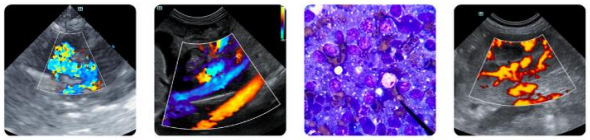


PATIENT

Lola Conner

SPECIES

Canine

BREED

Chihuahua Mix

SEX

FS

AGE

16yr

WEIGHT

14lb

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Beth Coe

HOSPITAL NAME

Riverside Animal Clinic

REFERRING VET

Dr. Heather Brenner

INVOICE

24772

DATE

05/08/2026

PRESENTING CLINICAL SIGNS

History: Vomiting starting 5/5/26, through night. Ate small amount food 5/6 am, no vomit. Drinking normally.
Patient is one Lasix18.75mg BID, Pimobendan 1.875mg BID, and Enalapril 1.25mg BID for CHF - stable currently.
She is also currently on Denamarin 225mg SID off and on for years. Relatively consistent previous two months.
Abnormal PE/Chem/CBC/UA Results: 5/6/26: PE Euthermic, severe dental disease, tense cranial abdomen. Grade 3-4/6 murmur (left sided, systolic). HR 120bpm, lungs clear. Abdominal rads: Enlarged liver with rounded margins. Opacities kidneys. NSF otherwise. CBC: Elevated PLT. Otherwise WRI. Chem: ALT 2368, ALKP 1651, GGT 12, AST 324, Chol 328. TBili WRI. NSF otherwise (mild increased BUN, Glob) (***Chem in 12/2025: ALT 147, ALKP 357*** Otherwise WRI/NSF.) cPL: WRI/Normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended. The urinary bladder wall is thin and smooth. The urine is anechoic. The bladder neck and proximal urethra are unremarkable. No cystoliths or sonographic evidence of inflammatory or neoplastic urinary bladder disease are identified.

The left kidney is normal in shape and size, measuring 3.89×2.11 cm. Cortical thickness measures 0.46 cm in the sagittal plane. The renal cortex is isoechoic relative to the hepatic parenchyma.

The right kidney is normal in shape and size, measuring 3.52×2.18 cm. Cortical thickness measures 0.42 cm in the sagittal plane. A small cortical cyst measuring approximately 0.39–0.47 cm is identified.

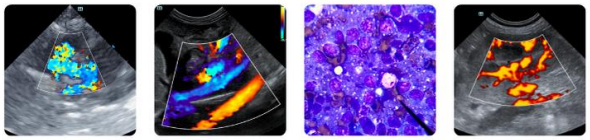
Both kidneys demonstrate preserved corticomedullary ratio and corticomedullary distinction. Mild multifocal nephrolithiasis is present, more apparent within the right kidney. No pyelectasia or hydronephrosis is identified. Color Doppler evaluation demonstrates a subjectively normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.89 cm at the cranial pole and 0.60 cm at the caudal pole. The right adrenal gland measures 0.77 cm at the cranial pole and 0.71 cm at the caudal pole.

Spleen

Splenic thickness is 1.10 cm. The splenic parenchyma demonstrates normal echogenicity and homogeneous fine echotexture with multiple small hyperechoic myelolipoma-like nodules, the largest measuring approximately 0.66×0.87 cm. The splenic capsule is smooth and regular. Splenic vasculature appears unremarkable.



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Liver

The liver is subjectively enlarged with preserved overall contour and relatively sharp margins. The hepatic parenchyma is predominantly homogeneous and isoechoic relative to the falciform fat, although mildly coarsened echotexture is present. Multiple small hyperechoic hepatic nodules/foci are identified, the largest measuring approximately 0.78×1.12 cm. Mild subjective dilation of the hepatic veins is also suspected. No hepatic lymphadenopathy is identified.

Gallbladder

The gallbladder is normally distended. Small intraluminal polypoid/mucosal projections compatible with mucosal hyperplasia or mucinous gland hyperplasia are present along the gallbladder wall. A large amount of biliary sludge is identified. The cystic duct/common bile duct region measures approximately 4.0–2.18–1.63 mm without convincing evidence of clinically significant biliary obstruction.

Gastrointestinal Tract

The stomach is empty and folded with small amounts of luminal fluid and gas. Gastric wall thickness measures approximately 2.99 mm with preserved mural layering.

The pyloric wall measures approximately 7.79 mm. Duodenal wall thickness measures approximately 3.35 mm. Jejunal wall thickness measures approximately 4.16 mm with preserved mural layering. The ileocecal junction is visualized. Mild focal mural thickening at the level of the cecum measures approximately 5.1 mm. No associated intraluminal mass, focal stenosis, or obstructive lesion is identified, and this finding may represent reactive or incidental mural change.

The colon measures approximately 2 mm in thickness and appears empty and mildly folded/redundant.

Pancreas

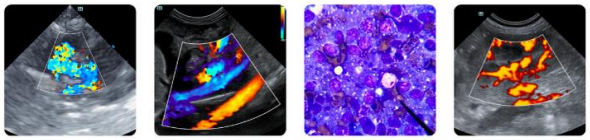
The pancreas measures approximately 7.50 mm in thickness. Pancreatic echogenicity is similar to the adjacent omental fat. No sonographic evidence of active peripancreatic inflammation is identified.

Free Abdomen

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

PRIMARY FINDINGS

- Mild bilateral adrenomegaly.



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- Hepatomegaly with mildly coarsened hepatic echotexture. Multiple small hyperechoic hepatic nodules/foci.
- Subjective mild hepatic venous distension.
- Gallbladder mucosal hyperplasia/polypoid change with marked biliary sludge.

SECONDARY FINDINGS

- Mild multifocal nephrolithiasis.
- Small right renal cortical cyst.
- Mild focal cecal mural thickening.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The combination of bilateral adrenal enlargement, hepatomegaly with mildly coarsened echotexture, marked biliary sludge accumulation, and gallbladder mucosal hyperplasia is most supportive of chronic metabolic/vacuolar hepatopathy, with hyperadrenocorticism representing an important differential consideration.
The multiple small hyperechoic hepatic nodules are nonspecific but most likely represent benign hepatocellular nodular change such as nodular hyperplasia and/or vacuolar regenerative change in this geriatric patient. No overt sonographic evidence of aggressive hepatic neoplasia is identified.
Mild subjective hepatic venous distension is also suspected. Given the patient's history of chronic congestive heart failure, a component of chronic hepatic venous congestion/congestive hepatopathy may additionally be contributing to the hepatic enlargement and biochemical abnormalities.

Marked biliary sludge and mild gallbladder mucosal hyperplasia are present without convincing ultrasonographic evidence of extrahepatic biliary obstruction or advanced gallbladder mucocele formation at this time.

Mild focal cecal mural thickening is present, with mildly reduced mural layer conspicuity in this region. No discrete mass effect, obstructive change, or associated regional inflammatory change is identified. This finding is nonspecific and may represent incidental or mild reactive change, although early inflammatory or infiltrative mural disease cannot be completely excluded sonographically.

No ultrasonographic evidence of acute pancreatitis is identified.

Recommendations

- Correlation with endocrine testing for hyperadrenocorticism could be considered if clinically appropriate.
- Serial monitoring of liver enzyme activity and hepatobiliary ultrasonographic changes is recommended.
- Continued hepatobiliary support therapy, including consideration of ursodeoxycholic acid (ursodiol), together with monitoring for progression of gallbladder disease, may be beneficial.
- Repeat abdominal ultrasound should be considered if gastrointestinal signs worsen or if there is concern for progression toward gallbladder mucocele formation or biliary obstruction. Re-evaluation of the mild focal cecal mural thickening for long-term stability could also be performed during future follow-up examinations.

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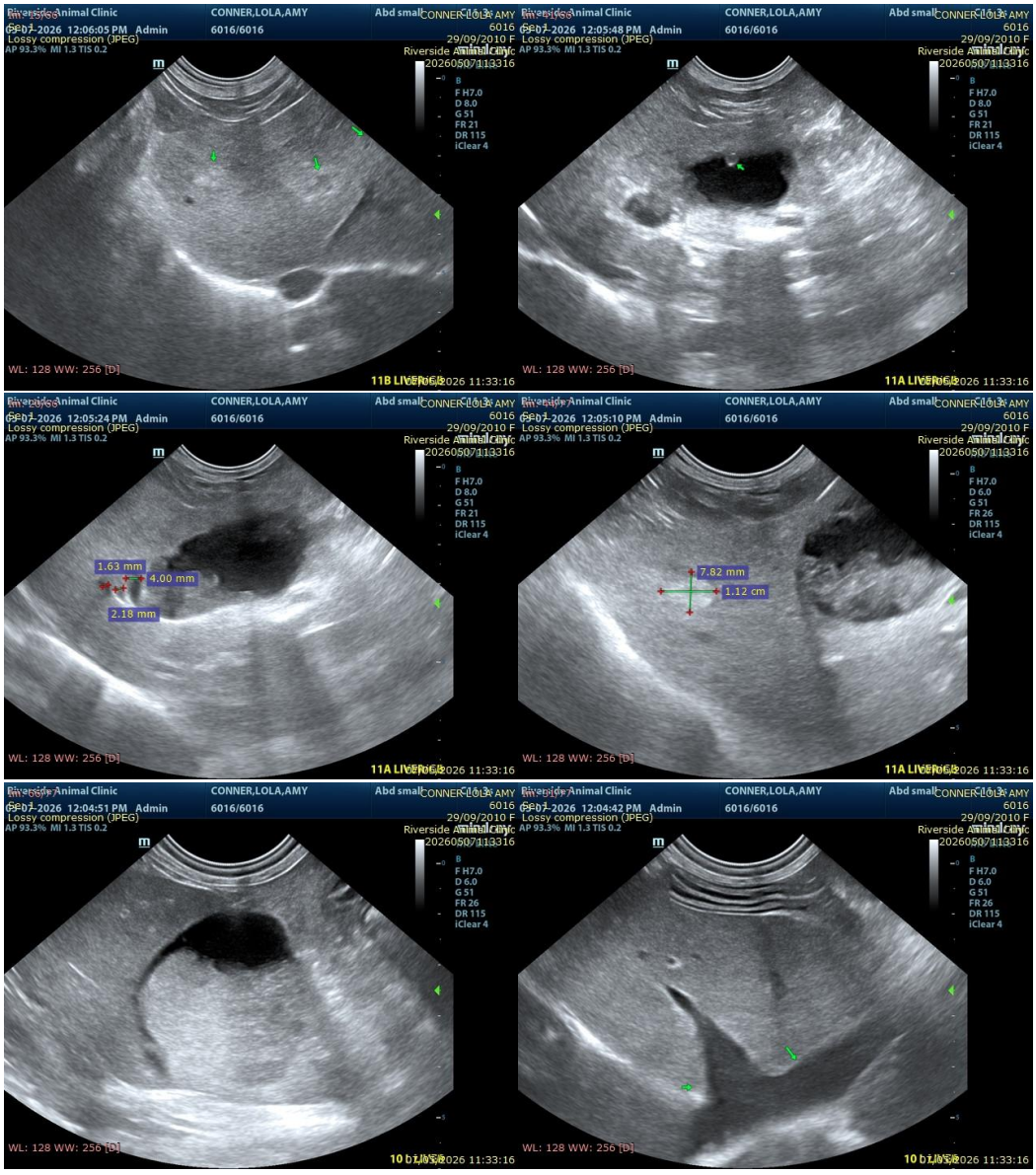
Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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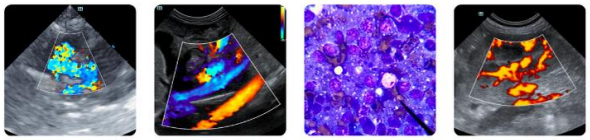

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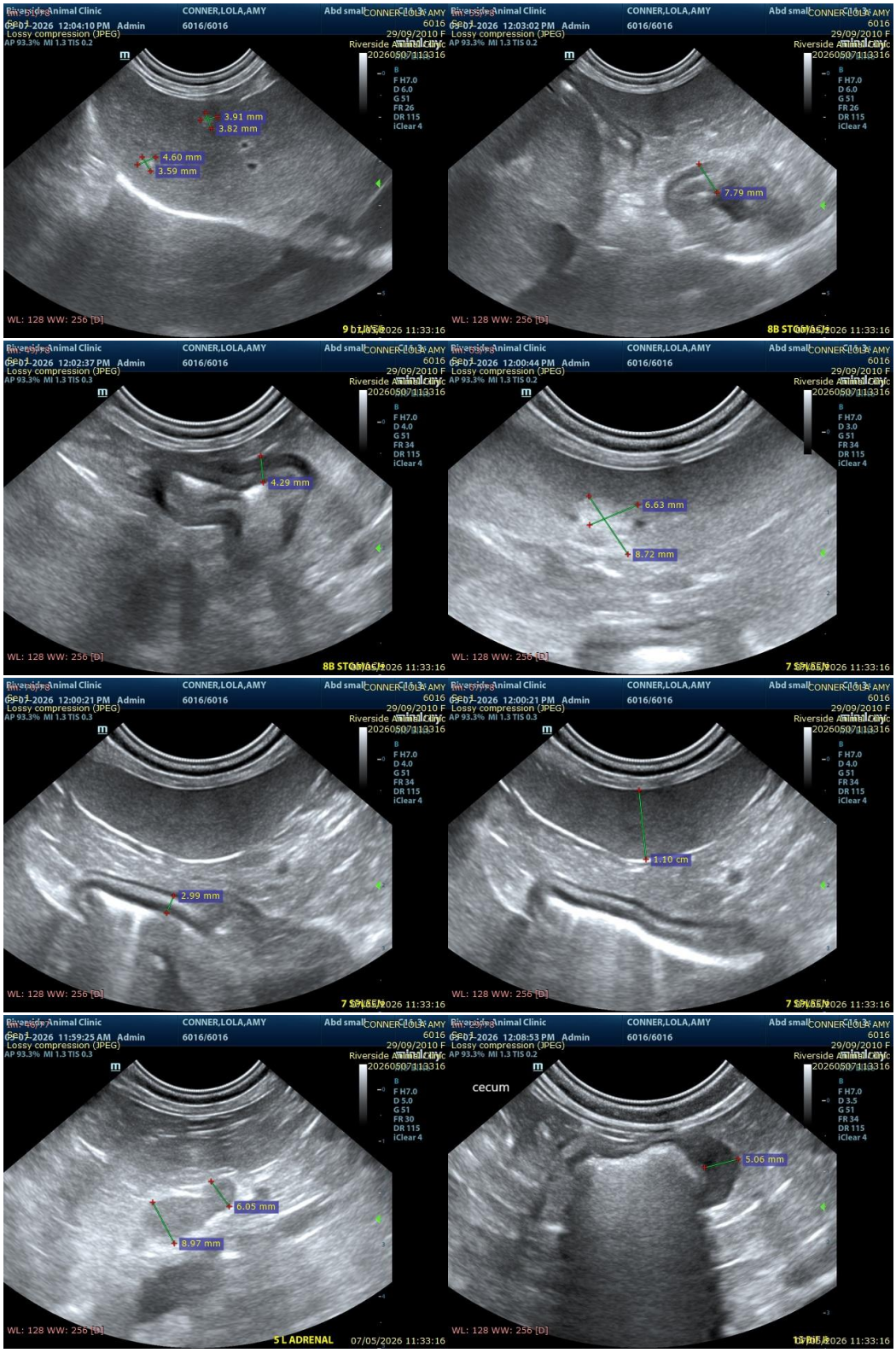

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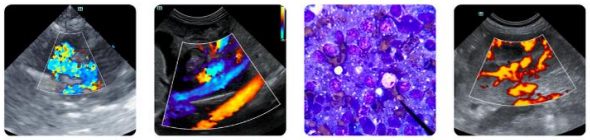

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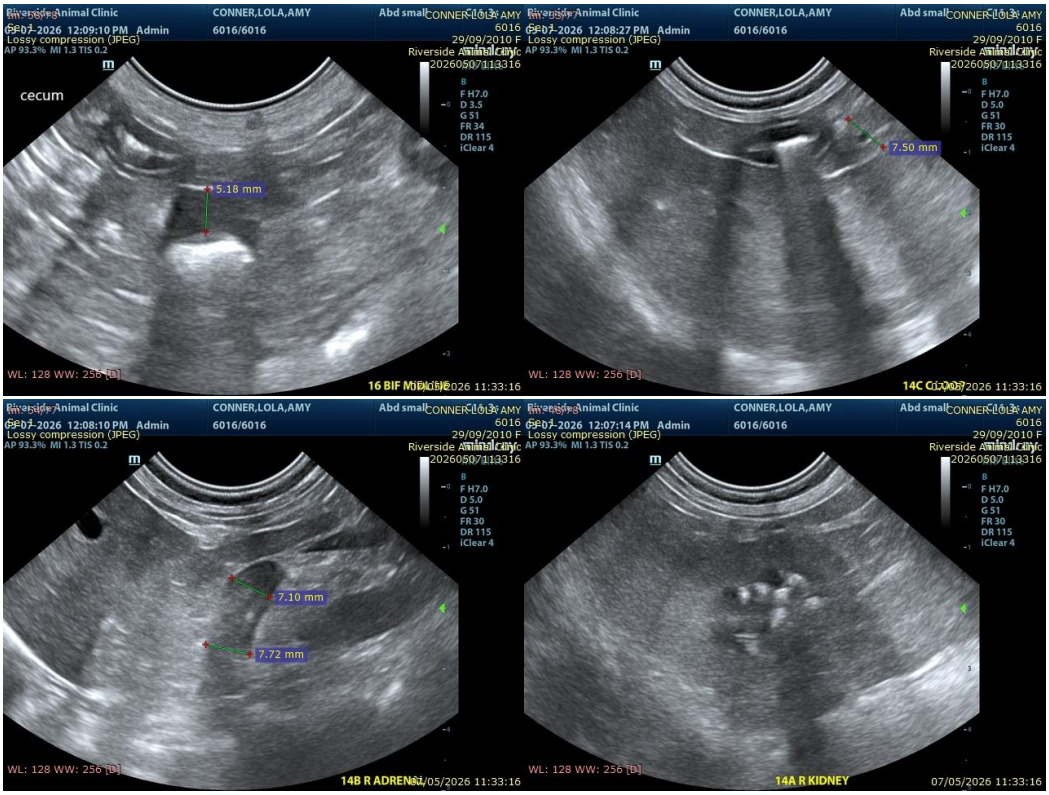

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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