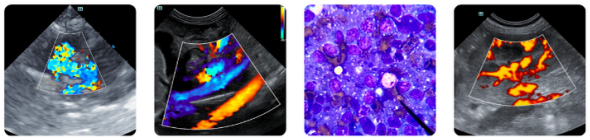

PATIENT

Lilly Stockdale

SPECIES

Canine

BREED

Lab

SEX

FS

AGE

6 years

WEIGHT

74

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Chrissy Shonk

HOSPITAL NAME

Court Street Veterinary Hospital

REFERRING VET

Dr. Chrissy Shonk

INVOICE

12115

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6/5/2026

PRESENTING CLINICAL SIGNS

Lilly initially presented for orthopedic surgery (TPLO of her left stifle/knee), though upon admittance Os reported concern for decreased appetite (hyporexia/anorexia) and for severe urinary incontinence has worsened over the last several weeks. P recently treated for UTI (Amoxi/Clav with full resolution of bacteriuria), though incontinence has not resolved. O reports no vomiting, diarrhea. No apparent risk of toxin/plant/humanRx/antifreeze/mushroom ingestion. Patient is not currently on preventative medications & is not vaccinated for Lyme/leptospirosis (Anaplasma positive on 5/8, otherwise negative). 2 serial rechecks of urine revealed NEG bacteria.

Abnormal PE/Chem/CBC/UA Results: 1. BP doppler today WNL 97-100mmHg. 2. Labs: HCT has decreased from 53% to 40% since 5/8. She also has several changes in white blood cell lines compared to 5/8 results: neutrophils have increased from 6.5K/uL to 11.4K/uL... and her monocytes have increased from 0.413K/uL 1.33K/uL (almost tripling).... Chemistry 5/8 all WNL, though today recheck revealed elevated ALT (573U/L) and AST)87U/L). USG today 1.028. 3. AXR: gas throughout jenjunum/gastric body, loss of detail cranial abdomen, no FF, no mass effects. NEG for radiopaque uroliths, no bone lesions appreciated. 1x L-Lat Thorax revealed no evidence of pulmonary metastatic disease.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is mildly underdistended, and the urinary bladder wall measures 5.29 mm and appears mildly irregular. Due to underdistension, wall thickness may be overestimated. The urine is anechoic. Normal appearance of the trigone and proximal urethra is observed. There are no calculi, and no evidence of obstructive uropathy or urinary tract neoplasia.

The left kidney is normal in shape and size, measuring 6.35×3.21 cm, with a cortical thickness of 0.60 cm in the sagittal plane. The renal cortex demonstrates normal echogenicity. The corticomedullary ratio is normal, and corticomedullary distinction is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size, measuring 6.64×3.32 cm, with a cortical thickness of 0.61 cm in the sagittal plane. The renal cortex demonstrates normal echogenicity. The corticomedullary ratio is normal, and corticomedullary distinction is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

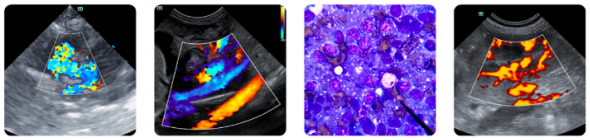
Adrenal Glands

Maximum dorsoventral diameters obtained from three measurements in the sagittal plane are as follows:

- Left adrenal gland: 0.51 cm at the cranial pole and 0.50 cm at the caudal pole.
- Right adrenal gland: not confidently visualized.

The visualized left adrenal gland demonstrates normal shape and echogenicity.

Spleen



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Splenic thickness is 2.23 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.

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 smooth. A small amount of biliary sludge is present and extends toward the gallbladder neck and cystic duct. No evidence of cystic duct or common bile duct dilation is identified.

Gastrointestinal tract

The stomach is predominantly empty and folded, containing only a small amount of partially digested ingesta within the fundus. Gastric mural thickness measures 3.15–3.47 mm with preserved wall layering.

The pyloric wall measures 6.42 mm.

The duodenal wall measures 2.53 mm.

The jejunal wall measures 2.60–3.16 mm.

Normal wall layering is preserved throughout the evaluated gastrointestinal tract. No evidence of gastrointestinal obstruction, inflammatory mural changes, ileus, or foreign material is identified.

The colonic wall measures 1.30 mm and contains a small amount of fecal material within the descending colon.

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

- Mild urinary bladder wall thickening and mild mural irregularity, although assessment is limited by under distension.
- Small amount of biliary sludge extending toward the gallbladder neck and cystic duct.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild urinary bladder wall thickening and mural irregularity are present; however, interpretation is limited by under distension of the urinary bladder. Mild chronic inflammatory change cannot be completely excluded, although no sonographic evidence of urolithiasis, urinary tract obstruction, urinary tract neoplasia, or other significant lower urinary tract pathology is identified.

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No sonographic cause for the reported urinary incontinence is observed. However, urethral sphincter mechanism incompetence remains a reasonable differential diagnosis: definitive diagnosis cannot be established sonographically.

A small amount of biliary sludge is present within the gallbladder and extends toward the gallbladder neck and cystic duct. No evidence of biliary obstruction, gallbladder wall disease, extrahepatic biliary tract dilation, or other significant structural hepatobiliary abnormality is identified.
No sonographic explanation for the marked elevation in liver enzyme activities is identified. The liver is normal in size, contour, echogenicity, and echotexture, and no focal hepatic lesions are observed. These findings do not exclude clinically significant hepatocellular disease. Reactive hepatopathy, early hepatitis, infectious hepatopathy, toxic hepatopathy, or other diffuse hepatic disorders may be present despite an otherwise unremarkable ultrasonographic appearance.

Overall, the cause of the reported hyporexia, progressive liver enzyme elevations, and worsening urinary incontinence is not definitively identified on the current examination.

Recommendations:

- Correlation with urine culture results, urinalysis findings, and clinical signs is recommended when assessing the significance of the mild urinary bladder wall changes.

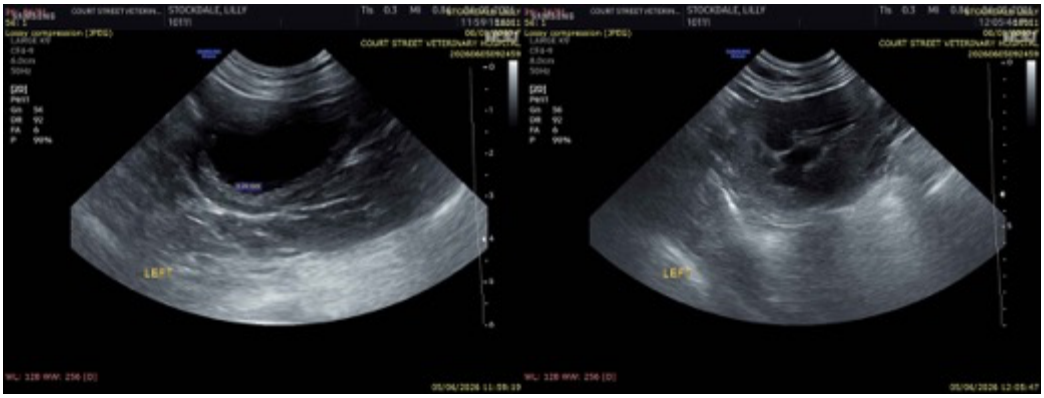
- Hepatoprotective therapy may be considered at the discretion of the attending veterinarian.

- Given the presence of biliary sludge and progressive hepatocellular enzyme elevations, treatment with ursodeoxycholic acid may be considered if clinically appropriate and if no evidence of biliary obstruction is present.

- Serial monitoring of liver enzyme activities is recommended.

- If liver enzyme abnormalities persist or progress, additional investigation of primary hepatobiliary disease may be warranted. Depending on clinical progression, this could include bile acid testing, hepatic cytology, or liver biopsy.

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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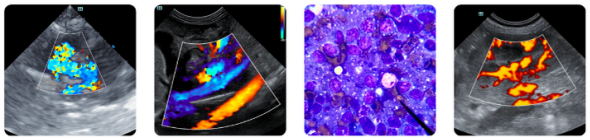

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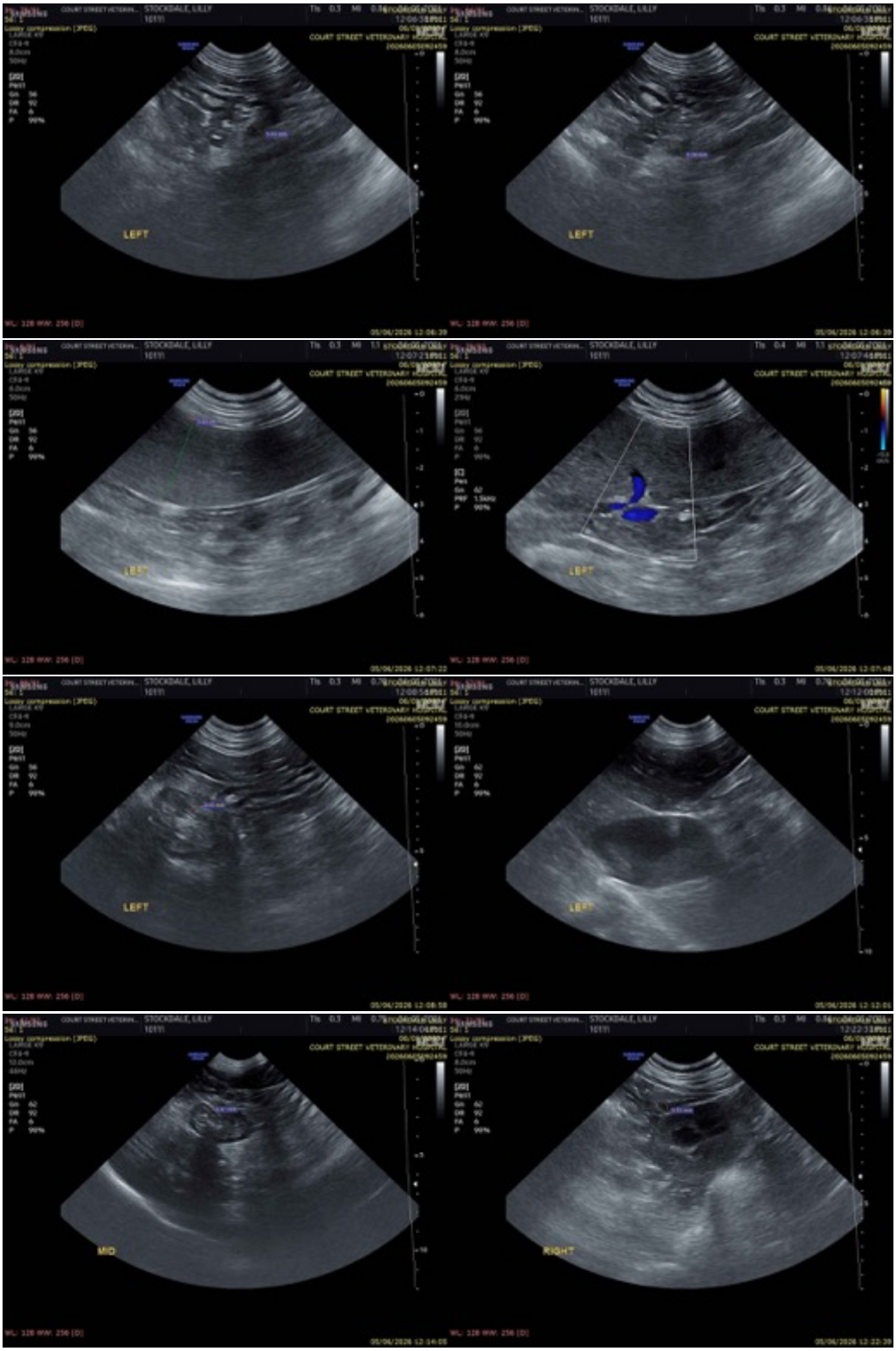

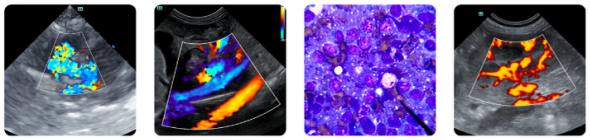

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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