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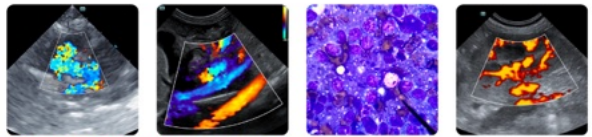


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Chloe Howarth

SPECIES
Canine

BREED
Labrador Retriever

SEX
Spayed female

AGE
10 years

WEIGHT
44.6 kg

INTERPRETED BY
Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY
Jessica Morgan RVT

HOSPITAL NAME
Oxford County VC

REFERRING VET
Dr. Lynes

INVOICE
78244

DATE
6/2/26

PRESENTING CLINICAL SIGNS

History: Presented 5/30/26 due to vomiting 3 times 2 days prior and 1x that morning. Vomit partially digested food and foamy white bile. Owners feel she is panting heavily, but in clinic she is always a very stressed, tense, and heavily panting dog. Skipped 1 meal the day before which is abnormal. Has had a foreign body ingestion in the past (carpet ingestion). Since Saturday, patient has vomited 1-2 more times and is not herself. Still examines BAR in clinic.
Abnormal PE/Chem/CBC/UA Results: Rectal temp 39.9*C 3v abdominal rads (included attachments): some areas of gas distension suspected in small intestine CBC, Chem 17, Lytes, cPL: MCV 59.2 (lower 61.6) MCH 20.8 (lower 21.3) Retic 21.6 (lower 22.3) MPV 14 (upper 13.2) TP 84 (upper 82) Glob 48 (upper 45) ALT 217 (upper 125) ALP 1325 (upper 212) - was 467 in May 2023 CPL wnl Attempted to scan patient with ultrasound to assess gallbladder but due to heavy panting I did not feel confident in what I was seeing, but did suspect seeing significant hyperechoic patterning in the GB indicative of GB sludge/mucocele.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no sonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 7.02×4.55 cm. A well-defined thin-walled anechoic cyst measuring approximately 4.42×4.34 cm is present at the caudal pole. The remaining renal parenchyma demonstrates normal echogenicity and preserved corticomedullary definition. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

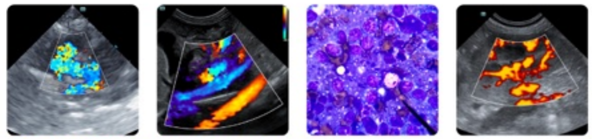
The right kidney is normal in shape and size, measuring 7.64×4.13 cm, with a cortical thickness of 0.71 cm in the sagittal plane. The cortex is isoechoic relative to the hepatic parenchyma. Corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The adrenal glands could not be confidently visualized.

Spleen

Splenic thickness is 1.90 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular. Splenic vasculature appears normal.



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Liver

The liver is mildly enlarged, with mildly rounded margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat, with a normal echotexture. No focal hepatic lesions or hepatic lymphadenopathy are identified.

The gallbladder lumen is normally distended. The wall is thin and smooth. A moderate amount of biliary sludge is present. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal tract

The stomach is empty and folded, with a mural thickness of 3.97 mm and preserved wall layering.

The pylorus measures 6.03 mm. The duodenum measures 4.76 mm and the jejunum measures 3.55 mm. Wall layering is preserved throughout the evaluated intestinal tract.

No sonographic evidence of gastrointestinal inflammation, obstruction, ileus, foreign material, or infiltrative intestinal disease is identified.

The colon measures 1.06 mm and contains formed fecal material within the descending segment.

Pancreas

The pancreas was only partially evaluated due to patient factors and imaging limitations. No overt pancreatic abnormalities were identified within the visualized portions; however, pancreatitis cannot be completely excluded.

Free Abdomen

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

PRIMARY FINDINGS

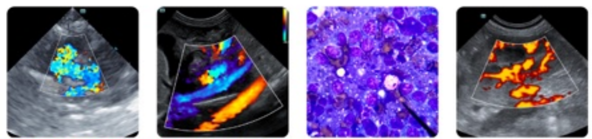
- Mild hepatomegaly with rounded hepatic margins and homogeneous hepatic echotexture.
- Moderate biliary sludge.

SECONDARY FINDINGS

- Large cyst arising from the caudal pole of the left kidney (4.42×4.34 cm).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild hepatomegaly with rounded hepatic margins and moderate biliary sludge are present. Although no sonographic evidence of gallbladder mucocele formation, biliary obstruction, or overt cholecystitis is identified, the hepatobiliary findings should be interpreted in conjunction with the patient's vomiting,



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fever, and marked liver enzyme elevations. An underlying hepatobiliary inflammatory process cannot be excluded.

A large simple cyst is present at the caudal pole of the left kidney. The lesion demonstrates benign ultrasonographic characteristics and is most consistent with a simple renal cyst. Although likely incidental, periodic monitoring and correlation with renal function are recommended.

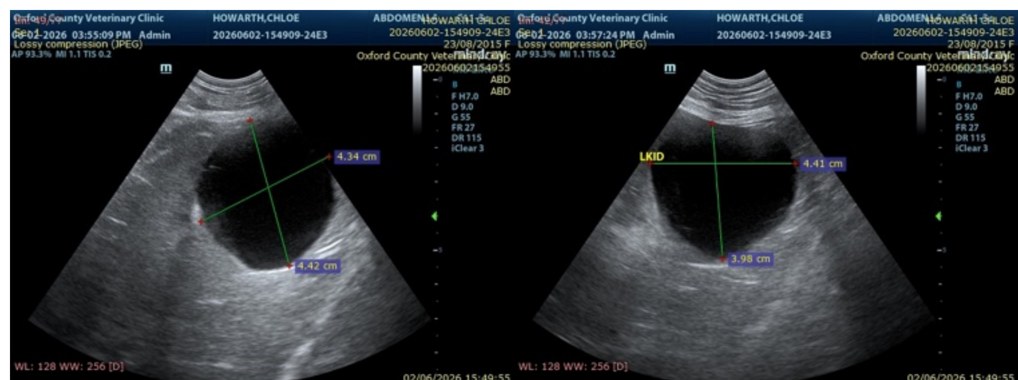
Although the pancreas was only partially evaluated, no overt pancreatic abnormalities were identified within the visualized portions. Furthermore, the normal cPL concentration and absence of secondary ultrasonographic findings commonly associated with pancreatitis (including peripancreatic fat inflammation, regional effusion, or peritonitis) make clinically significant pancreatitis a less likely explanation for the patient's fever and vomiting.

The cause of the patient's vomiting and fever is not definitively identified on this examination. No sonographic evidence of intestinal obstruction, foreign body disease, abdominal neoplasia, or other significant abdominal pathology is identified. However, evaluation of the colonic lumen is inherently limited by the presence of intraluminal contents, and foreign material intermixed with fecal matter cannot be completely excluded ultrasonographically.

Recommendations

- Symptomatic treatment for vomiting and fever is recommended at the discretion of the attending veterinarian.
- Hepatoprotective therapy and ursodeoxycholic acid may be considered given the hepatobiliary findings and marked liver enzyme elevations.
- Serial monitoring of liver enzyme activity is recommended. If liver enzyme elevations continue to worsen or clinical signs persist, further investigation may be warranted, including bile acids, and cytologic or histopathologic evaluation of the liver as clinically indicated.
- Periodic ultrasonographic monitoring of the gallbladder and left renal cyst is recommended.
- Endocrine testing for hyperadrenocorticism may be considered in the future if supported by the patient's clinical presentation or if liver enzyme abnormalities continue to progress.

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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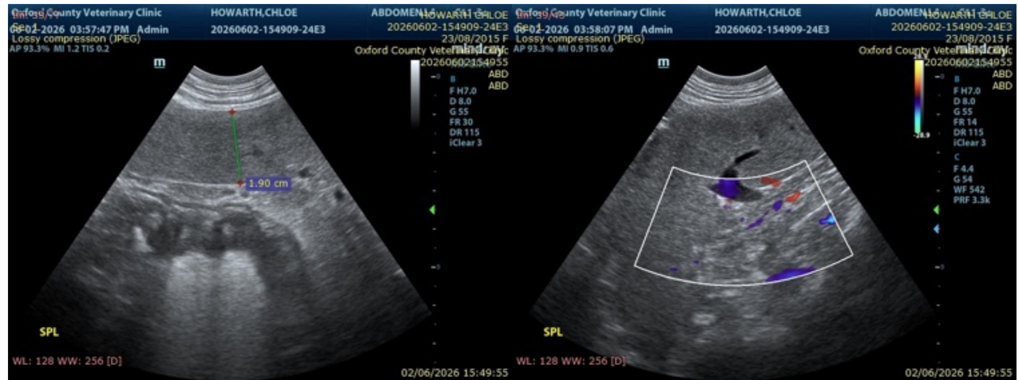

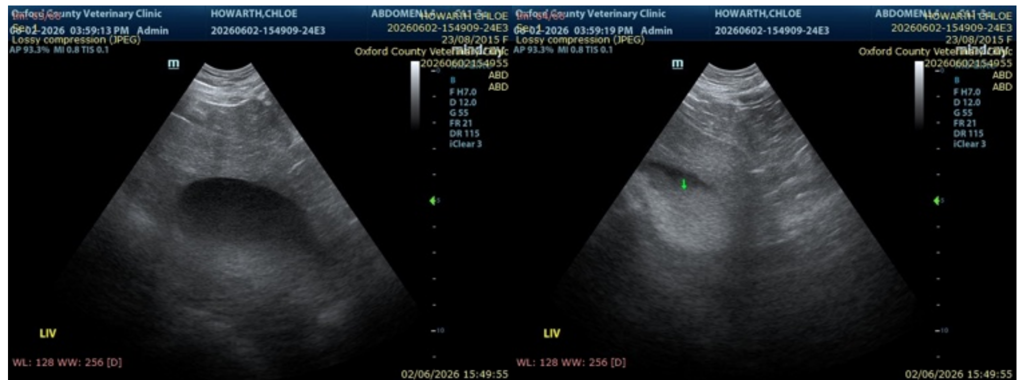

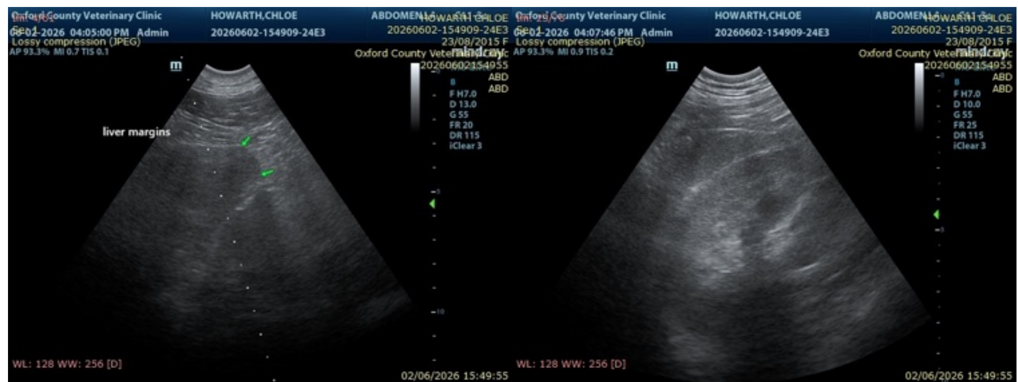

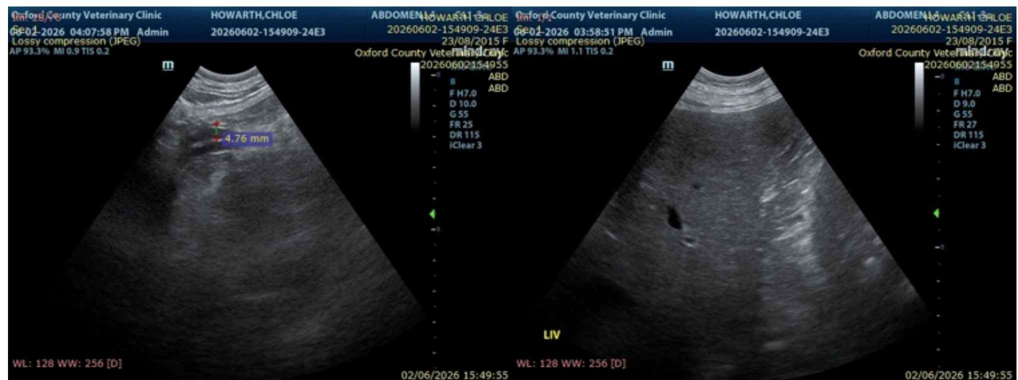

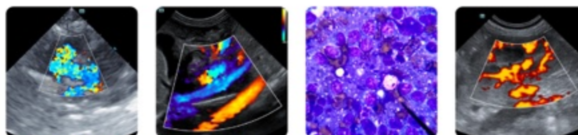

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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