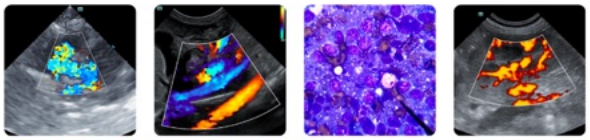




**PATIENT**

Scout Garton

**SPECIES**

Canine

**BREED**

Coonhound

**SEX**

Neutered male

**AGE**

11 years

**WEIGHT**

71 lbs

**INTERPRETED BY**

Alicia Angosto Guerrero, DMV, PgDip, MSc.

**IMAGING PERFORMED BY**

Brandon

**HOSPITAL NAME**

Dillsburg VC

**REFERRING VET**

Dr. Amber

**INVOICE**

77716

**DATE**

5/19/26

## PRESENTING CLINICAL SIGNS

History: Scout was in for his annual with labwork. Labs showed a progressive increase in liver enzymes compared to bloodwork performed in February 2026. Scout was started on Denamarin ADV in December of 2025. He is also taking Apoquel for allergies.
Abnormal PE/Chem/CBC/UA Results: AST 72 (prev72), ALT528 (prev 471), ALKP 1820 (prev 1605). T4 0.6, free T4 20.9. USG 1.010 rest NSF in UA. CBC WNL. Accuplex negx4.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The bladder lumen is moderately distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 6.05×3.56 cm, and the thickness of the cortex is 0.63 cm in the sagittal plane. The right kidney is normal in shape and size: 6.47×4.00 cm, and the thickness of the cortex is 0.70 cm in the sagittal plane. The renal cortices demonstrate normal echogenicity bilaterally. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

### *Adrenal Glands*

Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.81 cm at the cranial pole and 0.86 cm at the caudal pole. The right adrenal gland is not confidently visualized for evaluation

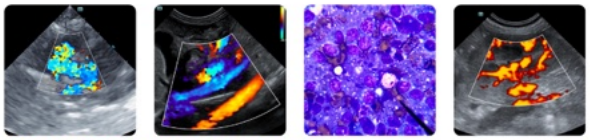
### *Spleen*

Splenic thickness is 2.33 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture. A well-defined hyperechoic splenic nodule measuring 0.80×0.85 cm is present, with imaging characteristics most compatible with a benign myelolipoma-like lesion/nodular hyperplastic change. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

### *Liver*

The is subjectively normal in size, remaining largely contained within the costal arch, with sharp edges and a regular contour. The hepatic parenchyma appears homogeneous and isoechoic relative to the falciform fat, with normal echotexture. No focal hepatic masses or nodules are identified within the submitted images/videos. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and smooth. A very small amount of non-shadowing biliary sludge is present. No dilation of the cystic duct or common bile duct is identified.





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### *Gastrointestinal*

The stomach is empty and folded, with mural thickness measuring 3.54 mm and preserved wall layering. The pylorus measures 5.69 mm in thickness. Duodenum: 3.18 mm. Jejunum: 3.07 mm, with preserved wall layering. No evidence of gastrointestinal obstruction, ileus, inflammatory mural change, or foreign material is identified. The colon measures 1.28 mm in thickness and contains formed fecal material within the descending segment.

### *Pancreas*

The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

### *Free Abdomen*

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

## PRIMARY FINDINGS

- Mild left adrenal enlargement.

## SECONDARY FINDINGS

- Small hyperechoic splenic nodule, most compatible with benign myelolipoma-like change/nodular hyperplasia.
- Minimal biliary sludge.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild left adrenal enlargement is present, with measurements mildly exceeding expected reference values for a dog of this size. Given the progressive marked cholestatic hepatopathy pattern on serum biochemistry, hyperadrenocorticism should be considered among the differential diagnoses, although unilateral adrenal enlargement alone is not diagnostic and the contralateral adrenal gland could not be confidently evaluated during this examination.

The liver demonstrates a relatively unremarkable ultrasonographic appearance despite the markedly elevated and progressive liver enzyme abnormalities. This does not exclude clinically significant hepatopathy, as vacuolar hepatopathy, steroid hepatopathy, early chronic hepatocellular disease, endocrine hepatopathy, and some diffuse metabolic or toxic hepatopathies may demonstrate minimal or only subtle ultrasonographic abnormalities, particularly in earlier stages.

No sonographic evidence of obstructive extrahepatic biliary disease, hepatic mass lesions, clinically significant gallbladder disease, or overt metastatic abdominal disease is identified within the current examination. Minimal biliary sludge is considered of doubtful independent clinical significance.

The small hyperechoic splenic nodule is most consistent with an incidental benign myelolipoma-like

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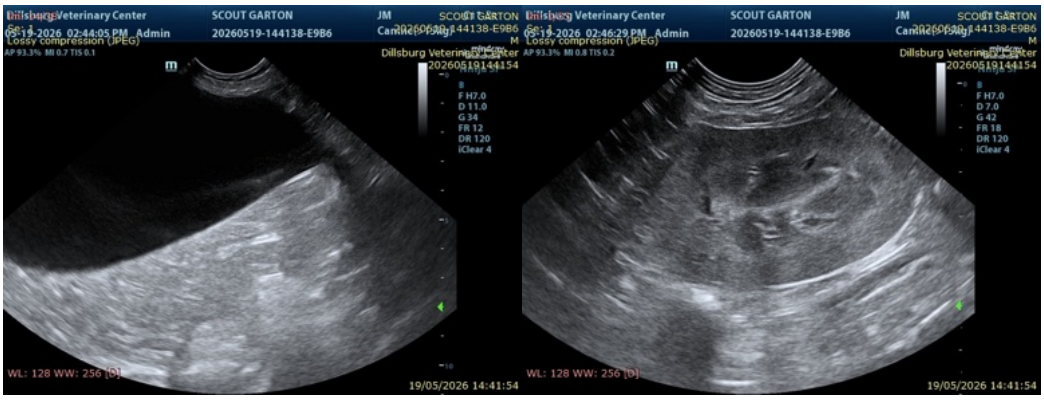
lesion or nodular hyperplastic change.

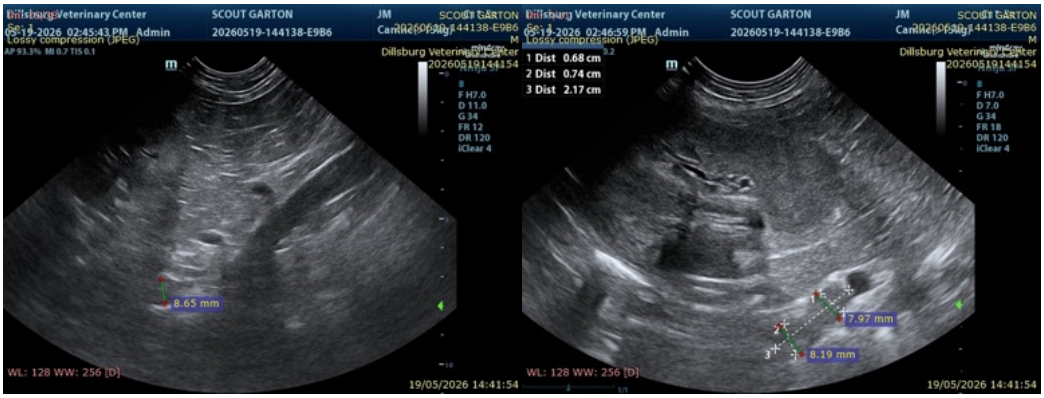
Urine specific gravity of 1.010 should be interpreted cautiously in the context of the current endocrine/hepatobiliary concerns and may warrant continued clinical monitoring and correlation with renal values and endocrine testing.

Recommendations

- Correlation with complete serum biochemistry trends, cholesterol, triglycerides, and blood pressure is recommended.
- Endocrine testing for hyperadrenocorticism may be clinically warranted given the progressive cholestatic hepatopathy pattern and mild left adrenal enlargement.
- Continued hepatoprotective therapy and serial liver enzyme monitoring are recommended.
- If liver enzyme abnormalities continue to progress despite medical management, further investigation including bile acids testing, and consideration of hepatic cytology/biopsy may ultimately be warranted depending on clinical 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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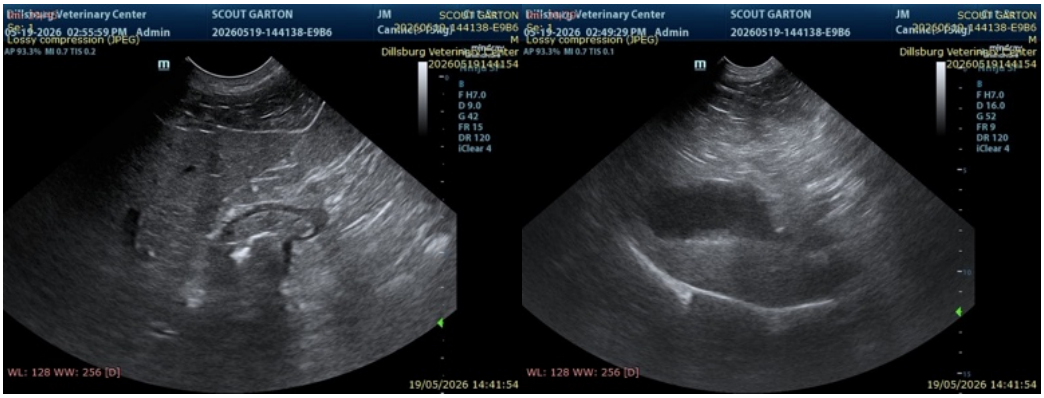


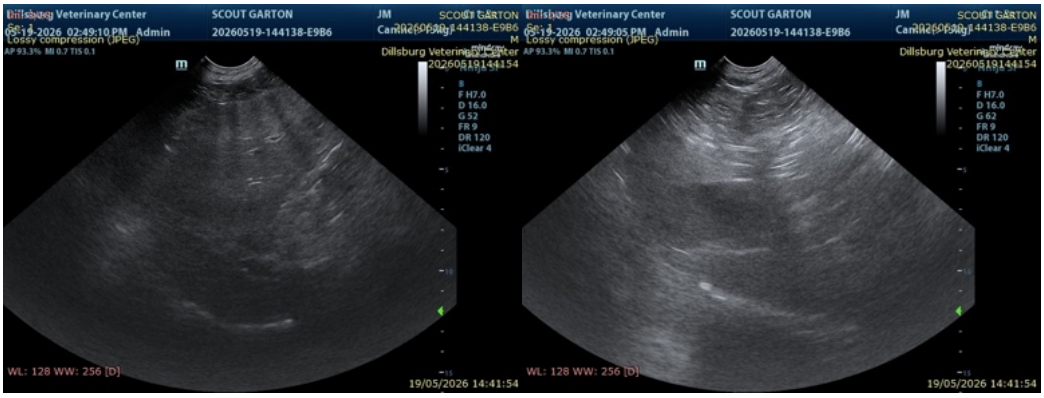


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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