



PATIENT

Betty Damore

SPECIES

Canine

BREED

Hound x

SEX

Spayed Female

AGE

13 Years 9 Months

WEIGHT

45 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal
Hospital

REFERRING VET

Dr. Alex Peters

INVOICE

72555

DATE

1/28/26

PRESENTING CLINICAL SIGNS

Hx: Patient was sedated with butorphanol. Patient has a hx of significant OA and pancreatitis as well as intermittent UTI. O has recently noticed PU/PD but no PP or panting. Recent screening bloodwork showed NSF except ALT 133, ALP 417, cpl 357 (equivocal range). Fecal NOS. UA - USG 1.009, quiet sediment. Patient was started on liver protectants. Recheck liver enzymes 1 month later: ALT 183, ALP 548, tbili 0.2. Here for screening ultrasound as next step: Current Diet: Royal Canin GI LF Chronic meds: Librela, Hepatosupport.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a mild amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (6.23 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 mineral or infarcts observed. Mild pyelectasia is noted.

The left kidney is normal is size (6.25 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 mineral or infarcts observed. Mild pyelectasia is noted.

Adrenal Glands

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Some likely age related parenchymal heterogeneity is present. Visible surrounding vasculature appears normal. Left measures 0.78 cm at the cranial pole and 1.67 cm at the caudal pole. Right measures 2.3 cm at the cranial pole and 1.0 cm at the caudal pole.

Spleen

Spleen is subjectively normal in size (1.6 cm thick at the hilus) with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is diffusely mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Additionally, in the left caudal liver there is a discrete homogeneous hyperechoic nodule measuring 1.3 cm x 0.90 cm in size. Visible vasculature and biliary tree appear normal without distension or congestion.

The 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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach contains a 3.3 cm in diameter echogenic density with strong acoustic shadow. 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 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 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.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- 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.
- Mildly heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Non-fully obstructive gastric foreign material can't be ruled out. Having said that, normal ingesta and gas can mimic this finding. Therefore, this finding should be interpreted in combination with when patient last ate. Follow up imaging after an additional 12-24 hours of fasting could be considered.

SECONDARY FINDINGS

- Mild amount of echogenic urinary bladder debris.
- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.



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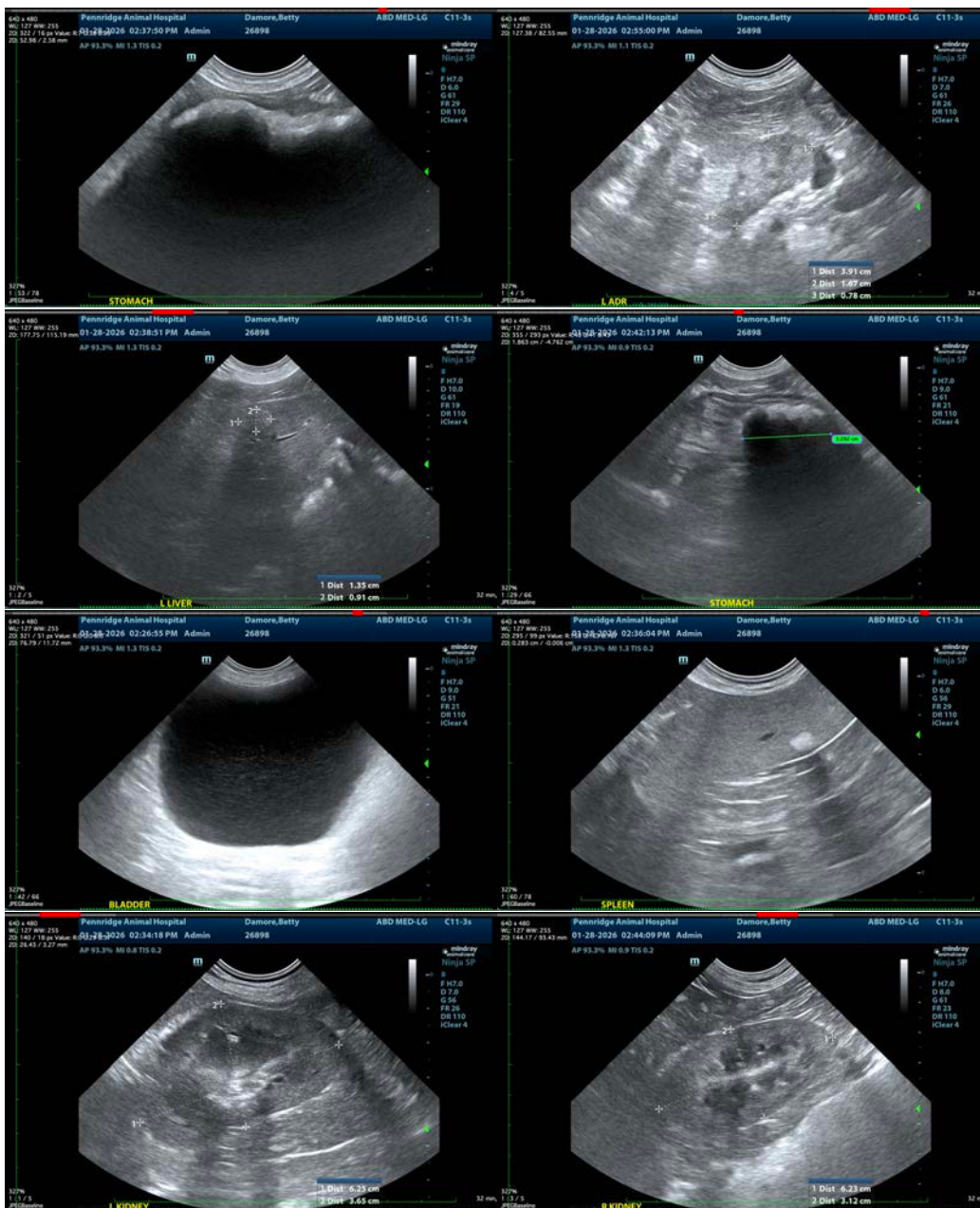
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a blood pressure is recommended.

Given the bilateral adrenal gland changes combined with appropriate clinical signs of adrenal disease i.e., PU/PD, hormone testing could be considered, beginning with a low-dose Dexamethasone suppression test.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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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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