



PATIENT

Yoshi Calabrese

SPECIES

Canine

BREED

Beagle Mix

SEX

Neutered Male

AGE

11 Years

WEIGHT

71 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Morris Hills VC

REFERRING VET

Dr. Hirshenson

INVOICE

35379

DATE

1/13/26

PRESENTING CLINICAL SIGNS

History: R/o adrenal cushings. Elev. blood glucose. BG-462 Elev. liver enzymes.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The prostate is unable to be visualized in these images.

Left kidney is normal in size (6.6 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. A hyperechoic band parallel to the corticomedullary border is present.

Right kidney is normal in size (8.24 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. A hyperechoic band parallel to the corticomedullary border is present.

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. The left adrenal gland measures 1.2 cm at the cranial pole and 1.2 cm at the caudal pole. The right adrenal gland measures 1.9 cm at the cranial pole and 0.77 cm at the caudal pole.

Spleen

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

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

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 stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less



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likely but cannot be definitively ruled out. If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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 echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The left limb of the pancreas is visible, mildly hypoechoic to surrounding tissue, but only very subtly prominent. The pancreas is more difficult to definitively identify on the right side, but what I believe is the pancreas, is more prominent/enlarged in appearance, mildly irregular in shape, with a course hypoechoic appearance, compared to surrounding tissue. **See Free Abdomen

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

There appears to be some non-specific ill-defined diffusely enhanced hyperechoic fat throughout the abdomen, most appreciated in the cranial abdomen adjacent to the pancreatic changes described above.

ULTRASONOGRAPHIC FINDINGS

- The mildly prominent pancreas surrounded by subjectively ill-defined hyperechoic fat suggests some possible mild to moderate acute pancreatitis or potentially an acute on chronic low grade smoldering process. Having said that, enhanced hyperechoic fat/steatitis secondary to other abdominal disease, including diffuse gastrointestinal disease versus other, can't be ruled out.
- 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.
- Bilateral medullary rim sign- This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.



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- Mildly heterogenous liver- Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypochoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

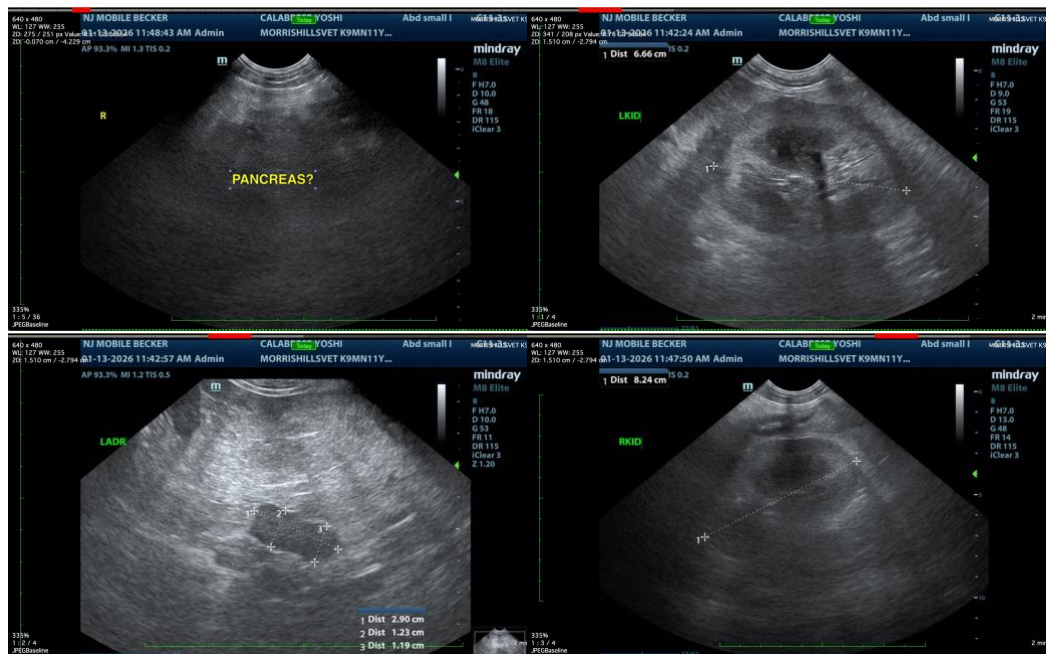
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

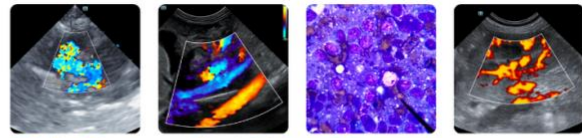
If not recently evaluated, urinalysis, and if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

A blood pressure is recommended.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Further evaluation of the bilateral adrenomegaly is largely dependent on patient's clinical signs. If hyperadrenocorticism is suspected, a low dose dexamethasone suppression test could be considered. If it's diagnosed, then based on imaging alone, it's likely pituitary dependent.





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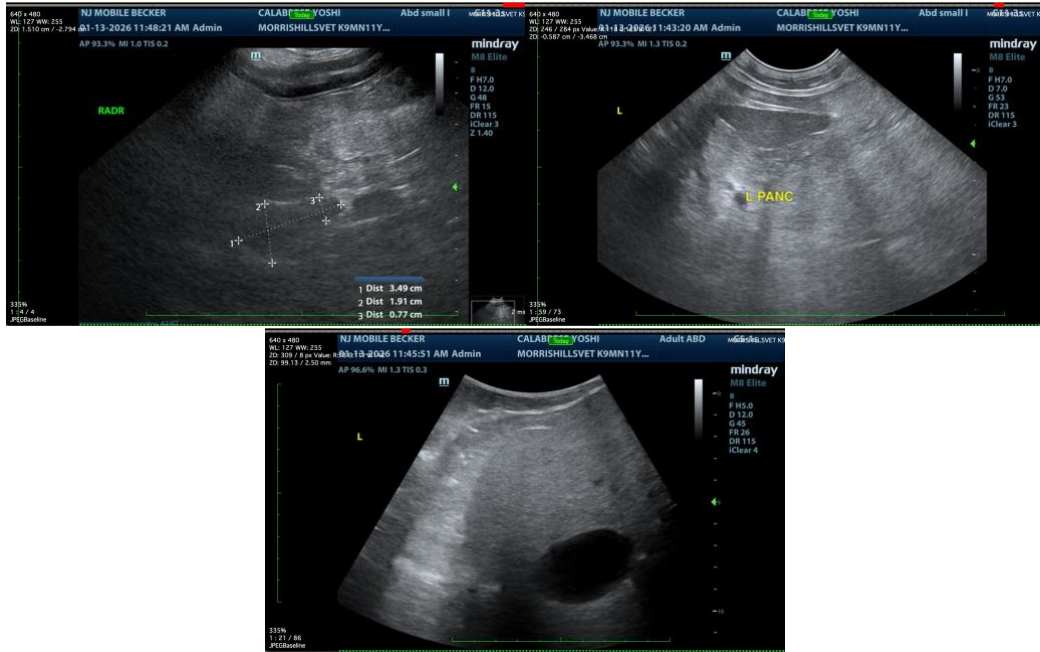
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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