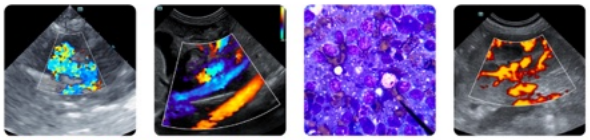


PATIENT

Wally Randecker

SPECIES

Canine

BREED

Scottish Terrier

SEX

Neutered male

AGE

14 years

WEIGHT

23.76 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Mayra Sanchez

HOSPITAL NAME

Sunset AH

REFERRING VET

Dr. Polit

INVOICE

73633

DATE

3/19/26

PRESENTING CLINICAL SIGNS

- Recent onset of PU/PD
- Long history of elevated ALP
- History of seizures - on Levetiracetam
- PE: palpable hepatomegaly CBC: RBC 5.5 Chem: ALP 1188, T bili 0.8, Ca 11.8 UA: USG 1.010 Radiographs: Hepatomegaly

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended. The wall contains multiple polypoid structures, including a large polypoid lesion arising from the ventral wall and occupying a significant portion of the bladder lumen. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. There are no calculi.

The left kidney measures 5.61×3.27 cm, with a cortical thickness of 0.67 cm. The right kidney measures 6.07×3.50 cm (cortical thickness not provided). The renal cortex is hyperechoic relative to the liver. Multiple small cortical cysts are present, the largest measuring 5.3×8.5 mm. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.60 cm at the cranial pole and 0.63 cm at the caudal pole. The right adrenal gland is partially visualized, measuring 0.67 cm at the caudal pole.

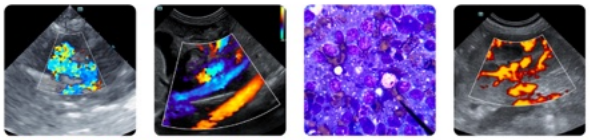
Spleen

Splenic thickness is 1.09 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively enlarged, with rounded margins and a regular contour. The hepatic parenchyma is mildly hyperechoic relative to the falciform fat, with a homogeneous echotexture. Multiple small hyperechoic nodules are distributed throughout the parenchyma. No hepatic lymphadenopathy is observed.

The gallbladder lumen is markedly distended. The wall is thin, and the contents are predominantly anechoic with a moderate amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal system

The stomach is empty and folded, with preserved wall layering (wall thickness not provided). The pylorus measures 0.85 cm.

Duodenum: 3.88 mm. Jejunum: 3.24 mm, with preserved wall layering. No signs of inflammation, ileus, or foreign material are identified.

Colon: 0.97 mm, with formed feces in the descending segment.

Pancreas

The right pancreatic limb measures 1.09 cm, and the left limb measures 7.86 mm. The parenchyma is mildly hypoechoic relative to the adjacent omental fat. No signs of active peripancreatic inflammation are identified.

Peritoneal cavity

There is no sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Several bladder polypoid lesions, including a large intraluminal polypoid mass.
- Hepatomegaly with diffuse mild hyperechogenicity and multiple hyperechoic nodules.
- Marked gallbladder distension with biliary sludge.
- Adrenal glands at upper limits of normal size but normal shape and echogenicity.

SECONDARY FINDINGS

- Renal cortical hyperechogenicity with multiple small cysts.
- Mild pancreatic hypoechogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant finding is the presence of multiple polypoid lesions within the urinary bladder, including a large lesion occupying a substantial portion of the lumen. The ultrasonographic appearance and location of these lesions are most consistent with polypoid cystitis; however, transitional cell carcinoma cannot be excluded based on ultrasound alone, particularly given the size of the dominant lesion. The absence of urethral involvement and the presence of multiple lesions favor a benign inflammatory process; however, the size and extent warrant further investigation.

The liver is enlarged, mildly hyperechoic, and contains multiple small hyperechoic nodules. In a dog with markedly elevated ALP and PU/PD, this pattern is highly consistent with vacuolar hepatopathy, which

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may be associated with hyperadrenocorticism or chronic steroid exposure. The nodules are most likely benign nodular hyperplasia in the context of chronic hepatopathy. There are no features suggestive of hepatic neoplasia.

The adrenal glands are within the upper limits of normal in size and appear morphologically normal, although the cranial pole of the right adrenal gland was not fully evaluated. While not overtly enlarged, these measurements do not exclude functional hyperadrenocorticism, particularly in early or moderate disease. Importantly, the hepatic findings and clinical signs (PU/PD, elevated ALP, hepatomegaly) are strongly supportive of an underlying endocrine process.

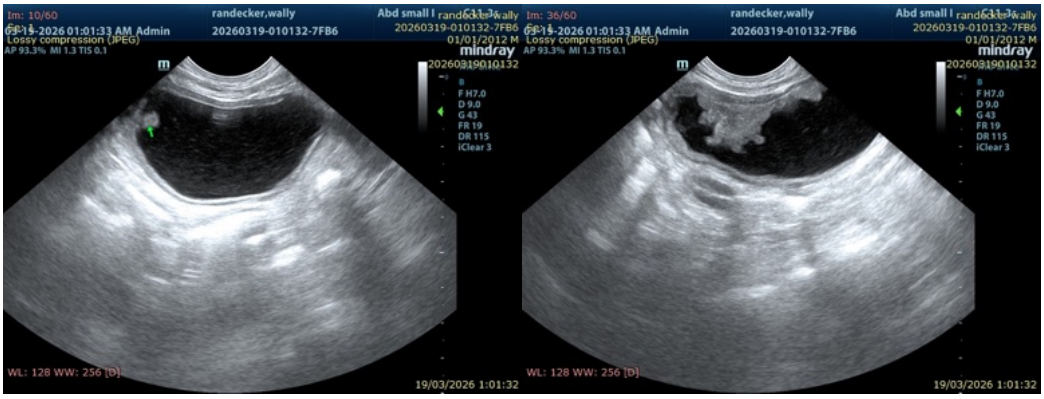
Renal changes (cortical hyperechogenicity and small cysts) are most consistent with age-related or chronic degenerative change and do not currently suggest clinically significant renal disease, although the low urine specific gravity remains clinically relevant and may be secondary to endocrine disease.

The pancreas shows mild hyperechogenicity without surrounding inflammation, most consistent with age-related or chronic change, with no evidence of active pancreatitis.

Recommendations

- Urine BRAF mutation testing (CADET BRAF) may be considered as a non-invasive initial screening tool. Urine cytology (including traumatic catheterization) and/or cystoscopy with biopsy may be pursued for definitive diagnosis.
- Given the clinical picture and hepatic findings, endocrine testing for hyperadrenocorticism is recommended.
- Medical hepatobiliary management may be considered.
- Monitor renal parameters and urine concentrating ability over time.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, based on the complete clinical context.



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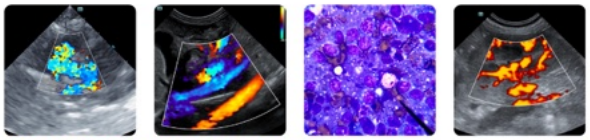

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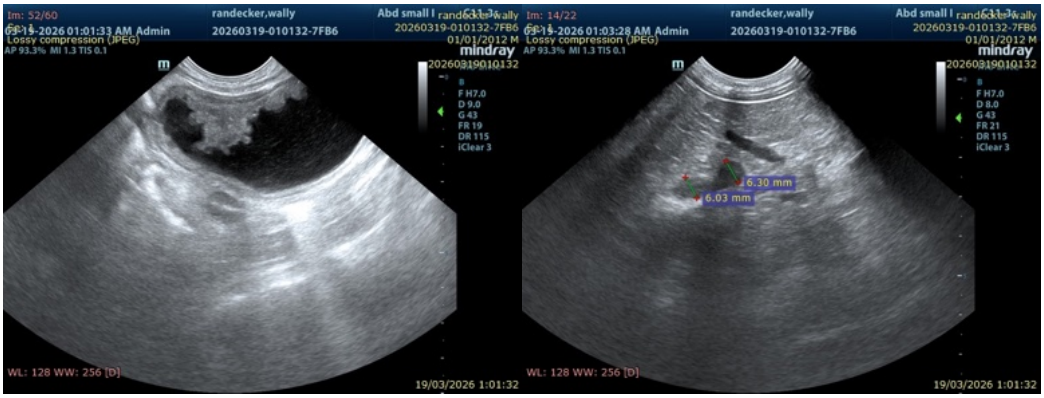

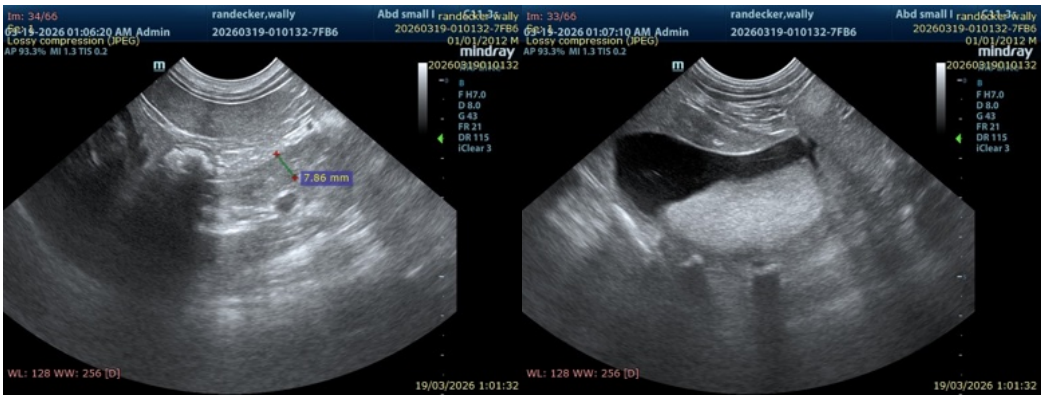

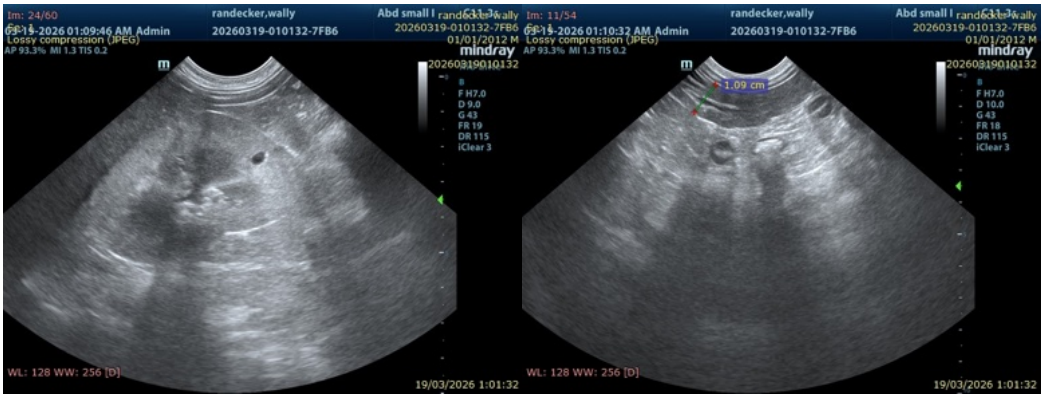

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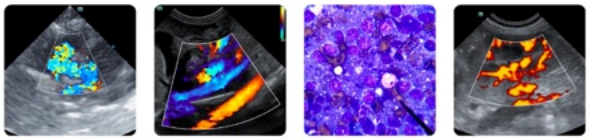

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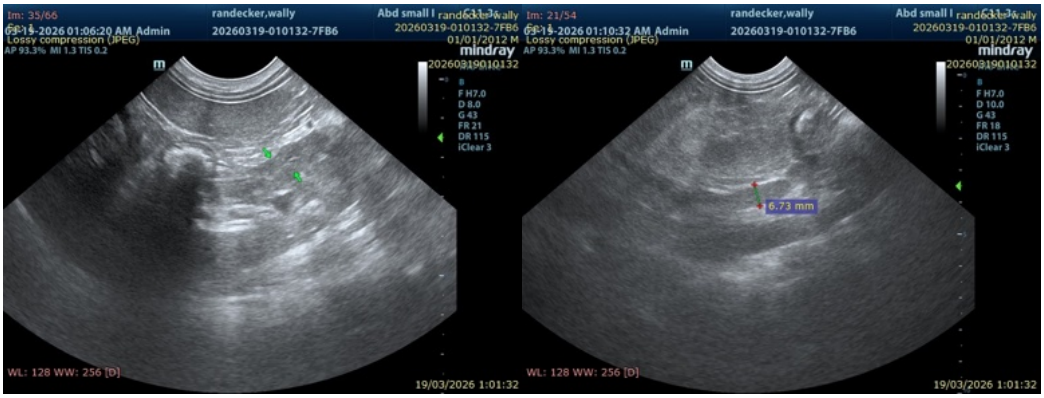

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

MV Esp Ultrasound in Domestic and Wild Animals

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