



PATIENT

Riley Goecke

SPECIES

Canine

BREED

West Highland White
Terrier

SEX

SF

AGE

9 years

WEIGHT

24 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Allison Maxey

HOSPITAL NAME

Evergreen Animal
Hospital

REFERRING VET

Dr. Allison Maxey

INVOICE

11601

DATE

3/31/2026

PRESENTING CLINICAL SIGNS

Moderate ALP elevation and proteinuria on routine annual labwork. LDDST pending for HAC. Pet mostly asymptomatic other than maybe increased panting and possibly polyuric.

Abnormal PE/Chem/CBC/UA Results: ALP 729 U/I UPC 1.4

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.

Age related kidneys -

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. There is no evidence of mineral or infarcts observed. Left kidney measures 4.2 cm. The right kidney measures 4.9 cm and contains trace pyelectasia.

Adrenal Glands

The right adrenal gland is normal in size (0.43 cm at cranial pole and 0.35 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 cm at cranial pole and 0.51 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is generally normal in size and shape with a smooth capsular contour. Parenchyma is diffusely nodular in appearance characterized by small discrete hypoechoic nodules. 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. Multifocal discrete homogenous, hyperechoic nodules are noted throughout the liver parenchyma with a representative one in the left measuring 0.4 cm x 1.0 cm in size. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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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 pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. 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.

ULTRASONOGRAPHIC FINDINGS

- Liver nodules – Differentials for a discrete hyperechoic liver nodules 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.
- Moderate gallbladder debris - 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. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- Splenic micronodular hyperplasia pattern – This nodular change is often associated with benign aging nodular hyperplasia. Infiltrative neoplasia, however, including both early hemangiosarcoma as well as round cell neoplasia cannot be ruled out.

SECONDARY FINDINGS

- Mild to moderate age-related kidney changes with trace pyelectasia in the right kidney.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The adrenal glands as described above appear normal, however, that doesn't rule out hyperadrenocorticism. Therefore, if clinical signs are consistent with hyperadrenocorticism, and another cause of the alkaline phosphatase, proteinuria, etc. is not identified then testing may be appropriate, beginning with a low dose dexamethasone suppression test. Additionally, in the meantime, if not recently evaluated a blood pressure is recommended.

Otherwise, given the changes described above or in the meantime fine needle aspirates of the spleen and liver could be considered if patient's coagulation status is appropriate and/or hepato nutraceuticals including ursodiol could be considered while monitoring the gallbladder debris for



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improvement.

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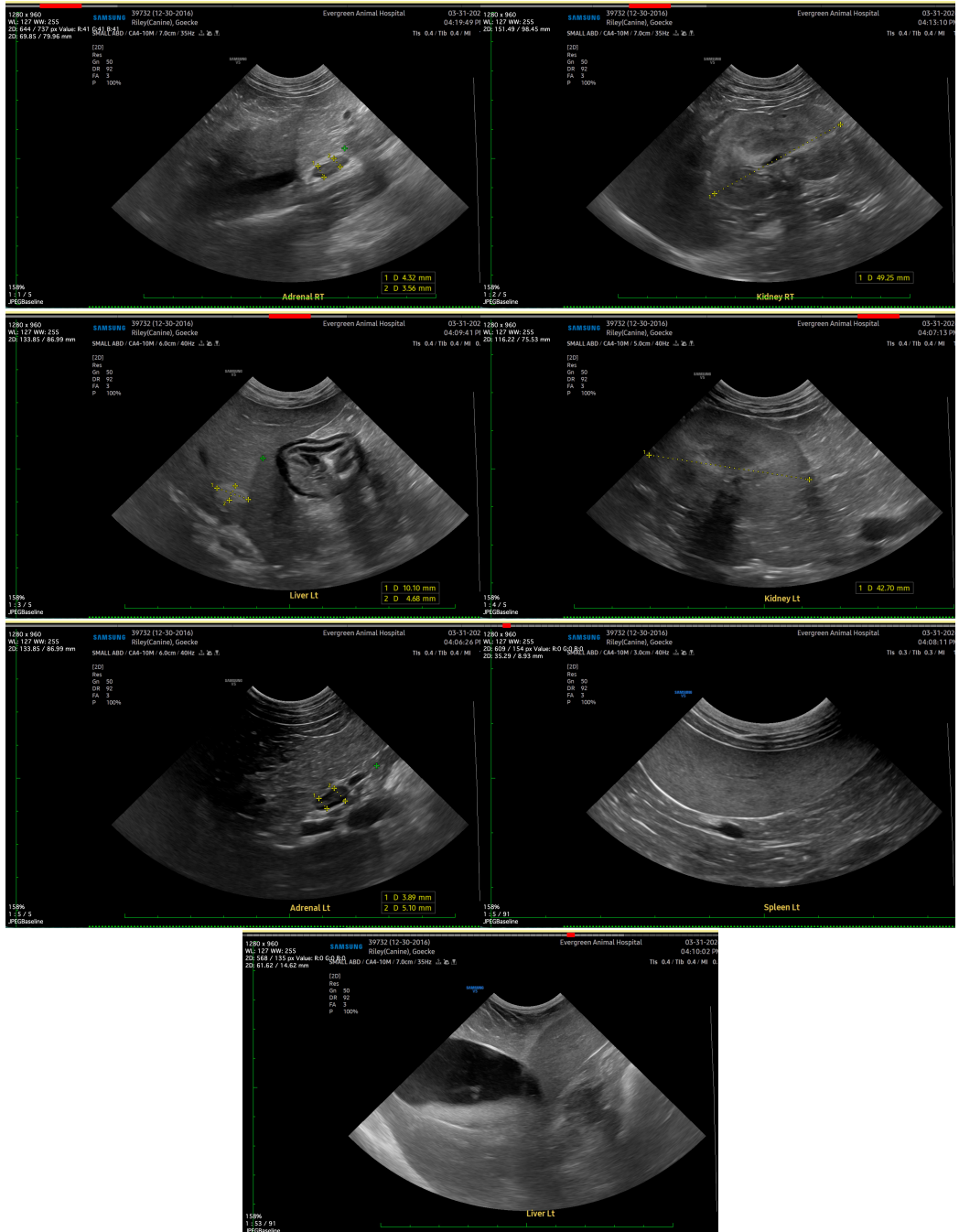
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance please contact me.

Beth Johnson, DVM, DACVIM
info@sonopath.com