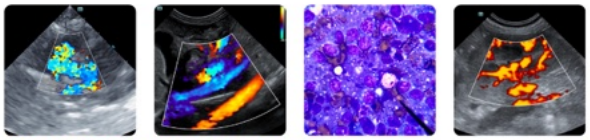


PATIENT

Yoda Cabrera

SPECIES

Canine

BREED

American Pitbull Terrier

SEX

Spayed female

AGE

12 years

WEIGHT

68 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Mario Valverde

HOSPITAL NAME

TLC AH

REFERRING VET

Dr. Mayra

INVOICE

78812

DATE

6/17/26

PRESENTING CLINICAL SIGNS

History: Patient initially presented on 06/01/2026 for evaluation of hematuria. Abdominal radiographs were recommended at that time but were declined by the owner. During an ultrasound-guided cystocentesis, multiple small mineralized structures consistent with cystoliths were visualized within the urinary bladder.
Laboratory findings included a Cystatin B concentration of 185 and urine specific gravity of 1.024. Urinalysis revealed marked proteinuria (+4), hematuria (+3), 15–20 RBCs/HPF, bacteriuria (rods 9–40/HPF), and ammonium magnesium phosphate crystals (+2; 6–20/HPF). CBC demonstrated hemoconcentration. Serum biochemistry revealed mild to moderate hepatocellular and cholestatic enzyme elevations, with ALT approximately 2× the upper reference limit and ALP approximately 4× the upper reference limit. Pre- and post-prandial bile acids were within normal limits.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is markedly underdistended. The urinary bladder wall measures approximately 4.20 mm in thickness; however, this measurement is likely overestimated due to the marked lack of luminal distension. Small echogenic intraluminal crystalline material is present. Evaluation of the bladder wall is limited by the degree of underdistension; however, no focal mural are identified.

The left kidney is normal in shape and size, measuring 6.65×3.80 cm, with a cortical thickness of 0.65 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 6.25×3.71 cm, with a cortical thickness of 0.60 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.

Adrenal Glands

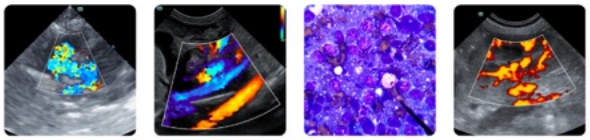
Dorsoventral diameters measured in the sagittal plane:

The left adrenal gland is partially visualized and measures 0.56 cm at the caudal pole.

The right adrenal gland is not visualized.

Spleen

Splenic thickness measures 2.02 cm. The splenic parenchyma demonstrates normal overall echogenicity and a fine homogeneous echotexture. Multiple small hypoechoic splenic nodules measuring less than 1 cm in diameter are present throughout the parenchyma. The splenic capsule is smooth and regular.



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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. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal tract

The stomach is poorly distended and folded. Gastric wall thickness measures approximately 7.0 mm with preserved wall layering. Subjectively, the gastric wall appears mildly thickened; however, assessment is limited by the collapsed state of the stomach.

The duodenum measures 3.12 mm and maintains normal wall layering.

The jejunum measures 2.91 mm and demonstrates normal wall layering.

No evidence of gastrointestinal obstruction, foreign material, focal mural masses, or ileus is identified.

The colon measures 0.79 mm in wall thickness and contains formed fecal material within the descending segment.

Pancreas

The pancreatic regions included in the examination 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

- Markedly underdistended urinary bladder containing a small amount of echogenic crystalline sediment.
- Mild subjective gastric wall thickening.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Evaluation of the urinary bladder is limited by marked underdistension. Small amounts of echogenic crystalline material are present within the lumen, consistent with the previously documented crystalluria. The marked proteinuria may be at least partially attributable to concurrent hematuria and lower urinary tract inflammation. Reassessment following resolution of the urinary tract disease may be warranted if clinically indicated.

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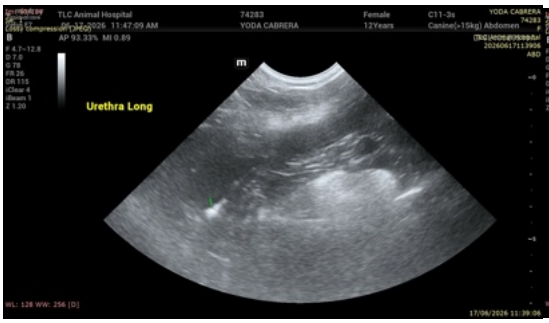
No convincing ultrasonographic explanation for the reported liver enzyme elevations is identified. The liver maintains a normal size, contour, and echotexture, and there is no evidence of clinically significant hepatobiliary disease. The combination of mild to moderate ALT and ALP elevation with normal bile acids may reflect early, mild, or diffuse hepatocellular disease below the threshold of ultrasonographic detection, vacuolar hepatopathy, enzyme induction, metabolic or endocrine disease, or other non-structural hepatic disorders. Importantly, normal ultrasonographic findings do not exclude clinically significant hepatic disease.

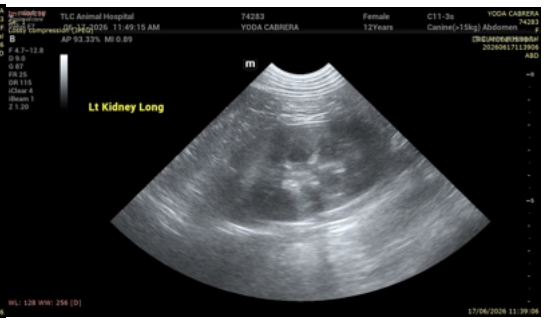
Mild diffuse gastric wall thickening is present. While gastric collapse may contribute to apparent mural thickening, the degree of thickening and subjective appearance of the gastric wall raises suspicion for inflamation. This finding is nonspecific and may reflect gastritis, mucosal edema, reactive change, medication-related gastropathy, or other diffuse gastric diseases. Correlation with clinical signs and medication history is recommended.

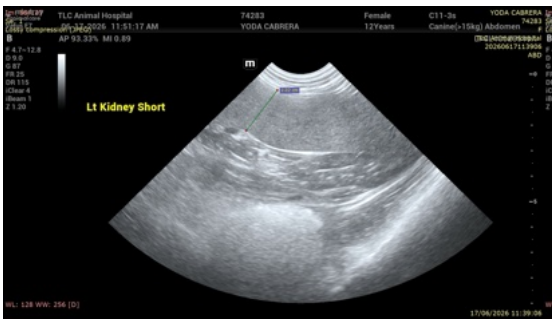
Recommendations

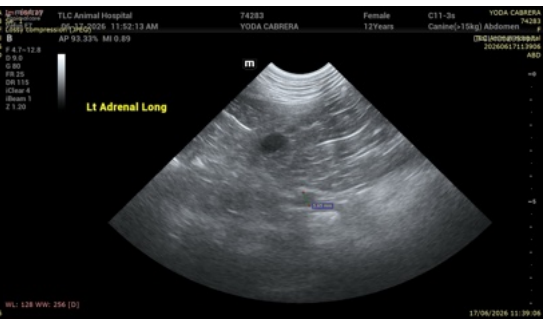
- Correlate the urinary findings with urinalysis, urine culture, and stone analysis if calculi are subsequently recovered.
- Consider repeat urinary bladder evaluation when the bladder is more adequately distended if hematuria persists or clinical signs worsen.
- Continue monitoring liver enzyme activities. Although no significant hepatobiliary abnormalities are identified ultrasonographically, normal ultrasound findings do not exclude clinically relevant hepatocellular disease.

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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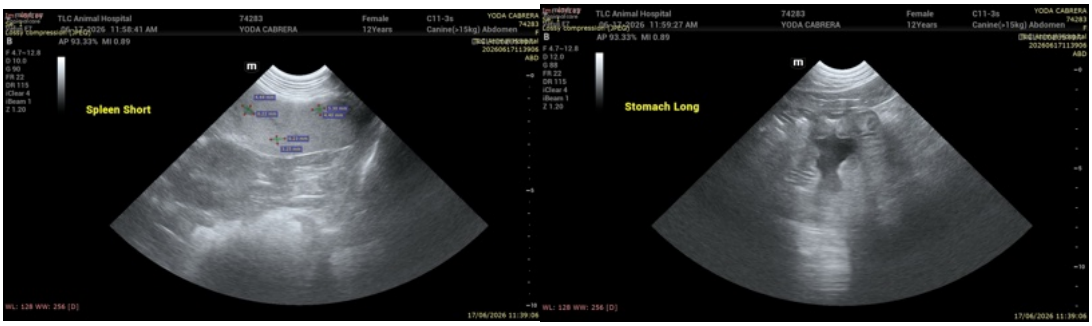

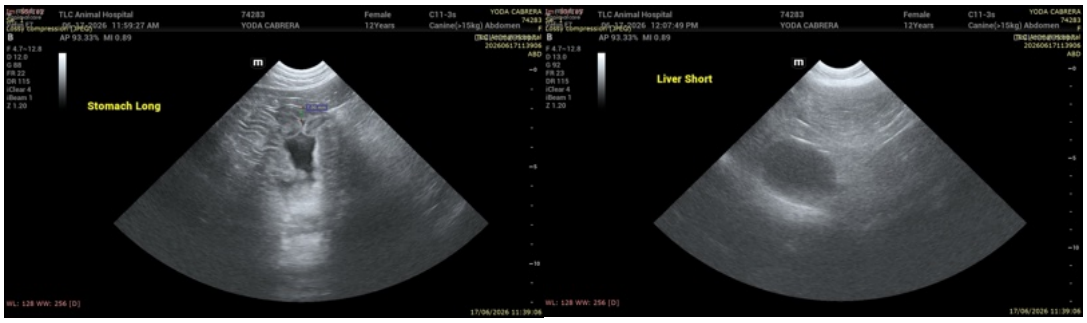

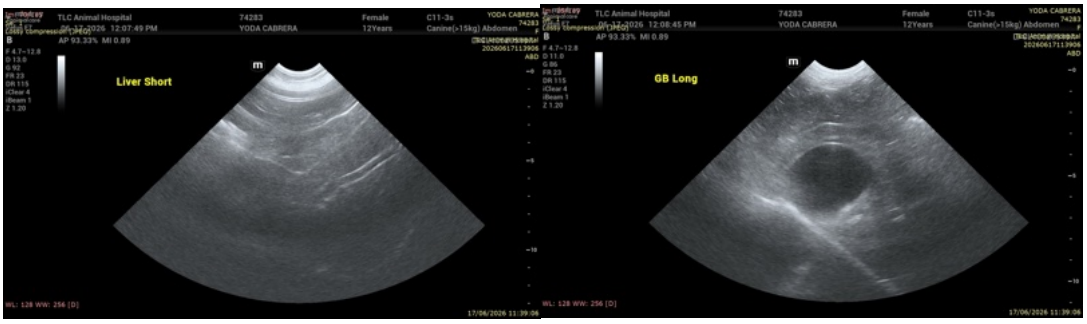

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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