



**PATIENT**

Marley Evans

**SPECIES**

Canine

**BREED**

Dachshund

**SEX**

FS

**AGE**

15yr

**WEIGHT**

7.45kg

**INTERPRETED BY**

R. McKenzie Daniel,  
DVM, DABVP  
(Canine and Feline)

**IMAGING PERFORMED BY**

McFarlen, Judy

**HOSPITAL NAME**

Westview Veterinary  
Hospital

**REFERRING VET**

McFarlen, Judy

**INVOICE**  
23065

**DATE**

11/24/2025

**PRESENTING CLINICAL SIGNS**

recent onset dementia/head pressing/neuro signs. Responded to iv fluids and antibiotics. alp >5000 alt moderate elevation, bili normal

Abnormal PE/Chem/CBC/UA Results: pu/pd, prior diagnosis of Cushings on LDDS test. (. 1yr ago) No treatment , alp >5000 alt moderate elevation, bili normal -urine could not be collected until after antibiotics started . usg 1.004 usually around 1.012 Plan: continue amoxicillin/restart trilostane again-stopped this in Jan. suspected acute cholecystitis or fatty liver

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Bilateral areas of minor focal medullary mineral were present. The left kidney measured 4.7 cm in length. The right kidney measured 5.0 cm in length.

The area of the aortic trifurcation was free of pathology.

**Adrenal Glands**

The bilateral adrenal glands were enlarged in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.82 cm width in the caudal pole. The right adrenal gland measured 0.73 cm width in the caudal pole.

**Spleen**

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Multifocal, small well-defined, symmetrical, echogenic nodules were present throughout the cranial to caudal parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas. Pinpoint hyperechoic splenic foci suggestive of areas of microinfarction, fibrosis or mineralization were present.

**Liver/Gallbladder**

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with moderate non-dependent non-organized to



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elongated congealed was present. No evidence of peripheral gallbladder inflammation or wall edema was present. The cystic and common bile ducts were normal.

Transdiaphragmatic view revealed mild comet tail lung pattern, which is echogenic sound wave interface with microconsolidations within the caudal lung field. The lung field should not be visualized by sonogram unless pathology is present. Chest radiographs are recommended to rule out alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation.

### **Gastrointestinal**

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

### **Pancreas**

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

### **Free Abdomen**

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary**

- Benign hepatopathy- chronic marked steroid or vacuolar hepatopathy, concurrent inflammatory disease, non-obstructive cholestasis, less likely lipidosis or occult neoplasia
- Non-organized gallbladder debris (non-mucocele)
- Chronic renal changes, exhibiting mild medullary mineral and pyelectasia
- Bilateral adrenomegaly- most consistent with PDH criteria
- Remodeled pancreas
- Mild transdiaphragmatic cometose artifact

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Assessment of systemic BP for evidence of hypertension as well as baseline coagulation profile to assess for possible hypercoagulable state if evidence of thoracic pathology on three view chest radiographs is suggested. Hepatop supportive medications may prove beneficial. Although no evidence of hepatic neoplastic criteria or post-hepatic stasis, screening FNA cytology of the liver could be considered for further clarification, primarily to assess for inflammatory criteria.



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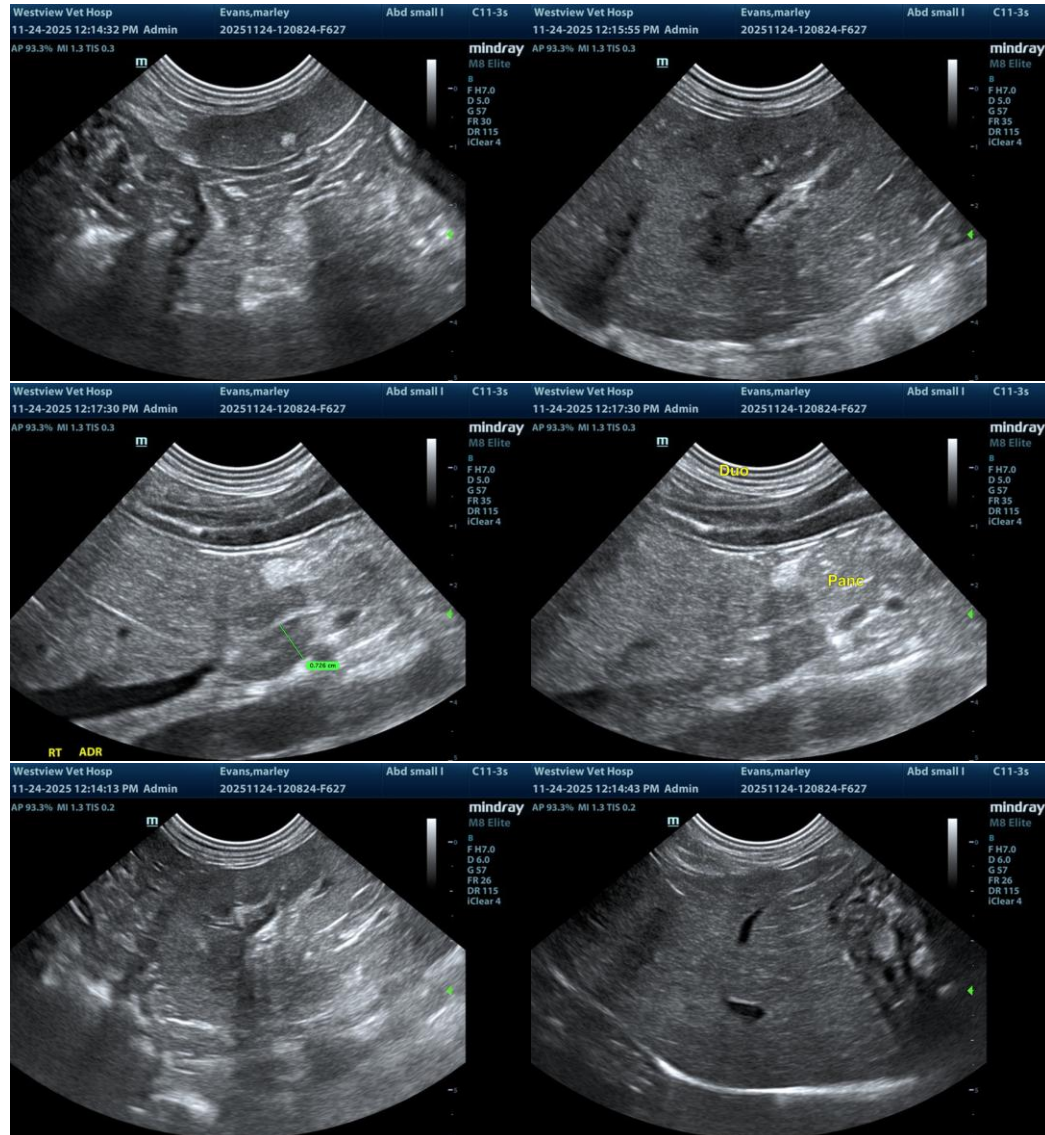
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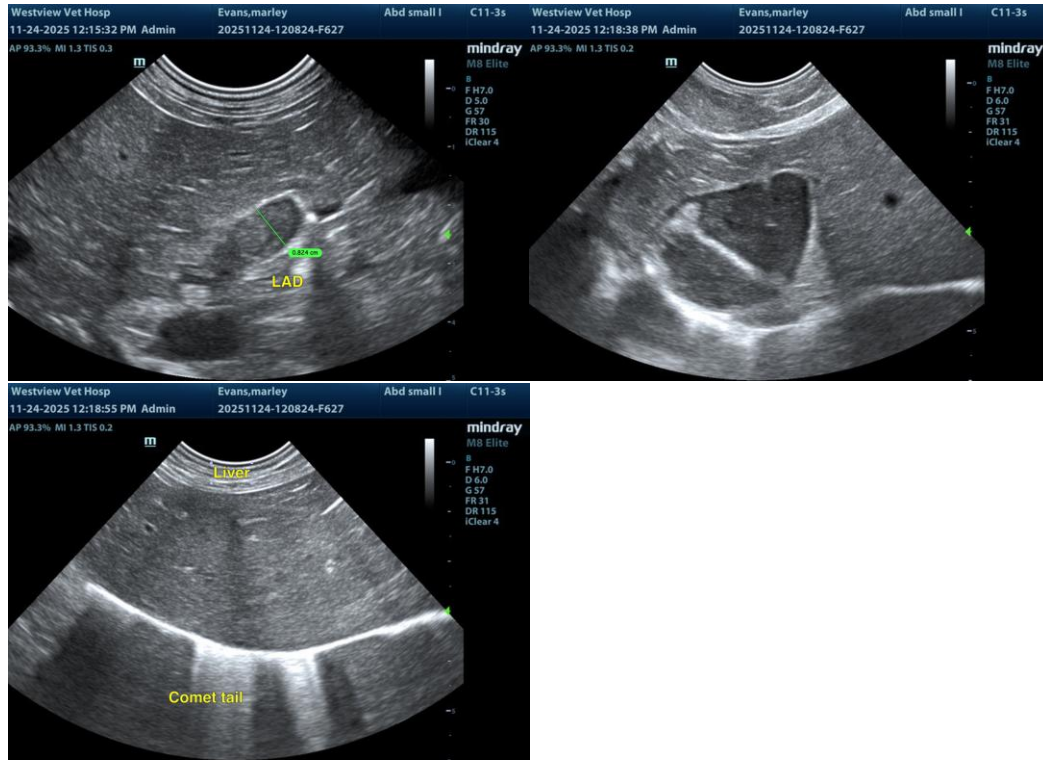
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)  
[info@sonopath.com](mailto:info@sonopath.com)