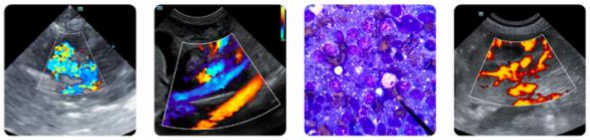




SonoPath.com info@sonopath.com 1.800.838.4268

**PATIENT**

Opie Balcom

**SPECIES**

Canine

**BREED**

Dachshund

**SEX**

Neutered Male

**AGE**

9 Years

**WEIGHT**

23 Pounds

**INTERPRETED BY**

Dr Brittany Sinclair, BVSc(hons), DACVECC

**IMAGING PERFORMED BY**

Dr. Megan Bray

**HOSPITAL NAME**

Taylorsville VC

**REFERRING VET**

Dr. Megan Bray

**INVOICE**

35937

**DATE**

2/23/26

## PRESENTING CLINICAL SIGNS

- Presented for dental procedure today, possible tooth root abscesses with purulent material noted.
- Due to abnormal lab work a AUS was done rather than a dental procedure
- Mild weight gain was noted. 17 lbs to today 23 lbs
- Abnormal PE/Chem/CBC/UA Results: Decreased USG, per owner not drinking more water. Laboratory Findings (from 02/19/2026): Hepatic: MILDLY ELEVATED liver values. One value is 332 (normal high is 160). This may be secondary to the severe dental disease. Endocrine: MILDLY ELEVATED blood glucose, suspected to be stress-induced. Renal/Urine: Urine was NOT CONCENTRATED. Owner does not report any clinical signs of polyuria or polydipsia. See attached labs

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The left kidney measured 4.39 cm in length. The right kidney measured 4.8 cm in length.

### *Adrenal Glands*

Both adrenal glands were visualized and recognized. Both were subjectively prominent. No specific masses or nodules seen. The phrenic vasculature, glandular echogenicity and detail were unremarkable. The left adrenal gland measured 1.4 cm in length and 0.75 cm at the caudal pole and 0.89 cm at the cranial pole. The right adrenal gland measured 2.14 cm in length and 0.83 cm at the caudal pole and 0.64 cm at the cranial pole.

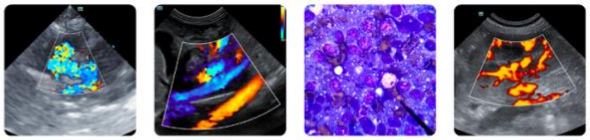
### *Spleen*

The spleen was normal with age-appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

### *Liver*

The liver is subjectively normal in size with a diffusely slightly hyperechoic and coarse echotexture. There are multifocal variably sized generally small, poorly defined hypoechoic nodules throughout. There are no specific masses visualized.

Gall bladder is moderately distended. There is gravity dependent nonshadowing debris, as well as a curvilinear shadowing object within the lumen of the gallbladder. This object is not visible in every view.





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## *Gastrointestinal*

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

## *Pancreas*

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

## *Lymph Nodes*

No clinically significant lymphadenopathy or abnormalities noted.

## *Free Abdomen*

No masses or free fluid were noted.

## ULTRASONOGRAPHIC FINDINGS

- Mild hepatic parenchymal changes with hyperechogenicity and poorly defined small nodules
- Gallbladder debris with possible developing cholelith
- Bilateral adrenomegaly

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Liver changes are a common benign age-related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. No significant disruption of architecture noted to suggest significant pathology. In the face of elevated liver enzymes, fine needle aspirate is recommended to further characterize parenchymal changes, and bile acid profile to assess liver function, especially if any weight loss is noted or for baseline cytological assessment. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol if bilirubin elevated or gallbladder sludge) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued.

The material within the gallbladder appears consistent with a developing cholelith in some views. Their presence can cause inflammation and may cause subclinical or clinical cholangitis which can cause elevations in liver values. GI signs of inappetence or vomiting may be seen as their presence can cause intermittent abdominal pain and nausea. Their presence may act as a nidus of infection and predispose to cholangiohepatitis. They have the potential to move into the common bile duct causing obstructive cholangitis. Abdominal radiographs may be of use to further visualize choleliths.

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Adrenomegaly is bilateral and may represent stressful illness or hormonal stimulation as is seen with pituitary dependent hyperadrenocorticism. If corresponding clinical signs are present, a urine cortisol creatinine ratio could be used as a screening test, and subsequent testing for hyperadrenocorticism should be considered (ACTH stimulation test vs LDDST).

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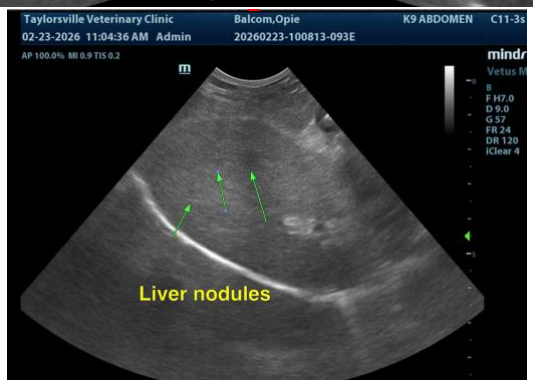


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com