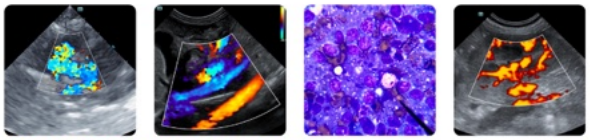


PATIENT

Stanley McCrory

SPECIES

Canine

BREED

Doodle

SEX

Neutered male

AGE

9 years

WEIGHT

26.8 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Danielle RVT

HOSPITAL NAME

Orchard VC

REFERRING VET

Dr. Gudelot

INVOICE

74970

DATE

4/29/26

PRESENTING CLINICAL SIGNS

History: Presented August 2025 for large abscess (at other clinic). BW at that time showed incidental elevations in ALT and ALP. Have been trending values since then, and ALT, ALP, and cholesterol are slowly climbing but not markedly elevated. T4/TSH normal. No clinical signs at home. On Zentonil. Owners elected to pursue abdominal ultrasound to r/o any concerning pathology. Suspect benign age-related changes.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended, with a thin and smooth wall. The urine is anechoic. The bladder neck and proximal urethra appear normal. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney measures 6.27×3.65 cm, with a cortical thickness of 0.65 cm in the sagittal plane. The right kidney measures 6.07×3.53 cm, with a cortical thickness of 0.62 cm in the sagittal plane. Both kidneys are normal in shape and size for a dog of this body weight (expected length approximately 5.5–7.5 cm). Cortical thickness is within normal limits (~0.5–0.8 cm). The cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland measures 0.57 cm at the cranial pole (within normal limits). The caudal pole is enlarged, measuring 1.10×1.59 cm, and appears hyperechoic and relatively homogeneous. The right adrenal gland measures 0.73 cm at the cranial pole and 0.80 cm at the caudal pole, which is mildly enlarged relative to expected values (typically ≤0.7 cm).

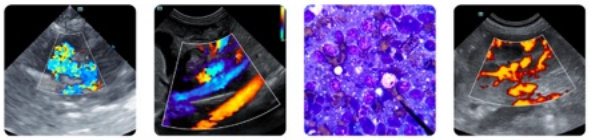
Spleen

Splenic thickness is 2.05 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 mildly enlarged, with rounded margins and regular contour. The parenchyma is mildly hyperechoic relative to falciform fat, with a homogeneous echotexture. No hepatic lymphadenopathy is identified.

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



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Gastrointestinal

The stomach is nearly empty, containing minimal ingesta, with a wall thickness of 1.94 mm and preserved layering (within normal limits). The duodenum measures 3.94 mm, the jejunum 3.93–4.14 mm, and the ileum 3.37 mm, all within normal limits, with preserved wall layering. The ileocecal junction appears normal. No ultrasonographic evidence of inflammation, ileus, or foreign material is identified. The colon measures 0.63–0.92 mm, within normal limits, with formed feces in the descending segment.

Pancreas

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

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Marked enlargement of the caudal pole of the left adrenal gland
- Mild enlargement of the right adrenal gland.
- Hepatomegaly with diffuse mild hyperechogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant finding is bilateral adrenal enlargement, with marked asymmetric enlargement of the left adrenal gland. The left adrenal gland demonstrates a nodular, hyperechoic, and relatively homogeneous enlargement of the caudal pole, while the right adrenal gland is mildly enlarged.
This pattern is most consistent with adrenocortical disease, with hyperadrenocorticism being the leading consideration. The presence of bilateral involvement, although asymmetric, favors pituitary-dependent hyperadrenocorticism over a unilateral adrenal tumor; however, the degree of enlargement and nodular change on the left side raises the possibility of nodular adrenal hyperplasia or less likely an adrenal mass with contralateral stimulation.

The hepatic findings are consistent with vacuolar hepatopathy, which commonly occurs secondary to chronic glucocorticoid excess and aligns with the adrenal findings and the biochemical trends (elevated ALP, ALT, and cholesterol).

Importantly, the patient is clinically asymptomatic, and the biochemical abnormalities have been mild and slowly progressive. This supports the possibility of subclinical or early hyperadrenocorticism, which may not yet be associated with overt clinical signs.

Recommendations

- Endocrine testing (LDDS) may be considered to further evaluate adrenal function. However, in patients without overt clinical signs, results can be inconclusive or difficult to interpret, as early

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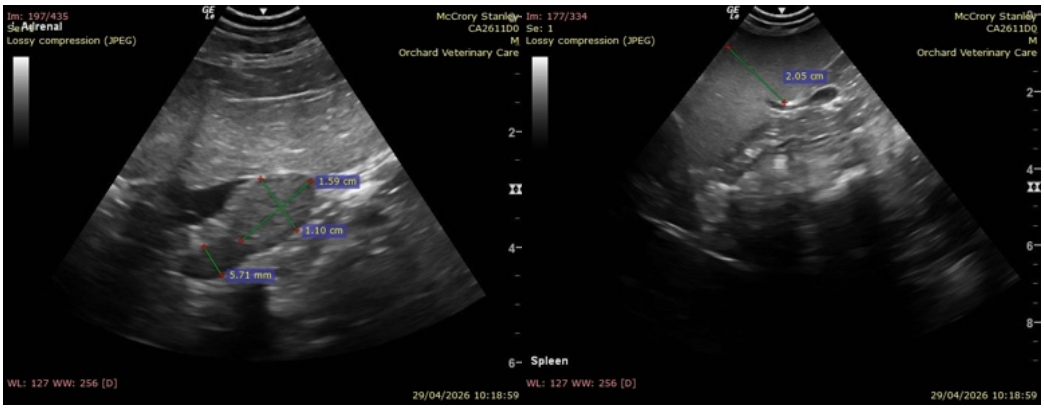
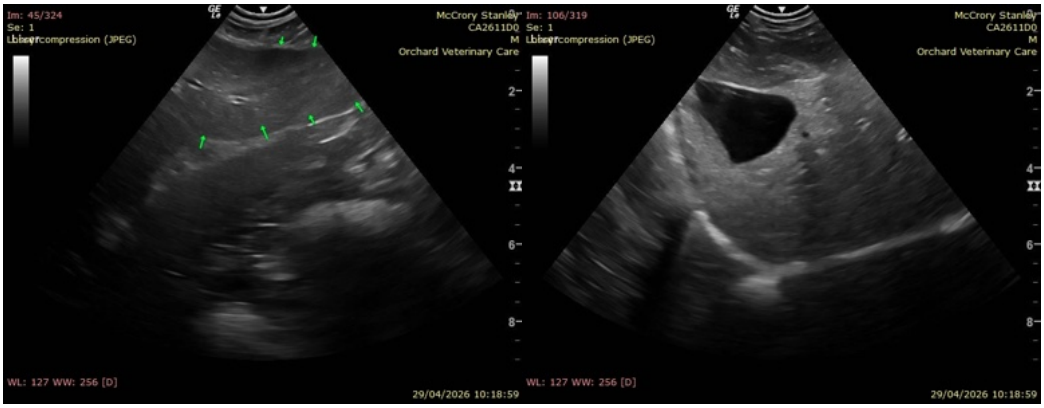
or subclinical hyperadrenocorticism may not yet produce consistent abnormalities in dynamic testing. For this reason, test results should be interpreted with caution and always in conjunction with clinical progression before considering therapeutic intervention.

- Hepatoprotective therapy may be beneficial, although current findings suggest a secondary hepatopathy, and identification of an underlying cause (adrenal disease) remains clinically relevant.
- Continued monitoring of liver enzymes and cholesterol is appropriate.

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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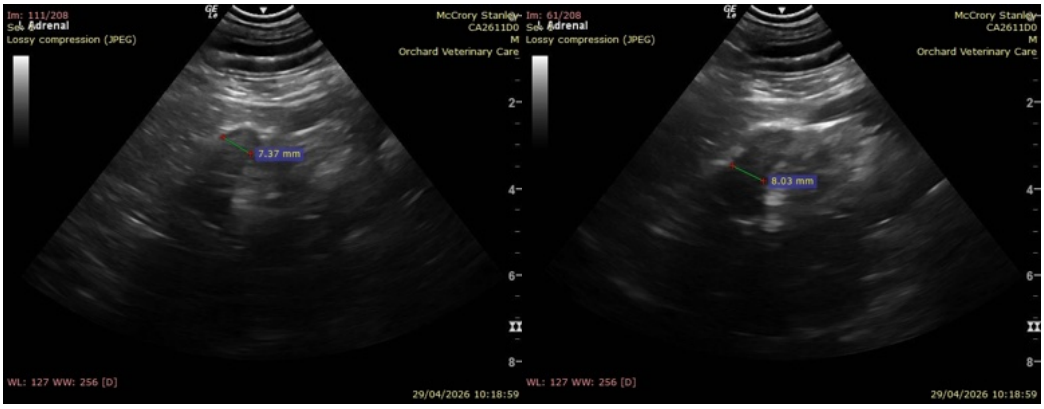

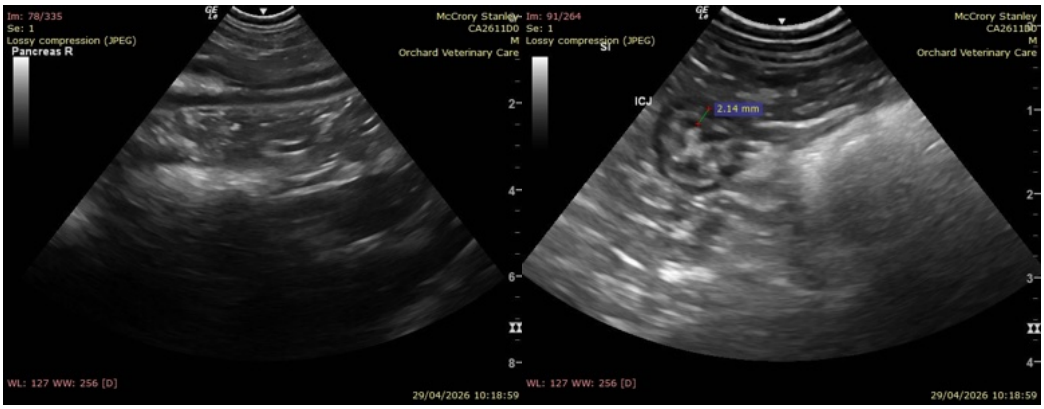

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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