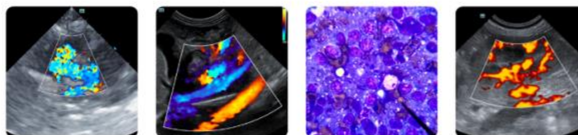


SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Lulu Treible

SPECIES

Canine

BREED

Coonhound

SEX

Spayed Female

AGE

13 Years 8 Months

WEIGHT

44.8

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Allen

HOSPITAL NAME

Montville Animal Hospital

REFERRING VET

Dr. Karen Schubert

INVOICE

16370

DATE

06/05/26

PRESENTING CLINICAL SIGNS

Snap cPL abnormal, had Panoquel May 26-28th. P is still not eating right.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is under distended, and the urinary bladder wall measures 3.86 mm and appears smooth. Due to under distension, 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 inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 5.45×3.33 cm, with a cortical thickness of 0.67 cm in the sagittal plane. A small cortical cyst measuring 2.13×2.88 mm is present.

The right kidney is normal in shape and size, measuring 5.76×2.96 cm, with a cortical thickness of 0.60 cm in the sagittal plane.

Both kidneys demonstrate normal cortical echogenicity relative to the liver. The corticomedullary ratio is normal, and corticomedullary distinction is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland is sub-optimally visualized. It measures approximately 0.57 cm at the cranial pole and 0.59 cm at the caudal pole. The right adrenal gland could not be confidently visualized.

Spleen

Splenic thickness measures 1.83 cm. Multiple small hyperechoic nodules are present throughout the splenic parenchyma, consistent with myelolipoma-like lesions. An additional mixed-echogenicity splenic nodule measuring 0.67×0.81 cm is identified. 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 with normal echogenicity and echotexture. No focal hepatic lesions or hepatic lymphadenopathy are identified.

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

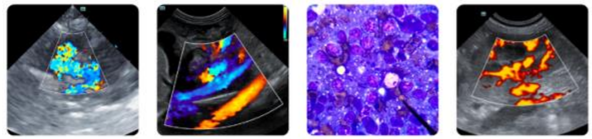
Gastrointestinal tract

The stomach is empty and folded, with a mural thickness of 3.80 mm and preserved wall layering.

The duodenum measures 4.38 mm in thickness and contains mild fluid distension. No evidence of mechanical obstruction is identified.

The jejunal wall measures 5.39 mm, with preserved wall layering.

No evidence of foreign material, focal mural lesions, or mechanical gastrointestinal obstruction is identified.



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The colonic wall measures 1.06 mm. A small amount of formed fecal material is present within the descending colon.

Pancreas

The visualized portions of the pancreas do not demonstrate convincing sonographic evidence of active pancreatitis. Pancreatic parenchyma appears isoechoic relative to the adjacent mesenteric fat. No pancreatic enlargement, focal pancreatic lesions, peripancreatic fat inflammation, or regional free fluid is identified.

Free Abdomen

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

PRIMARY FINDINGS

- Fluid distension of the duodenum without evidence of mechanical obstruction.
- Mild diffuse jejunal mural thickening (5.39 mm) with preserved wall layering.

SECONDARY FINDINGS

- Multiple small splenic myelolipoma-like nodules.
- Small mixed-echogenicity splenic nodule measuring 0.67×0.81 cm.
- Small incidental left renal cortical cyst.

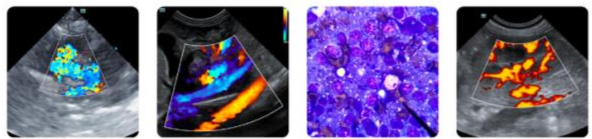
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild diffuse jejunal mural thickening is present with preservation of normal wall layering and without associated mesenteric lymphadenopathy or focal mass formation. This finding is may reflect mild inflammatory or reactive enteropathy.
Mild fluid distension of the duodenum is present without evidence of mechanical obstruction. Although the duodenal wall remains within normal limits in thickness and preserves normal wall layering, this finding may represent a reactive or functional change and can be seen in association with gastroduodenal inflammation, pancreatitis, or transient gastrointestinal dysmotility.
No convincing sonographic evidence of active pancreatitis is identified within the visualized pancreatic tissue. However, the previously abnormal SNAP cPL result, persistent hyporexia, and mild fluid distension of the proximal small intestine raise the possibility of mild or partially resolved pancreatitis, which cannot be excluded based on ultrasonography alone.

Multiple small hyperechoic splenic nodules are present and are most consistent with benign myelolipoma-like lesions. An additional small mixed-echogenicity splenic nodule measuring 0.67×0.81 cm is identified. This lesion is nonspecific but most likely represents a benign nodular process such as nodular hyperplasia. Definitive characterization cannot be made based on ultrasonographic appearance alone.

No sonographic evidence of gastrointestinal obstruction, abdominal neoplasia, lymphadenopathy, peritonitis, or other significant abdominal pathology is identified.

Recommendations
- Consider quantitative Spec cPL testing.



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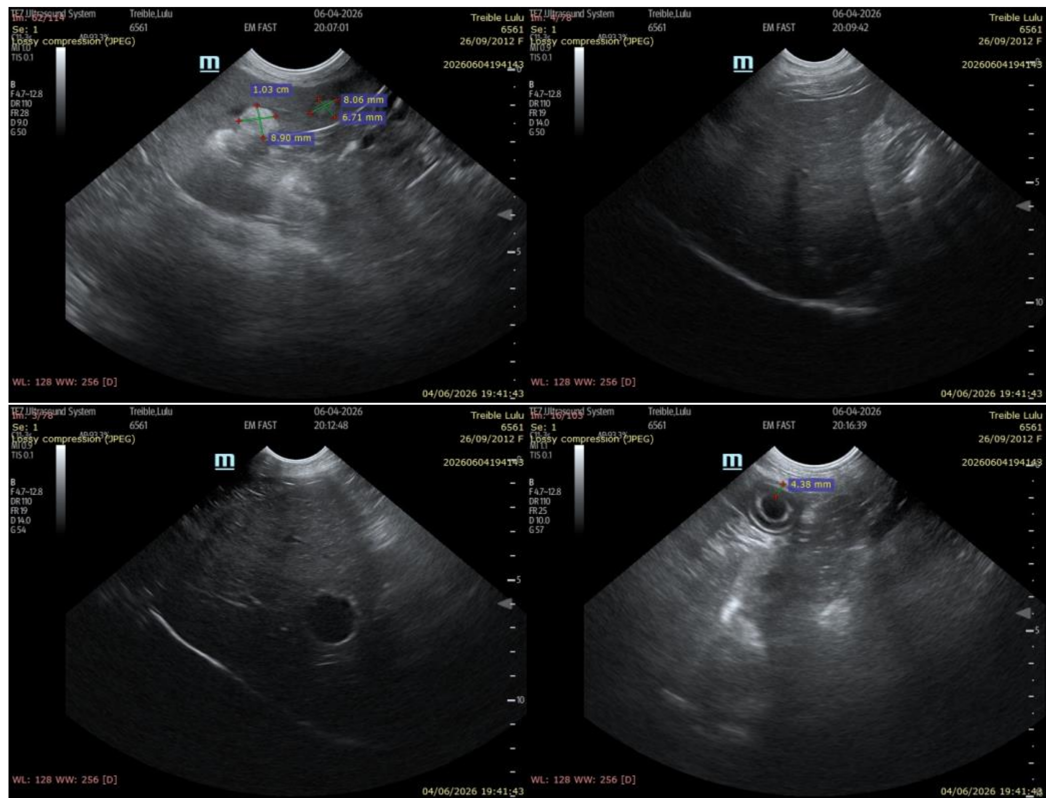
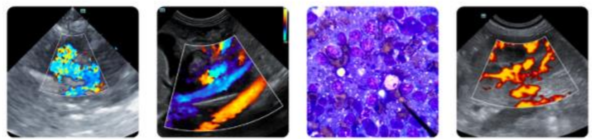
- Supportive management for suspected mild pancreatitis and/or gastrointestinal inflammation would be reasonable at the discretion of the attending veterinarian based on the patient's ongoing clinical signs.
- If hyporexia persists despite appropriate supportive care, further investigation of gastrointestinal disease may be considered.

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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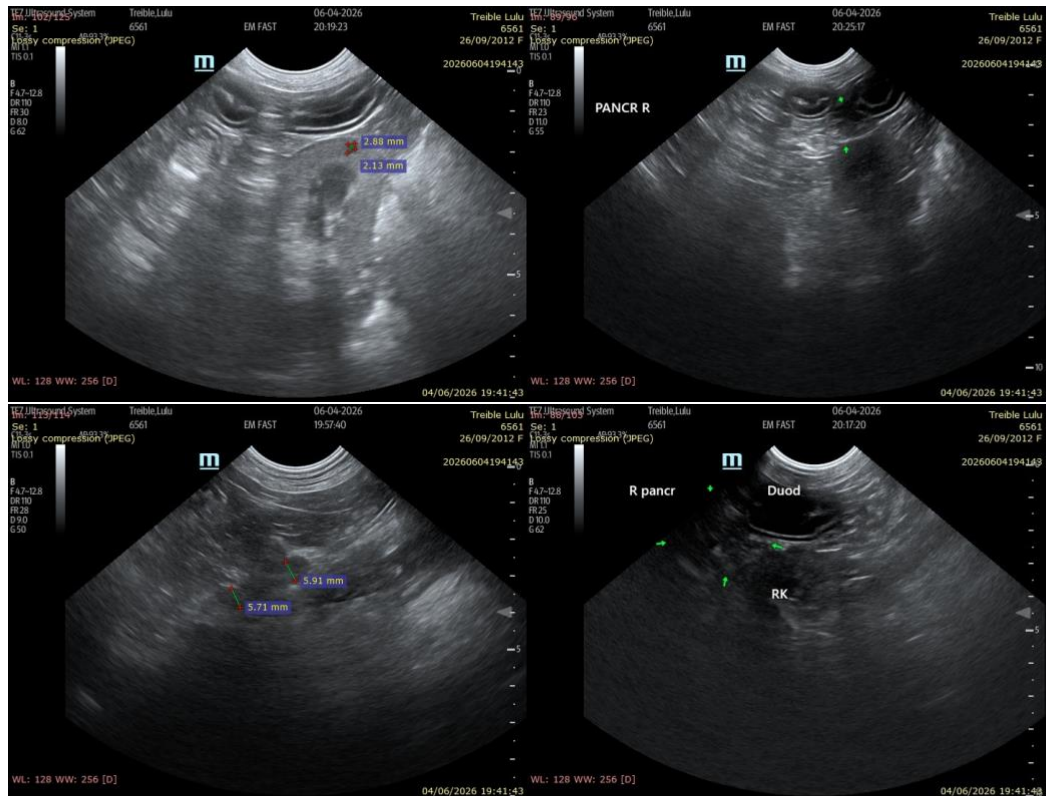

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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