

## PATIENT

Alice Katz

## SPECIES

Canine

## BREED

Dachshund

## SEX

Spayed female

## AGE

14 years

## WEIGHT

8.18 kg

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Ryan Bergner, LVT

## HOSPITAL NAME

Waterville VC

## REFERRING VET

Dr. Gilchrist

## INVOICE

73903

## DATE

3/30/26

## PRESENTING CLINICAL SIGNS

Abnormal PE/Chem/CBC/UA Results: Historical Problem List - Chronic neck pain with cervical IVDD (noted 1/27/25, ongoing as of 4/07/25) - Multiple subcutaneous lipomatous masses (first noted 4/2024, progressive through 4/07/25) - Solitary hepatic mass (detected 1/27/25, monitored without biopsy) - Hepatopathy with elevated ALP and gallbladder debris (ALP 618 U/L 01/27/25 → 1009 U/L 10/16/25) - Chronic hypotrichosis and alopecia (present since 2024, persistent 4/07/25) - Right forebrain lesion with prior neurologic deficits (documented 1/27/25; neurologic function returned to normal by 2/12/25) Today's presenting complaints - Polydipsia and polyuria - Differential diagnoses include hyperadrenocorticism, chronic kidney disease, diabetes mellitus, and hepatopathy.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder lumen is normally distended, and the wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. No calculi are identified, and there is no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size (3.32×2.43 cm), with a cortical thickness of 0.44 cm in the sagittal plane. The right kidney is normal in shape and size (3.99×2.55 cm), with a cortical thickness of 0.49 cm in the sagittal plane.

Both kidneys: The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. Several hyperechoic foci are observed within multiple areas of the renal calyces, consistent with small nephroliths or mineralization foci in formation, without clear distal acoustic shadowing. There is no evidence of pyelectasia or hydronephrosis.

### Adrenal Glands

Dorsoventral diameters measured in the sagittal plane:

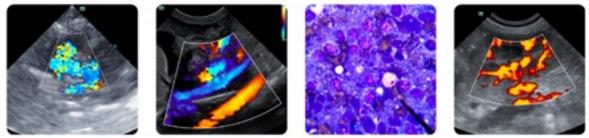
The left adrenal gland measures 0.51 cm at the cranial pole and 0.62 cm at the caudal pole. The right adrenal gland is sub optimally visualized and measures 0.55 cm at the cranial pole and 0.49 cm at the caudal pole.

### Spleen

Splenic thickness is 0.91 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

### Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The parenchyma is uniform and isoechoic relative to the falciform fat, with a coarse echotexture. Multiple hypoechoic nodules are distributed throughout the hepatic parenchyma. No hepatic lymphadenopathy is identified.



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## Gallbladder

The gallbladder lumen is normally distended. The wall is thin, with a small intraluminal polypoid structure. The contents are primarily anechoic with a moderate amount of biliary sludge. There is no evident dilation of the cystic duct or common bile duct.

## Gastrointestinal

The stomach is empty and folded, with mural thickness of 2.46 mm and preserved wall layering. Pylorus: 4.04 mm. Duodenum: 3.27 mm. Jejunum: 2.79 mm. Wall layering is preserved throughout. No evidence of inflammation, ileus, or foreign material is identified.

Colon: 0.67 mm, with minimal content.

## Pancreas

Pancreatic thickness is 9.24 mm. Parenchyma is isoechoic relative to the adjacent omental fat. No peripancreatic fat hyperechogenicity is identified. The evaluated regions do not show evidence of overt inflammation or nodular disease.

## Free Abdomen

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

## PRIMARY FINDINGS

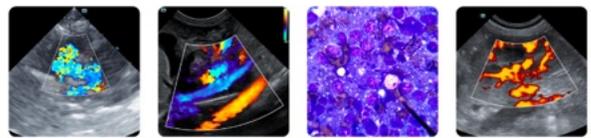
- Mild bilateral adrenal gland enlargement.
- Coarse hepatic echotexture with multiple hypoechoic nodules.
- Moderate biliary sludge with small gallbladder polypoid lesion.

## SECONDARY FINDINGS

- Multiple non-shadowing hyperechoic foci within renal calyces.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left adrenal gland measures up to 0.62 cm in dorsoventral dimension, which is mildly above expected reference ranges for a dog of this size (generally  $\leq 0.54$ – $0.60$  cm), consistent with enlargement. The right adrenal gland measurements (0.55 cm cranial pole, 0.49 cm caudal pole) fall within to borderline the upper limits of normal, although evaluation is limited by suboptimal visualization. In the context of PU/PD, progressive ALP elevation, and dermatologic changes this pattern raises suspicion for hyperadrenocorticism, with findings more suggestive of pituitary-dependent disease. However,



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ultrasonography does not assess adrenal function, and endocrine testing is required for definitive diagnosis and classification.

The liver shows a coarse echotexture with multiple hypoechoic nodules, indicating a multifocal parenchymal process. In this clinical context, nodular hyperplasia associated with steroid hepatopathy is most likely; however, chronic hepatopathy cannot be excluded based on ultrasound alone due to known imaging overlap.

Gallbladder sludge and a small polypoid lesion are consistent with biliary stasis and mucosal hyperplasia. No evidence of biliary obstruction is identified.

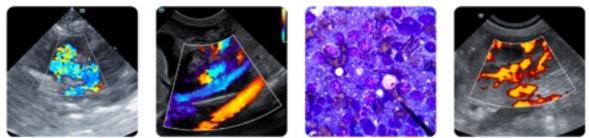
Renal architecture and cortical thickness (0.44–0.49 cm) are within expected limits, with preserved corticomedullary definition. Non-shadowing hyperechoic foci within the calyces are compatible with early mineralization/nephrolithiasis, currently non-obstructive and likely incidental.

### Recommendations

- Perform low-dose dexamethasone suppression test (LDDS) to confirm hyperadrenocorticism and differentiate PDH vs adrenal-dependent disease.
- Initiate hepatoprotective therapy (S-adenosylmethionine and/or silybin). The use of ursodeoxycholic acid may be considered given the presence of biliary sludge, provided there is no evidence of biliary obstruction. Identification of the underlying cause remains important.
- Recommend ultrasound monitoring of the gallbladder for potential progression.

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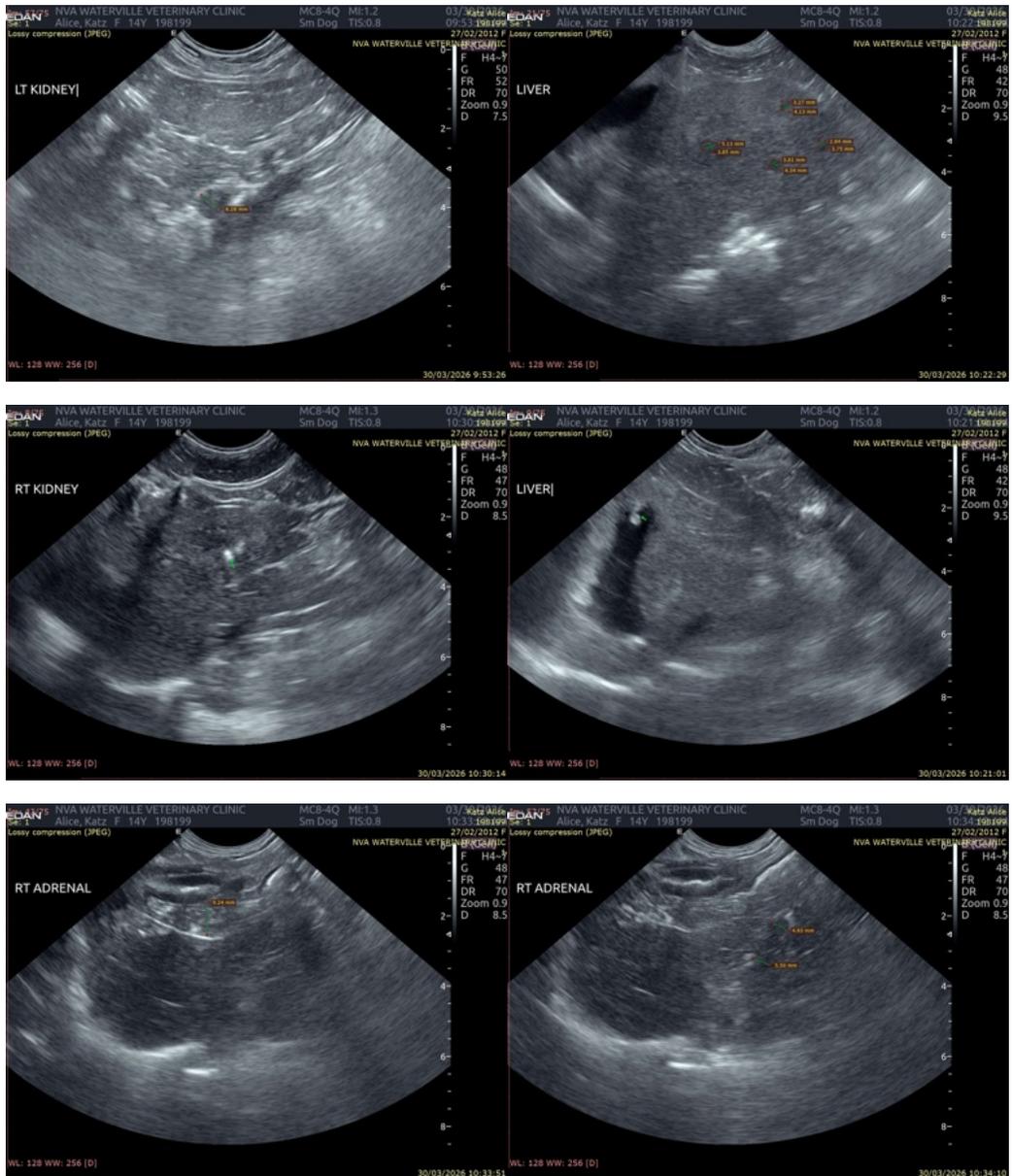
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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