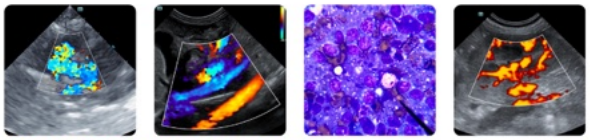


PATIENT

Teddy Stoddard

SPECIES

Canine

BREED

Mix

SEX

Neutered male

AGE

12 years

WEIGHT

8 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Brian Klug

HOSPITAL NAME

Sondle Family VC

REFERRING VET

Dr. Frankenthal

INVOICE

73911

DATE

3/30/26

PRESENTING CLINICAL SIGNS

- hx of Cushing's well controlled with Vetoryl
- recent BW shows significant increase in ALK P to 1100 (last checked in July 2025 and was 330). want to rule out hepatic neoplasia, mucocele, etc.
- also has hx of uroliths and has been on Royal Canin SO so wondering if stones are still present or if they have dissolved

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder contains a 1.56 cm calculus. The bladder wall is thickened and irregular, with focal mucosal irregularities suggestive of proliferative changes.

The left kidney is normal in shape and size (3.96×2.22 cm), with a cortical thickness of 0.50 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. Several small cortical cysts are present, the largest measuring 2.86×3.40 mm. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size (3.95×1.99 cm), with a cortical thickness of 0.46 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. Several small cortical cysts are present, the largest measuring 1.63×2.35 mm. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland measures 0.70 cm (cranial pole) and 0.64 cm (caudal pole). The right adrenal gland measures 1.02 cm (cranial pole) and 0.40 cm (caudal pole). A 3.26×5.15 mm hyperechoic nodule is present at the cranial pole.

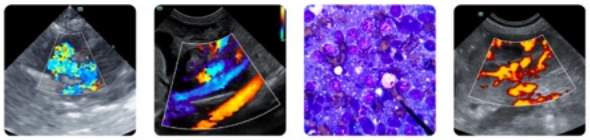
Spleen

Splenic thickness is 0.89 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 increased in size, with sharp edges and a regular contour. The parenchyma is uniform and isoechoic relative to the falciform fat, with a fine echotexture. No focal lesions or hepatic lymphadenopathy are identified.

The gallbladder is normally distended. Findings are consistent with mucous gland hyperplasia and biliary sludge. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded, with a wall thickness of 2.48 mm and preserved layering. The pylorus measures 6.06 mm, with muscularis thickness of 4.56 mm.

Duodenum: 3.49 mm. Jejunum: 2.51 mm. Ileum: 1.83 mm. Wall layering is preserved throughout. The ileocecal junction appears normal. No evidence of inflammation, ileus, or foreign material is identified.

Colon: Ascending 1.25 mm, transverse 1.30 mm, descending 1.05 mm, with minimal fecal content. Wall layering is preserved.

Pancreas

Pancreatic thickness is within normal limits. The parenchyma is mildly hyperechoic relative to adjacent omental fat. No peripancreatic inflammatory changes are identified.

Free Abdomen

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

PRIMARY FINDINGS

- Urinary bladder calculus (1.56 cm) with wall thickening and mucosal hyperplasia.
- Hepatomegaly.
- Gallbladder mucous gland hyperplasia with biliary sludge
- Bilateral adrenal enlargement (right > left) with small right adrenal nodule.
- Mild pancreatic hyperechogenicity.
- Few bilateral small renal cortical cysts.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hepatobiliary findings are consistent with steroid hepatopathy in a patient with known hyperadrenocorticism. The marked increase in ALP is therefore most likely attributable to progression or fluctuation of hyperadrenocorticism-related hepatic enzyme induction.
The gallbladder shows mucous gland hyperplasia with biliary sludge, a common finding in dogs with hyperadrenocorticism. There is no evidence of organized immobile content, stellate pattern, or wall compromise to support a gallbladder mucocele at this time, although progression along this spectrum is possible.

Both adrenal glands are enlarged relative to expected reference ranges, with asymmetry and a small hyperechoic nodule in the right adrenal gland (up to 1.02 cm). The lack of contralateral atrophy does not support a classic adrenal-dependent pattern; however, the asymmetry and nodular change prevent confident classification as pituitary-dependent disease based on ultrasonography alone.

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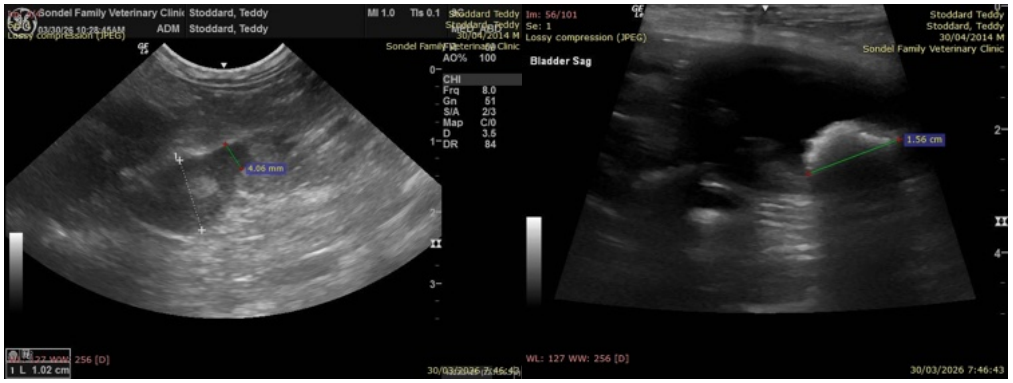
The pancreas is mildly hyperechoic, most consistent with pancreatic lipomatosis, which may be associated with hyperadrenocorticism.

The urinary bladder findings are most consistent with chronic cystitis and mucosal hyperplasia secondary to urolithiasis.

Recommendations

- Recommend addressing the urinary bladder calculus, as it is large and associated with chronic wall changes; options include removal and/or further evaluation.
- Hepatoprotective therapy (S-adenosylmethionine and/or silybin) may be considered given the presence of hepatomegaly and biliary sludge. However, the marked ALP elevation is most likely related to hyperadrenocorticism-associated enzyme induction rather than primary hepatocellular disease, and treatment should primarily focus on appropriate control of the underlying endocrinopathy.
- Consider medical management (ursodeoxycholic acid) for biliary sludge, with periodic ultrasound monitoring for potential progression toward mucocele formation.

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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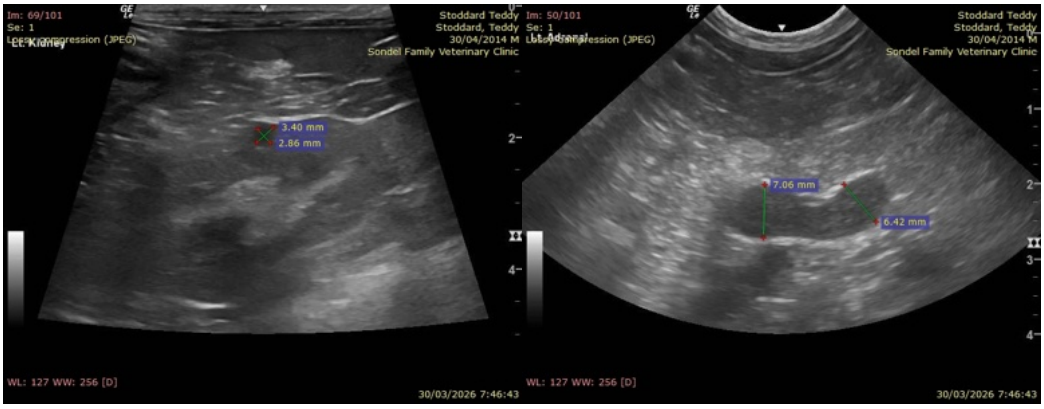

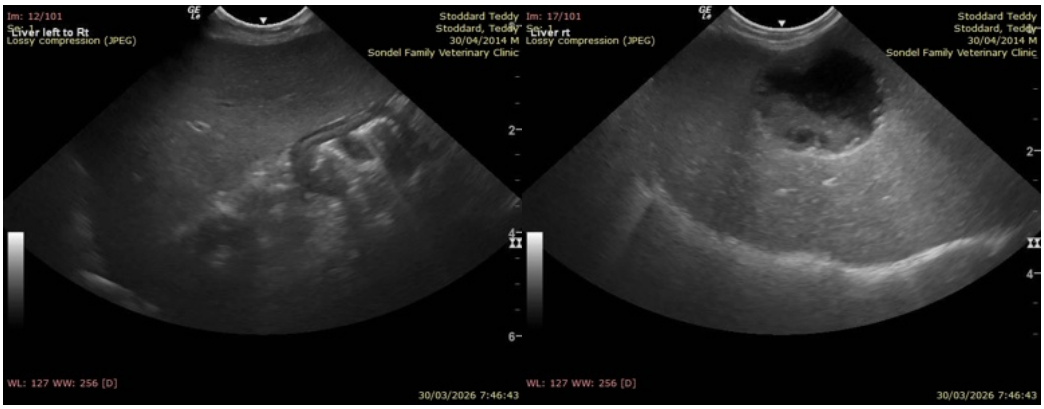

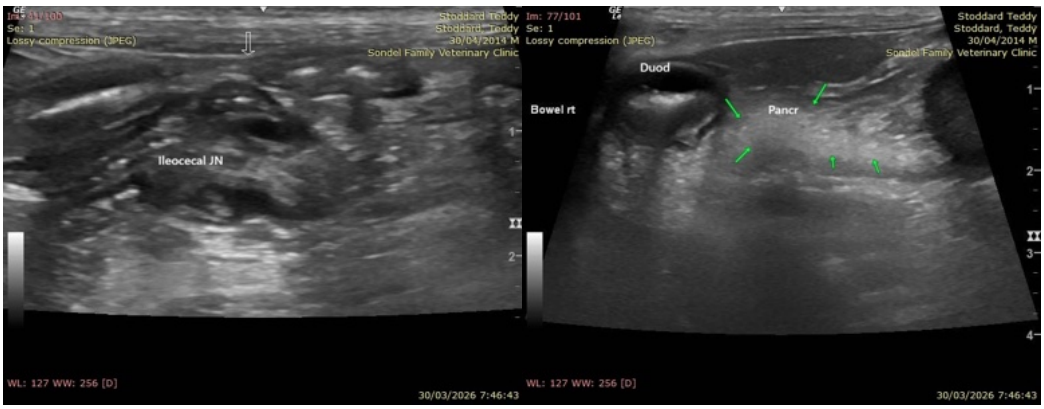

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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