic concern and continued close monitoring is warranted.

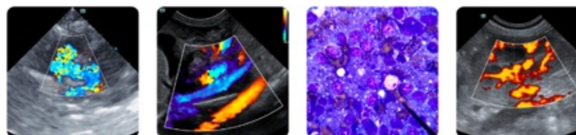
A well defined focal heterogeneous parenchymal region is also identified within the left medial liver lobe. The significance of this finding is uncertain, and focal prior hepatocellular injury/necrosis, or localized periportal/hepatocellular remodeling secondary to the previous hepatobiliary episode, focal reactive hepatopathy, or regional regenerative change are considered.

Recommendations

- Continued serial monitoring of liver enzymes, bilirubin, gallbladder ultrasonographic appearance, and overall clinical status is recommended.
- Continued medical management with ursodiol/hepatoprotective therapy appears reasonable given the current clinical improvement and absence of obstructive biliary disease.
- Ultrasonographic follow-up of the focal hepatic parenchymal alteration is recommended to assess stability, progression, or resolution over time. Re-evaluation with color Doppler interrogation is also recommended to further assess lesion vascularity and better characterize the regional hepatic architecture over time.
- Ultrasound-guided sampling could be considered if the lesion enlarges, becomes more structurally defined, liver enzymes worsen again, or clinical signs recur, although lesion depth/location may currently limit sampling accessibility.
- Surgical consultation/cholecystectomy may ultimately become necessary if progressive organization of gallbladder contents, biliary obstruction, recurrent hepatobiliary episodes, or clinical instability develops.

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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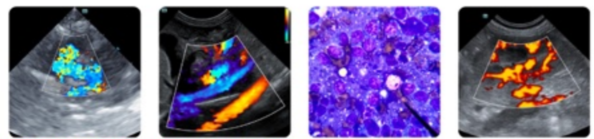

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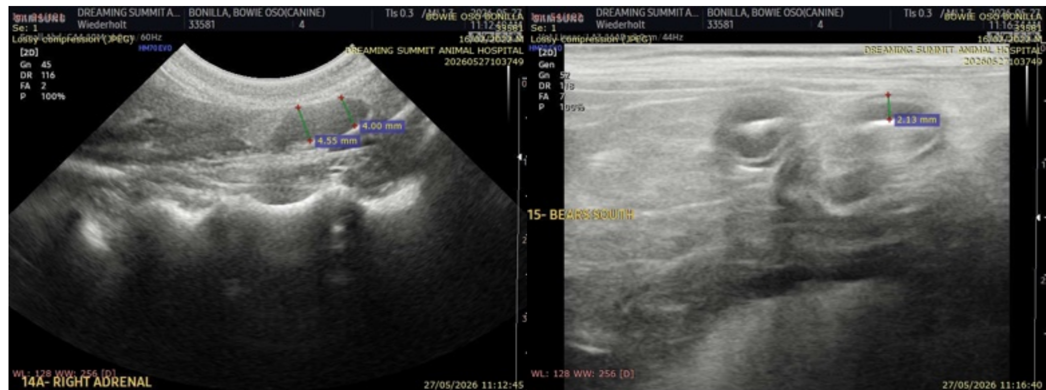

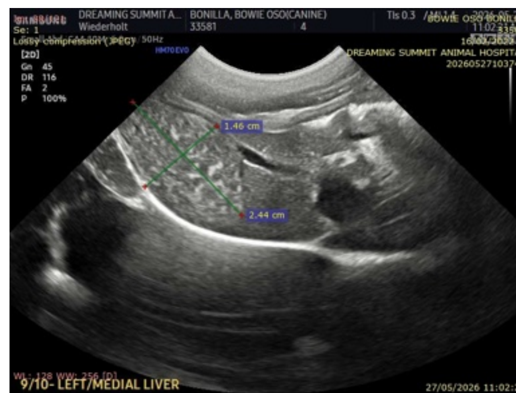

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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