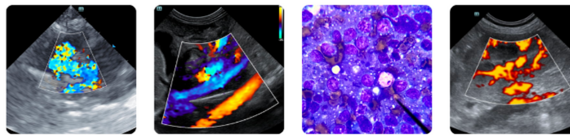

PATIENT

Richard Gabel

SPECIES

Canine

BREED

Dachshund

SEX

MN

AGE

14 years

WEIGHT

11 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

MountainView Animal
Hospital

REFERRING VET

Dr. Pablo Mendoza

INVOICE

11164

DATE

1/19/2026

PRESENTING CLINICAL SIGNS

11/26 urinary incontinence and signs of pain in the spine. Labwork WNL - 1/16 urinary frequency and inappropriate urination, no incontinence episodes since November. Arching back, tucking tail, offloading weight, pacing, crying when ambulating. No N/V/D. Eating and drinking normal. Hx of kidney stones and plump adrenal glands on prior scans.

Abnormal PE/Chem/CBC/UA Results: BP- 130.138.138 25mg trazadone + Gabapentin for AUS

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture, and echogenicity for a neutered male.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. Punctate non-obstructive nephroliths are noted bilaterally. There is no evidence of pyelectasia or infarcts observed. Left kidney measures 4.01 cm, and the right kidney measures 4.48 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.47 cm at cranial pole and 0.64 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is mildly plump in size (1.0 cm at the cranial pole and 0.72 cm), normal in shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. A hyperechoic nodule is noted in the cranial pole measuring 0.5 cm x 0.6 cm in size. Nodule does not disrupt normal shape and/or architecture.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. One discrete homogenous, hyperechoic nodule is noted mid liver approximately 1.0 cm in diameter. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder

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sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen is moderately distended with an echogenic curvilinear intraluminal interface with strong acoustic shadow. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- The left adrenomegaly is subjectively mildly progressive from the previous exam and should be interpreted in combination with any clinical history of adrenal disease as normal patient variant, chronic stress, etc. can't be ruled out. Similarly hyperechoic adrenal nodule in the cranial pole of the left adrenal. Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.
- Liver nodule – Differentials for a discrete hyperechoic liver nodule include primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, myelolipomas, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.
- Emerging mucocele – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.
- The gastric contents described above could represent normal ingesta/gas if patient has recently eaten although given the shadowing pattern, foreign material can't be ruled out, especially in a

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fasted patient. An additional 12 – 24 hours of fasting followed by recheck imaging of the stomach could be considered.

SECONDARY FINDINGS

- Age related pancreatic remodeling.
- Age related kidney changes with punctate non-obstructive nephroliths bilaterally.

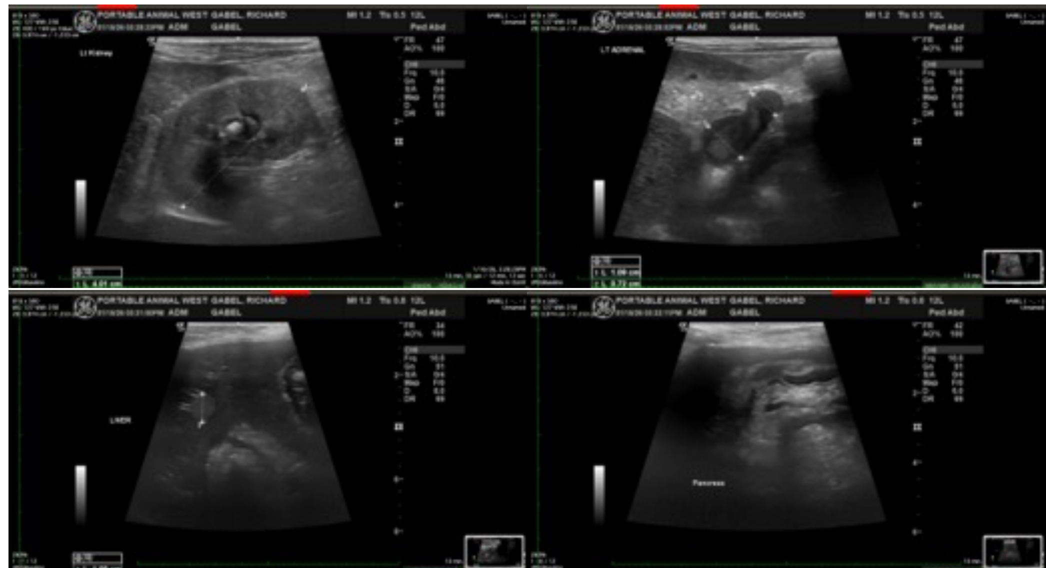
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study is largely static to very mildly progressive in terms of the subtle mild pathologies described above with the primary change being the very mildly progressive left adrenomegaly and mildly subjectively progressive gallbladder debris. There is not a definitive ultrasonographically visible intraabdominal explanation for patient's reported clinical signs.

Further workup, given these signs, include:

- A blood pressure if not recently evaluated.
- Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.
- Additionally, a full general metabolic health screen is recommended if not recently evaluated to also include CBC, chemistry panel, and electrolytes.

Beyond that, further neurologic evaluation, potentially consultation with a veterinary neurologist and/or even advanced imaging would be appropriate.



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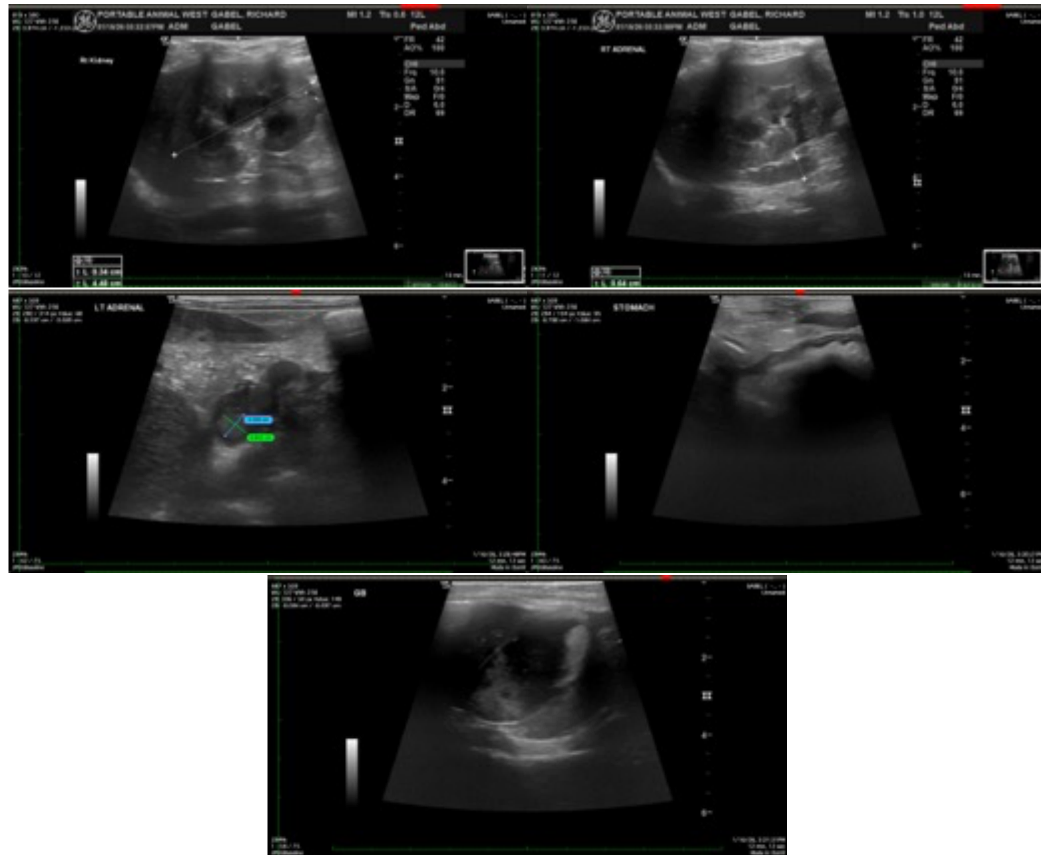

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com