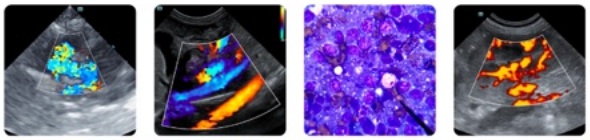


PATIENT

Hope Murphy

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Spayed female

AGE

5 years

WEIGHT

13.6 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Allen

HOSPITAL NAME

Montville AH

REFERRING VET

Dr. Schubert

INVOICE

78796

DATE

6/17/26

PRESENTING CLINICAL SIGNS

History: history - 2 day history of diarrhea and lethargy and inappetence, exam findings unremarkable, patient has a history of FB surgery, is on a GI sensitive stomach diet for history of GI issues , no pain on palpation, normal CPL snap. 3 view abdominal rads NAF, no UA performed
serum noted icteric
Lymphopenia. Eosinopenia. Mild anemia. elevated ALKP

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The left kidney is normal in shape and size, measuring 3.74×2.25 cm, with a cortical thickness of 0.32 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 4.03×1.84 cm, with a cortical thickness of 0.39 cm in the sagittal plane.

Both kidneys demonstrate normal cortical echogenicity. Corticomedullary distinction and corticomedullary ratio are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler interrogation demonstrates a normal vascular pattern.

Adrenal Glands

The visualized adrenal glands are normal in size, shape, and echogenicity. Dorsoventral diameters measured in the sagittal plane:

The left adrenal gland measures 0.46 cm at the cranial pole and 0.42 cm at the caudal pole.

The right adrenal gland is partially visualized and measures 0.43 cm at the caudal pole.

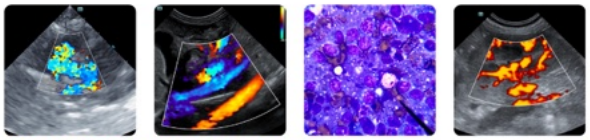
Spleen

Splenic thickness is 1.02 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 margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the surrounding falciform fat, with a normal echotexture. No focal hepatic lesions are identified. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The gallbladder wall is diffusely thickened, measuring 2.27 mm. Multiple small polypoid mural projections are present along the gallbladder wall. The lumen



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contains a moderate amount of non-shadowing biliary sludge. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal tract

The stomach is empty and folded, containing a moderate amount of intraluminal gas. Gastric wall thickness measures 2.05 mm with preserved wall layering.

The pylorus measures 8.33 mm and maintains normal wall layering.

The duodenum measures 3.72 mm.

The jejunum measures 2.52-2.96 mm and demonstrates normal wall layering.

The colon measures 0.77-0.87 mm in wall thickness and contains semi-formed fecal material within the descending segment.

No focal gastrointestinal masses, obstructive lesions, or ultrasonographic evidence of enteritis are identified.

Pancreas

The pancreas is not confidently identified during this examination. No regional peritoneal effusion, mesenteric inflammation, or other secondary ultrasonographic evidence of pancreatitis is observed.

Free Abdomen

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

PRIMARY FINDINGS

- Diffuse gallbladder wall thickening (2.27 mm). Multiple small polypoid gallbladder mural projections. Moderate biliary sludge.
- Mild relative pyloric wall thickening.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary abnormality identified is chronic gallbladder disease characterized by diffuse mural thickening, multiple small polypoid mural projections, and moderate biliary sludge accumulation. These findings are most consistent with chronic gallbladder mucosal hyperplasia, cholesterolosis-like change, chronic cholecystopathy, or early polypoid degeneration of the gallbladder wall. No ultrasonographic evidence of gallbladder mucocele formation, extrahepatic biliary obstruction, or ascending biliary disease is identified.

The liver appears normal in size and echotexture, and no ultrasonographic evidence of clinically

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significant hepatopathy is detected.

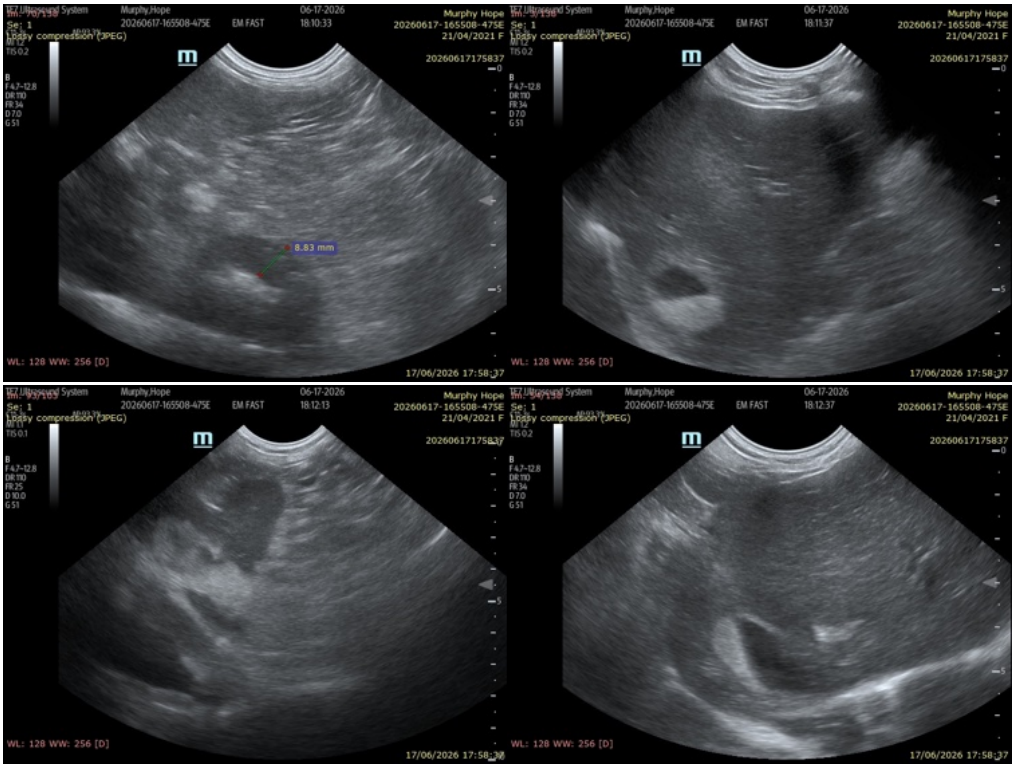
Relative pyloric wall thickening is noted. Although this is favored to reflect physiologic contraction and luminal collapse, mild inflammation cannot be completely ruled out.

The pancreas was not visualized. However, no secondary ultrasonographic changes suggestive of clinically significant active pancreatitis are identified. Mild or chronic pancreatic disease cannot be excluded based on ultrasound alone.

Recommendations

- Correlate the gallbladder findings with serum biochemistry, particularly ALP, GGT, ALT, bilirubin, cholesterol, and triglyceride concentrations.
- Consider medical management of chronic gallbladder disease (ursodeoxycholic acid where not contraindicated).
- If pancreatic disease remains a clinical concern, correlation with pancreatic lipase testing and clinical signs is advised, as the pancreas could not be directly evaluated during this examination.

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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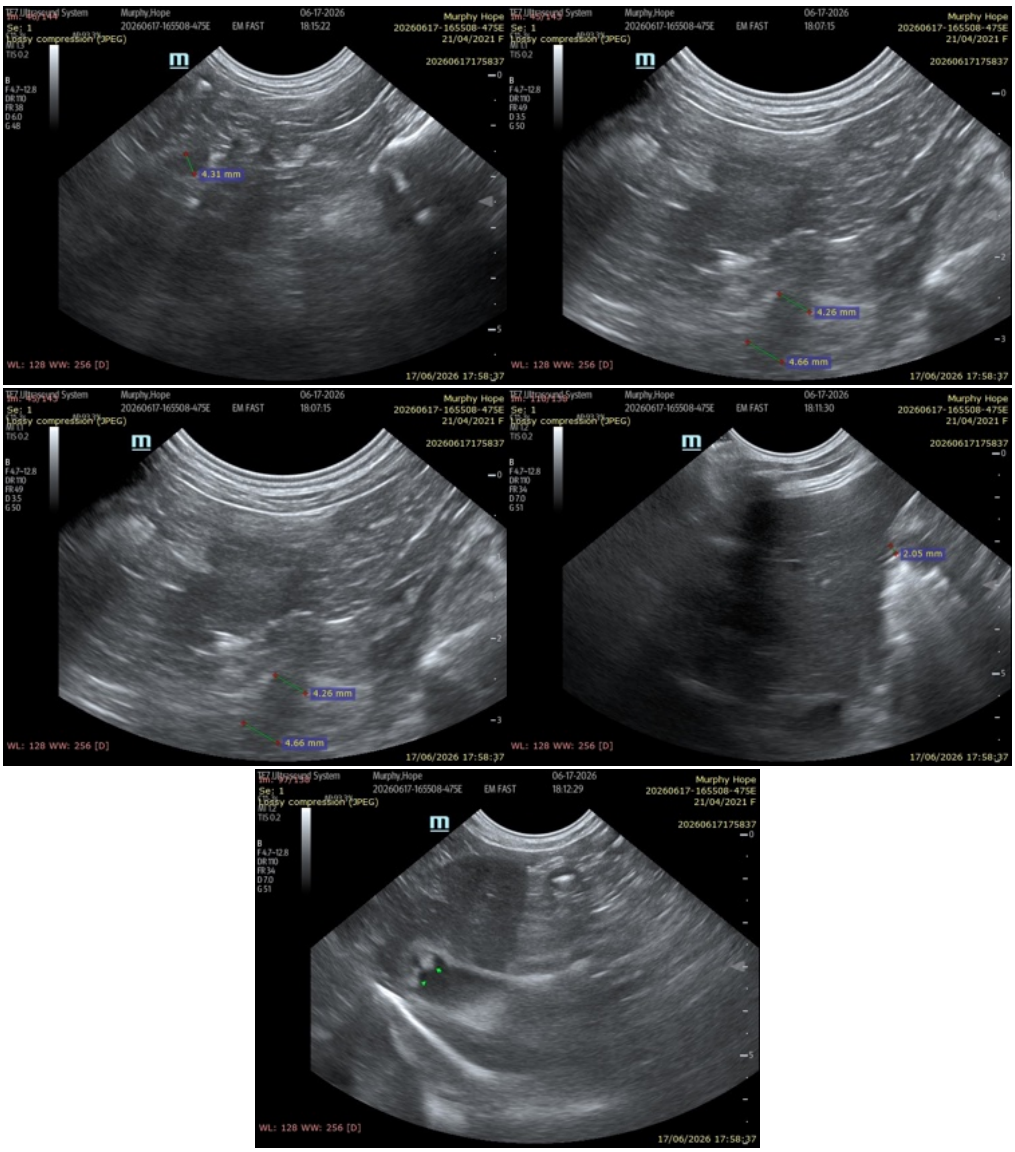

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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