



PATIENT

Truffles Nair

SPECIES

Canine

BREED

Shih Tzu

SEX

Spayed Female

AGE

12 Years

WEIGHT

16 lbs

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Village Centre Animal
 Hospital

REFERRING VET

Dr. Muthalavi

INVOICE

72324

DATE

1/21/26

PRESENTING CLINICAL SIGNS

Polyphagia (always hungry and begging for food).

Abnormal PE/Chem/CBC/UA Results: The primary concern is a significant and progressive elevation in liver enzymes: ALP has increased to 3,197 (normal 5-160). ALT has increased to 266.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 4.05 cm. Right kidney measures 4.4 cm.

Adrenal Glands

Adrenal glands are mildly subjectively plump for a patient this size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.74 cm at the cranial pole and 0.65 cm at the caudal pole. Right measures 1.1 cm at the cranial pole and 0.71 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. Multifocal mineral foci are noted. Splenic vasculature appears normal.

Liver

Liver is relatively normal in size and contour. Parenchyma is mildly heterogenous and coarse with mild likely age-related parenchymal remodeling noted. No focal lesions are observed. 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 with some echogenic debris noted. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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 empty with no evidence of obstruction, foreign material or infiltrative disease.



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

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Pancreas

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The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

SEX

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

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There is no apparent pathologic lymphadenopathy noted in these images.

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PRIMARY FINDINGS

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- Subjectively mild 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.
- Spleen mineralization – This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism.

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SECONDARY FINDINGS

- Moderate age related kidney changes and mild hepatobiliary changes.

IMAGING PERFORMED BY

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not already evaluated, a thorough evaluation of daily caloric intake is recommended to assure an adequate daily caloric intake is occurring vs an inadvertent reduction in calories due to change in diet and/or feeding schedule, competitive eating environment, etc.

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Differentials for a primary cholestatic liver enzyme pattern (increased ALP) are vast and non-specific. Differentials include, but are not limited to, benign nodular hyperplasia which occurs in 70% of older dogs and often does not result in an abnormal ultrasound, reactive or idiopathic/vacuolar hepatopathy, cholestasis and/or hyperadrenocorticism as well as many chronic non-hepatobiliary diseases such as chronic infections/inflammation from dental disease, IBD, neoplasia, hyperlipidemia, hypothyroidism, chronic pancreatitis, chronic stress, etc.

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- Given patient's concurrent polyphagia, especially if the polyphagia is in the face of a normal daily caloric intake and/or supported by any other signs of hyperadrenocorticism, hormone testing could be considered beginning with a low-dose Dexamethasone suppression test.

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- Ursodiol could be considered if gallbladder sludge is noted as a finding.
- A fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate.



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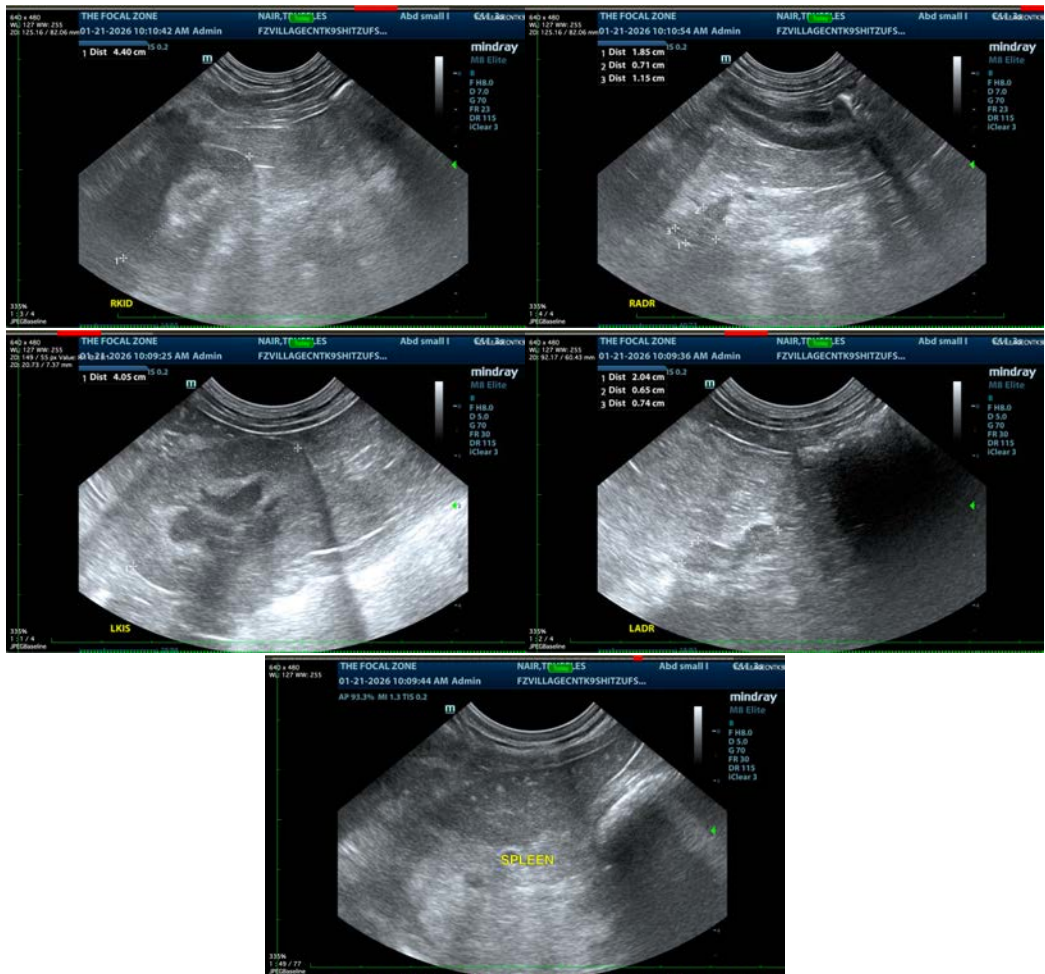
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- Otherwise, recommendations include addressing any other concurrent disease and monitoring. If values are progressive, recheck imaging is recommended.

If not recently evaluated, a 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 ratio is recommended.

A blood pressure is recommended.



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
info@sonopath.com