



**PATIENT**

Tango Gonzalez

**SPECIES**

Canine

**BREED**

Setter x

**SEX**

Neutered Male

**AGE**

11 Years

**WEIGHT**

26.8 kg

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Crystal Hill

**HOSPITAL NAME**

The Collegeway Animal  
 Hospital

**REFERRING VET**

Dr. Hanna

**INVOICE**

74741

**DATE**

4/23/26

**PRESENTING CLINICAL SIGNS**

Lethargy, increased water consumption, elevated liver values on bloodwork. Has been on Ursodial, proconceptis proliv supplement.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

Urinary bladder is markedly underdistended/almost empty. Apical urinary bladder wall is diffusely thick (0.70 cm thick). Mucosa is hyperechoic and irregular. The underdistended/empty state is likely at least in part exacerbating the thick, irregular wall. Therefore normal variant versus cystitis can't be ruled out. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

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

The right kidney is normal is size (6.8 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (6.56 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

**Adrenal Glands**

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 1.2 cm at the cranial pole and 0.85 cm at the caudal pole. Right measures 2.4 cm at the cranial pole and 0.95 cm at the caudal pole.

**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. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

**Gastrointestinal**

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.



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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 mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

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**

- Bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.
- Possible chronic cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes. \*Reassessment of a fully distended urinary bladder is recommended.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given patient’s reported increased water consumption and increased liver enzymes combined with the adrenomegaly, emerging adrenal disease could be a consideration. Having said that, that interpretation depends in large part on the degree of liver enzyme increase as well as the specific pattern i.e., primarily hepatocellular injury pattern versus cholestatic pattern, etc. Additionally, hyperadrenocorticism typically does not result in a sick patient, lethargy, etc. Therefore, prior to hormone testing, further evaluation/workup for other causes of a possible hepatopathy or causes of lethargy may be warranted.

A blood pressure is recommended 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.



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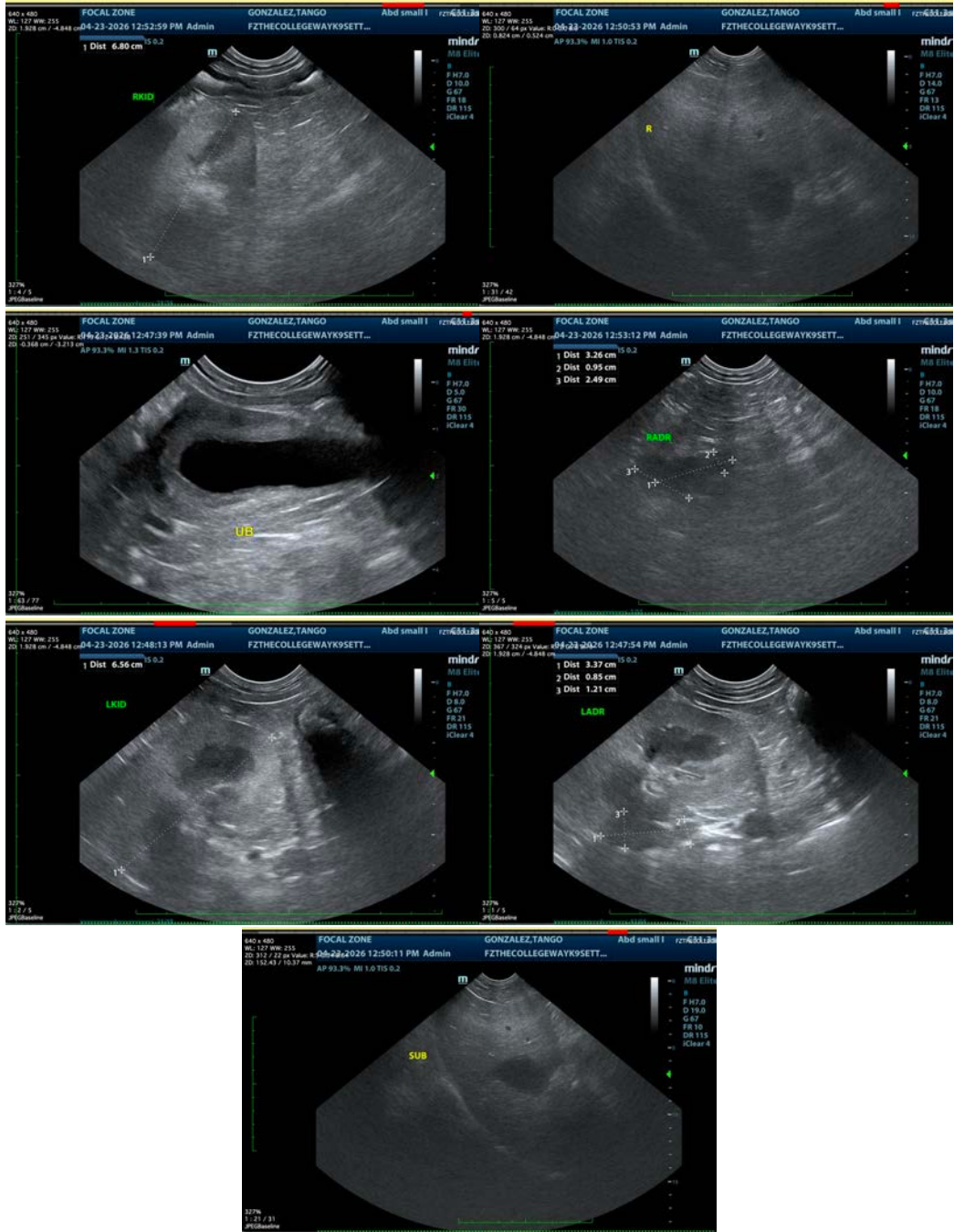
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

**Beth Johnson, DVM, DACVIM**  
[info@sonopath.com](mailto:info@sonopath.com)