



PATIENT

Jersey O'Toole

SPECIES

Canine

BREED

Mixed

SEX

Spayed female

AGE

12 years

WEIGHT

54 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

John Ammeraal, DVM

HOSPITAL NAME

Sova

REFERRING VET

Dr. Ammeraal

INVOICE

78110

DATE

5/29/26

PRESENTING CLINICAL SIGNS

History: Clinically doing well at home. No concerns. Abnormal lab findings are reason for exam
Abnormal PE/Chem/CBC/UA Results: Few fatty masses trunk Chem 27 ALT 465 U/L , ALKP 224 U/L
AST 84 U/L Globulin 4.2 g/dL T4 1.9 ug/dL CBC Normal Accuplex neg, Chronic Lyme positive rest ne

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is underdistended, and the urinary bladder wall appears diffusely thickened. Along the ventral bladder wall, multiple irregular polypoid mural proliferations are identified protruding into the lumen. The urine is anechoic. The bladder neck and proximal urethra appear unremarkable. No cystoliths are identified.

The left kidney is normal in shape and size, measuring 7.09×3.26 cm, with a cortical thickness of 0.76 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 7.13×4.14 cm, with a cortical thickness of 0.80 cm in the sagittal plane. Both kidneys demonstrate normal cortical echogenicity relative to the liver. Corticomedullary distinction and corticomedullary ratio are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler evaluation 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 0.77 cm at the cranial pole and 0.70 cm at the caudal pole. The right adrenal gland measures 0.97 cm at the cranial pole and 0.81 cm at the caudal pole.

Spleen

Splenic thickness measures 1.79 cm. The splenic parenchyma is otherwise homogeneous with normal echogenicity. Two small hypoechoic splenic nodules are identified, measuring 6.23×8.15 mm and 4.16×9.60 mm. 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 demonstrates a heterogeneous, patchy echotexture characterized by poorly defined multifocal hypoechoic regions, resulting in a diffuse remodeling-type appearance. No discrete hepatic nodules or mass lesions are identified. No hepatic hilar lymphadenopathy is observed.

The gallbladder is normally distended. The wall is thin and smooth. A small amount of dependent biliary sludge is present. No sonographic evidence of cystic duct or common bile duct dilation is identified.



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Gastrointestinal tract

The stomach is empty and folded, with a small amount of intraluminal gas. Gastric wall thickness measures 2.07 mm with preserved wall layering. The duodenal wall measures 1.63 mm. Jejunal wall thickness ranges from 2.19–2.94 mm, with preserved wall layering throughout. The colon measures 0.86 mm and contains a small amount of formed fecal material within the descending colon. No evidence of gastrointestinal obstruction, ileus, focal mural mass, or inflammatory mural thickening is identified.

Pancreas

Although the pancreas was not clearly visualized during this examination, no significant abnormalities are identified in the expected region of the pancreas.

Free Abdomen

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

PRIMARY FINDINGS

- Diffuse urinary bladder wall thickening with an irregular polypoid proliferative lesion arising from the ventral urinary bladder wall.
- Diffuse heterogeneous hepatic parenchymal remodeling pattern.
- Mild right adrenomegaly. Left adrenal gland in the upper limit.

SECONDARY FINDINGS

- Two small hypoechoic splenic nodules.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Irregular polypoid proliferative lesions associated with the ventral urinary bladder wall are present. Differential considerations include polypoid cystitis, chronic inflammatory mucosal hyperplasia, and less likely urothelial neoplasia such as transitional cell carcinoma. The ventral location and multifocal polypoid morphology may favor an inflammatory/reactive process; however, ultrasound alone cannot reliably distinguish benign proliferative disease from early neoplasia.

The liver demonstrates a diffuse heterogeneous remodeling pattern without a discrete mass lesion. This appearance is nonspecific and may be associated with chronic hepatocellular remodeling, vacuolar change, chronic inflammatory hepatopathy, fibrosis, nodular regenerative change below sonographic resolution, or other diffuse hepatopathies.

The small splenic hypoechoic nodules are nonspecific and may represent benign nodular hyperplasia, extramedullary hematopoiesis, or lymphoid hyperplasia. In the absence of additional aggressive splenic features, these are considered of low immediate concern.



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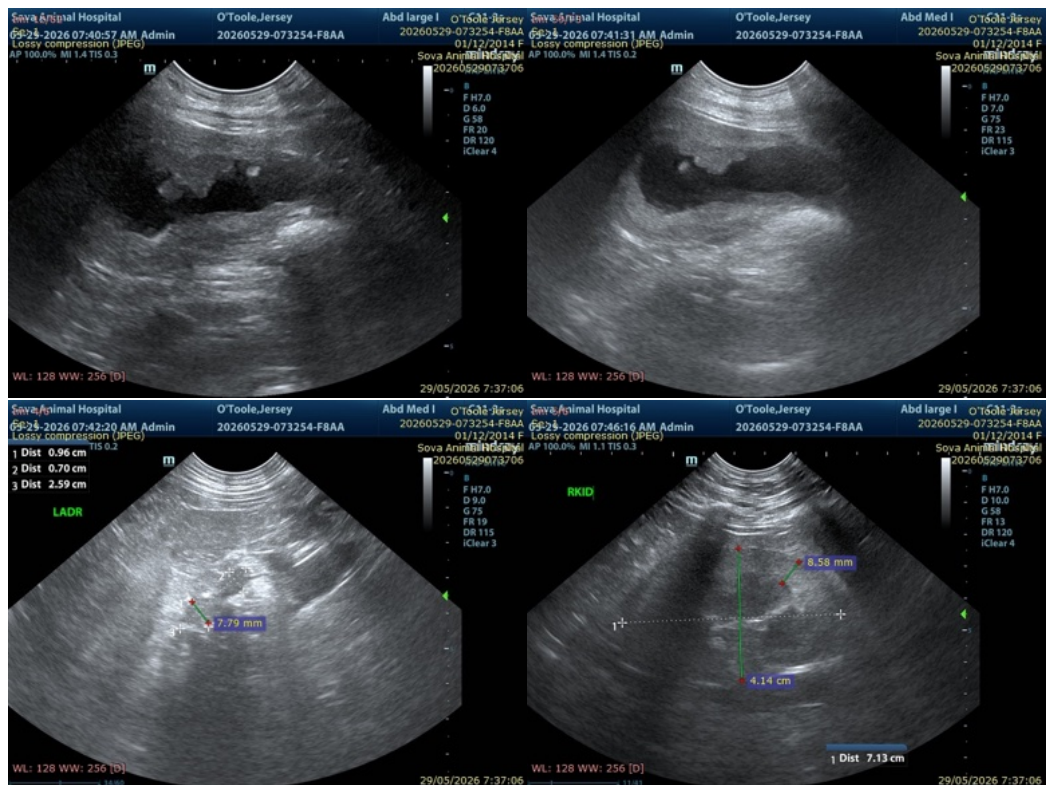
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Mild right adrenomegaly is present. The right adrenal gland measures 0.81 cm at the caudal pole, which is mildly above commonly reported upper reference limits for dogs of comparable size. Although nonspecific, this finding may be seen with adrenal hyperplasia or hyperadrenocorticism in the appropriate clinical setting. Correlation with clinical signs and endocrine testing may be considered if clinically warranted.

Recommendations

- Complete urinalysis with sediment examination and urine culture if not already performed.
- Consider traumatic catheterization cytology, cystoscopic evaluation, or tissue sampling of the bladder lesions if clinical signs persist or neoplasia remains a concern.
- If further investigation of the hepatic changes is desired, bile acid testing may be considered to assess hepatic function. Cytologic or histopathologic sampling may also be considered for definitive characterization of the hepatic parenchymal remodeling pattern.
- Correlation with clinical signs suggestive of hyperadrenocorticism is recommended. Endocrine testing may be considered if clinically indicated.

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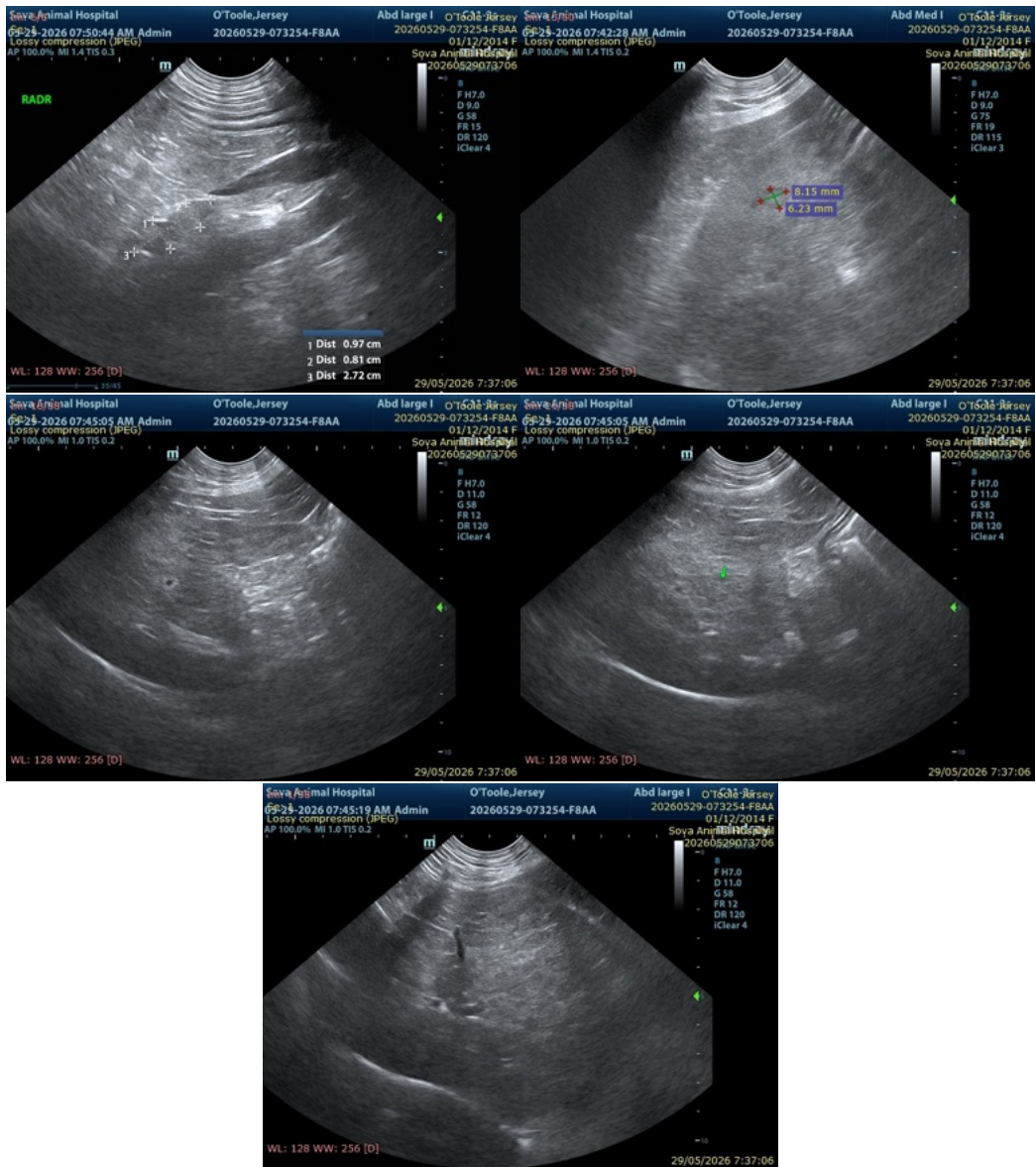
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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