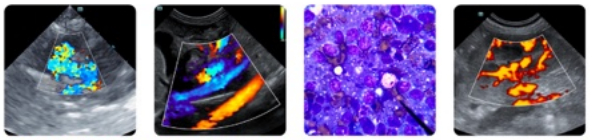




**PATIENT**

Shea Lee

**SPECIES**

Canine

**BREED**

Chihuahua

**SEX**

Spayed female

**AGE**

15 years

**WEIGHT**

11 lbs

**INTERPRETED BY**

Alicia Angosto Guerrero, DMV, PgDip, MSc.

**IMAGING PERFORMED BY**

Dr. Scott

**HOSPITAL NAME**

Wyckoff VH

**REFERRING VET**

Dr. Eisenberg

**INVOICE**

78181

**DATE**

6/1/26

## PRESENTING CLINICAL SIGNS

History: normal annual bw
Urine specific gravity 1.027, UPC 2.7, ALP 186, TP 7.9

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is underdistended, and the urinary bladder wall appears diffusely thickened and mildly irregular, measuring 2.56-2.74 mm. Due to underdistension, wall thickness may be overestimated. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no sonographic evidence of urinary bladder neoplasia.

The left kidney is normal in shape and size, measuring 4.63×2.79 cm, with a cortical thickness of 0.35 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.60×2.48 cm, with a cortical thickness of 0.40 cm in the sagittal plane. The renal cortices demonstrate normal echogenicity. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis

### *Adrenal Glands*

A heterogeneous left adrenal mass is identified, measuring 1.86×1.93 cm. The lesion effaces normal adrenal architecture. Invasion of the phrenicoabdominal vein cannot be excluded.

The right adrenal gland is within normal limits in size and echogenicity, measuring 0.56 cm at the cranial pole and 0.51 cm at the caudal pole.

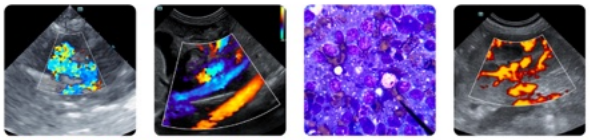
### *Spleen*

Splenic thickness is 1 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 rounded edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is moderately distended and contains abundant dependent echogenic sediment. Multiple fine hyperechoic striations are present within the luminal contents. These findings raise concern for early gallbladder mucocele formation. No dilation of the cystic duct or common bile duct is identified.





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## *Gastrointestinal tract*

The stomach is empty and folded, with a mural thickness of 2.01 mm and preserved wall layering.

The pylorus measures 5.03 mm. The duodenum measures 3.71 mm and the jejunum 3.01 mm. Wall layering is preserved throughout the examined intestinal tract.

No sonographic evidence of gastrointestinal inflammation, ileus, mechanical obstruction, or foreign material is identified.

The colon measures 0.93-1.03 mm and contains formed fecal material within the descending colon.

## *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 lymphadenomegaly is identified. The iliac trifurcation is normal.

## PRIMARY FINDINGS

- Large heterogeneous left adrenal mass (1.86×1.93 cm).
- Hepatomegaly.
- Marked biliary sediment with hyperechoic striations concerning for early gallbladder mucocele formation.

## SECONDARY FINDINGS

- Mild diffuse urinary bladder wall thickening and irregularity, although interpretation is limited by underdistension.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A large heterogeneous left adrenal mass is identified. Adrenocortical neoplasia is considered most likely. While ultrasonography cannot reliably distinguish between adrenal tumor types, the overall imaging and clinical findings are considered more suggestive of a cortical adrenal tumor than a pheochromocytoma. Possible invasion of the phrenicoabdominal vein cannot be excluded ultrasonographically.

Hepatomegaly is present. In the context of a large adrenal mass, this finding may reflect vacuolar hepatopathy or steroid hepatopathy, although it is nonspecific.
The gallbladder findings raise concern for early gallbladder mucocele formation. No sonographic evidence of extrahepatic biliary obstruction is identified.

The kidneys are sonographically unremarkable despite the documented proteinuria. This does not exclude glomerular disease, as significant protein-losing nephropathies may occur in the absence of

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detectable structural renal abnormalities on ultrasound.

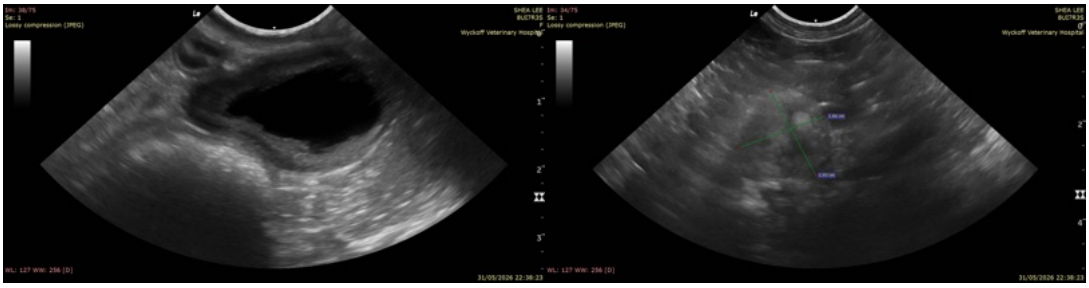
Mild urinary bladder wall thickening is present; however, interpretation is limited by underdistension. Mild chronic cystitis cannot be excluded.

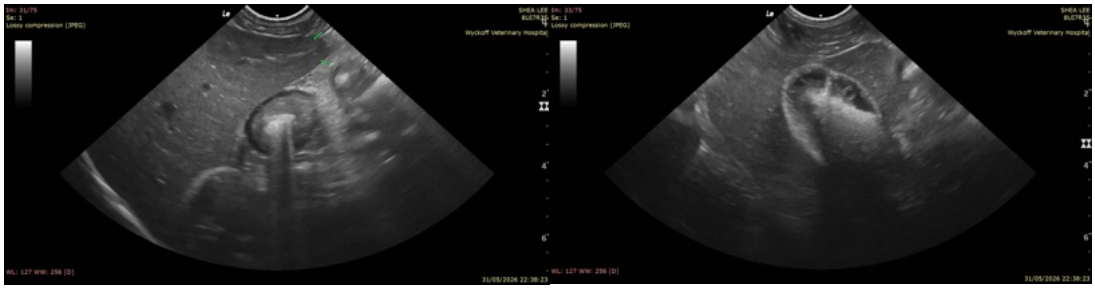
Overall, the left adrenal mass is considered the clinically dominant finding and warrants further investigation. Given the associated hepatobiliary changes and proteinuria, a functional adrenocortical tumor with adrenal-dependent hyperadrenocorticism should be considered a leading differential diagnosis.

Recommendations

- Endocrine testing as clinically indicated.
- Blood pressure measurement.
- Repeat UPC and complete IRIS proteinuria staging. Urine culture if clinically indicated.
- Consider advanced imaging (CT angiography) if surgical treatment of the adrenal mass is contemplated, particularly to assess vascular invasion.
- Serial ultrasonographic monitoring of the gallbladder.

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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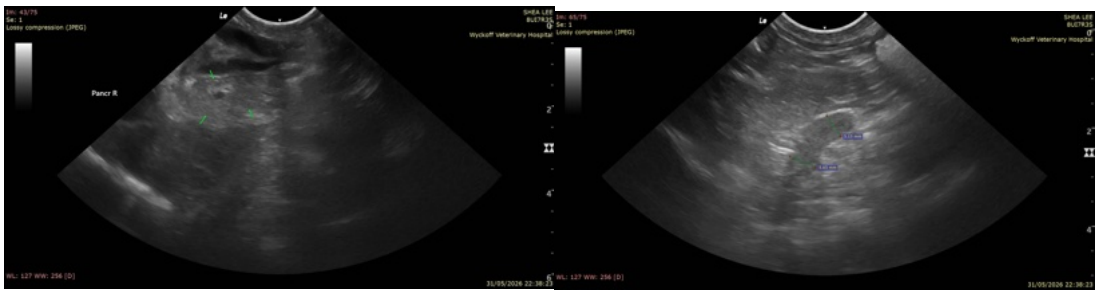

**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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