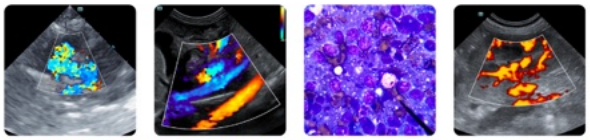


PATIENT

Rocco Pratt Mattson

SPECIES

Canine

BREED

Terrier Cross

SEX

Neutered male

AGE

15 years

WEIGHT

19.3 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Warner

HOSPITAL NAME

VTNH Vet Clinic

REFERRING VET

Dr. Jacobs

INVOICE

74688

DATE

4/21/26

PRESENTING CLINICAL SIGNS

History: Rocco is a 15 yr old terrier mix with hyperadrenocorticism that is well managed on Trilostane 10 mg (compounded SID).
In the past few weeks he developed PU/PD, needed to go out to urinate twice a night.
Eating well, no change in diet but lost 5# (was obese, now approaching good BCS).
His hearing is decreased and is developing cataracts.
No other imaging available.
Abnormal PE/Chem/CBC/UA Results: On April 1, 2026 he had a PE and CBC/Chem 10 and ACTH stim. CBC mild lymphopenia (1.03) and mild eosinopenia (0.03). Chem10 ALT mildly elevated (203), ALP severely elevated (>2000) No UA results available Results of ACTH stim were good- pre= 1.6, post = 1.9 with goal of 1.5-6 so hyperadrenocorticism is well controlled. Dog has high AP (>2000) with mild increase in ALT. BG was normal, renal values normal. A primary liver/gallbladder issue may be source of high AP as HAC appears well controlled. BP taken after US while on butorphanol w/gaba premeds but reasonably awake: 150mmHg

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is moderately distended, and the wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size, measuring 3.44×2.87 cm, with a cortical thickness of 0.44 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 4.15×3.58 cm, with a cortical thickness of 0.37 cm.

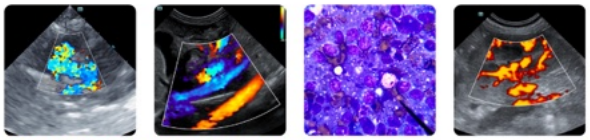
In both kidneys, cortical echogenicity is within normal limits. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Prostate

The prostate is small, homogeneous and hypoechoic, consistent with post-castration atrophy.

Adrenal Glands

Adrenal glands: the left adrenal gland is markedly enlarged and rounded, measuring 1.62 cm at the cranial pole and 1.31 cm at the caudal pole. These measurements are significantly above expected values for a dog of this size (<0.7 cm), indicating marked enlargement. The right adrenal gland measures 0.55 cm at the cranial pole and 0.60 cm at the caudal pole, which is within normal limits.



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Spleen

Splenic thickness is 1.08 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively enlarged, with mildly rounded margins and a regular contour. The hepatic parenchyma is diffusely hyperechoic relative to the spleen, with a fine echotexture and mild attenuation of the ultrasound beam. Several small hypoechoic foci measuring up to 1 cm are identified. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended. The wall is thin, and the contents are primarily anechoic with a small amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.83 mm and preserved wall layering. The pylorus measures 5.32 mm. The duodenum measures 2.52 mm, and the jejunum measures 2.98–3.53 mm, both within normal limits (<5 mm), with preserved wall layering. No signs of inflammation, ileus, or foreign material are identified. The colon measures 0.89 mm, with formed feces in the descending segment.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

Within the caudal vena cava, a hyperechoic intraluminal structure measuring 1.25×1.78 cm is identified, consistent with a thrombus. No abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Marked enlargement of the left adrenal gland.
- Intraluminal thrombus within the caudal vena cava.
- Hepatomegaly with diffuse hyperechogenicity and mild attenuation.

SECONDARY FINDINGS

- Few small hepatic hypoechoic foci.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most clinically significant findings are the marked unilateral enlargement of the left adrenal gland and the presence of a caudal vena cava thrombus. In a dog of this size, an adrenal diameter exceeding 1 cm is clearly abnormal, and measurements of 1.62 cm strongly support the presence of an adrenal mass, most consistent with an adrenocortical tumor. The contralateral (right) adrenal gland is within normal size limits, which further supports a unilateral neoplastic process rather than bilateral adrenal hyperplasia.

The concurrent identification of a caval thrombus raises strong concern for tumor-associated vascular involvement or secondary thrombosis, both of which are well recognized in association with adrenal neoplasia. However, bland thrombus is also possible.

The liver is enlarged and diffusely hyperechoic with mild attenuation, a pattern commonly associated with vacuolar hepatopathy, as expected in dogs with hyperadrenocorticism and consistent with the markedly elevated ALP. The small hypoechoic hepatic foci are nonspecific but, given their size and distribution, are most consistent with benign nodular changes such as nodular hyperplasia, although other etiologies cannot be entirely excluded.

Recommendations

- This is a clinically significant and potentially advanced adrenal disease, and further characterization is essential to guide prognosis and treatment options.
- Coagulation status and risk of thromboembolic complications should be clinically assessed; antithrombotic therapy may be considered based on the attending clinician's judgment.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.

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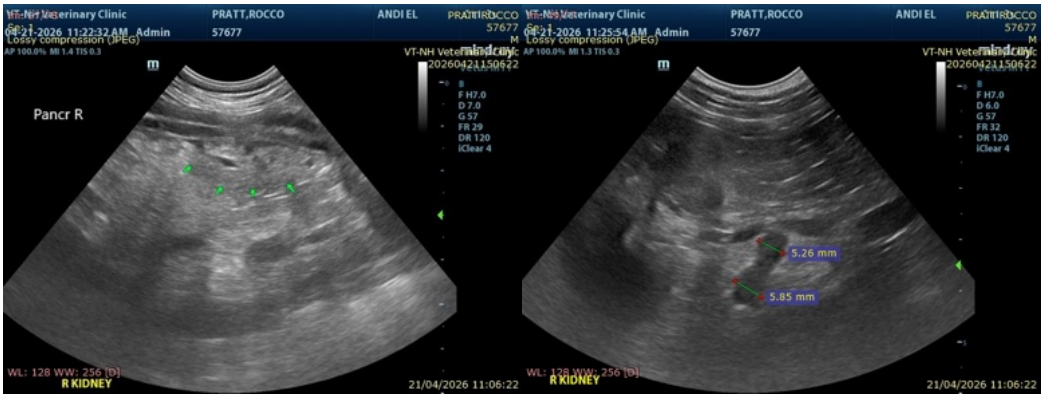

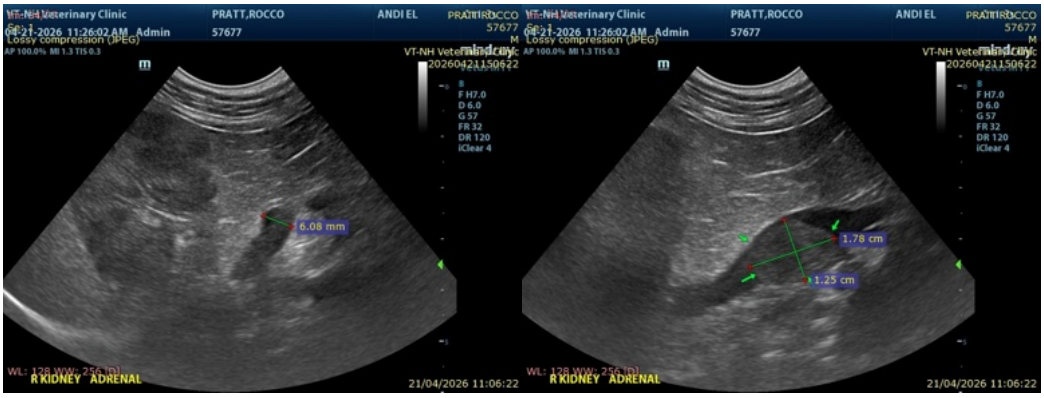

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com