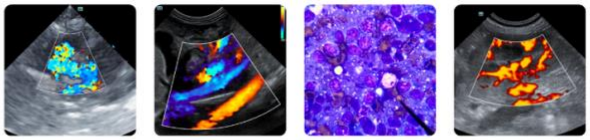


PATIENT

Sirius Black Grande

SPECIES

Canine

BREED

Labradoodle

SEX

Neutered Male

AGE

11 Years

WEIGHT

28 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Anthony Krawitz DVM

HOSPITAL NAME

Calusa Veterinary Clinic

REFERRING VET

Dr. Courtney Glotzer DVM

INVOICE

12484

DATE

11/26/25

PRESENTING CLINICAL SIGNS

Past 2 days has become very lethargic and loss of appetite and thirst. Previously has had raised hepatic enzymes long term however today much higher. A previous ACTH stimulation test earlier in the year was equivocal, however another one is being run today.

Abnormal PE/Chem/CBC/UA Results: Alk phos 2032 (last was 1287), ALT 3444 (was 737), GGT 17 (was 17), Total Bili 3.1 from 0.1 prior). PT normal but PTT raised at 127. PCV 42, TP 8.0 and Alb 3.0. Potassium 2.9. Platelet 50,000 and low normal WBC and neutrophils with suspected toxic band cells.

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

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. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted.

Right kidney is normal in size (6.2 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. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted.

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 0.90 cm at the cranial pole and 0.90 cm at the caudal pole. The right adrenal gland measures 1.0 cm at the cranial pole and 1.0 cm at the caudal pole.

Spleen

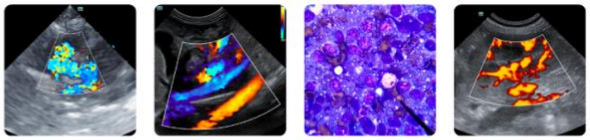
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

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



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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.

In the mid abdomen medial to the spleen is a loop of bowel with a mildly corrugated thick wall measuring 0.40 cm thick with normal intact layering that I believe represents the descending colon.

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.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Suspect mildly thick colon with intact layers in consistent with a benign colitis potentially parasitic, infectious, dietary related, or other benign inflammatory, etc. with an infiltrative neoplastic process being possible but considered less likely.
- An obvious cause for the subtle liver changes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia (considered unlikely), etc. cannot be definitively ruled out.

Secondary 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.
- Nonobstructive dystrophic mineralization bilaterally in the kidneys.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This is a largely static study in terms of the hepatic changes with very mild progression in the adrenomegaly and new mildly thick colon.

- While this patient's bilateral adrenomegaly could indicate emerging adrenal disease such as hyperadrenocorticism, the patient's clinical history and liver enzyme pattern is not consistent

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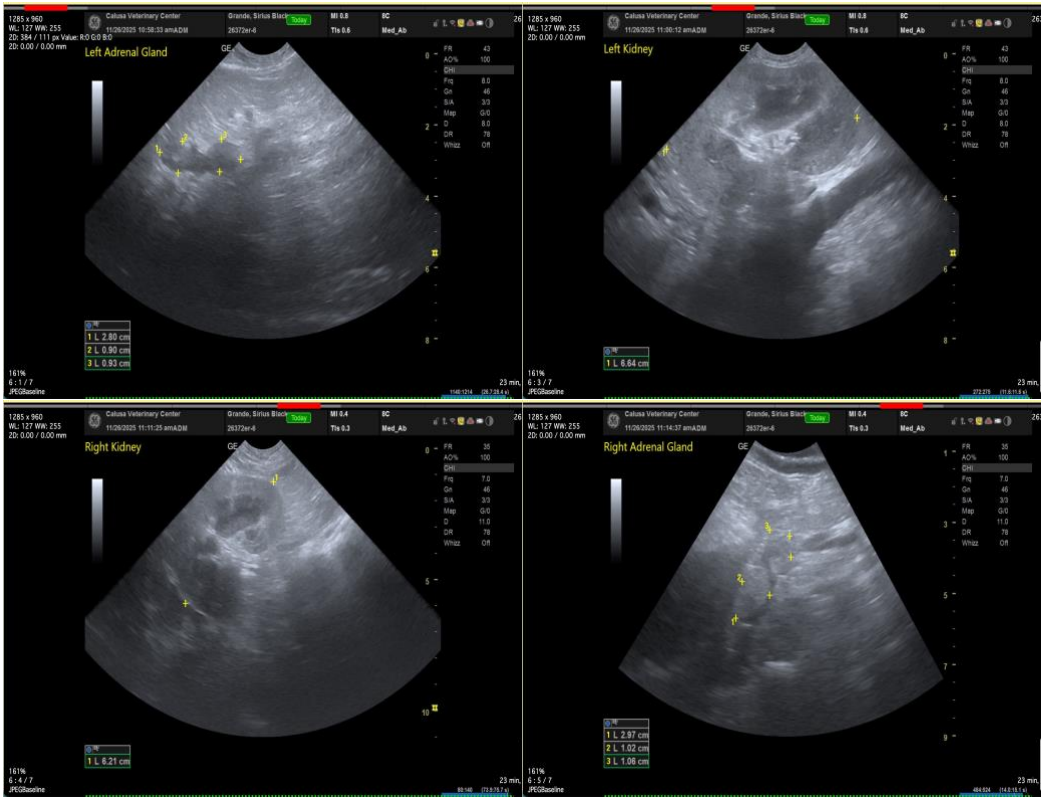
with hyperadrenocorticism as the sole cause and is more concerning for a primary hepatopathy given the hepatocellular injury pattern. Therefore, bile acids are recommended if patient's total bilirubin is not increased.

- Recheck testing for leptospirosis could be considered.
- Given the chronicity of the liver enzymes, ultimately, liver sampling is likely warranted. A fine needle aspirate could be considered if the patient's coagulation status is appropriate or ultimately, a biopsy may be necessary being sure to include copper level assessment if possible, for a definitive diagnosis and therefore to further guide medical management.
- In the meantime, especially in the face of any gastrointestinal signs, given the mild colon changes, a routine fecal/giardia exam could be considered as could 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.
- A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.
- Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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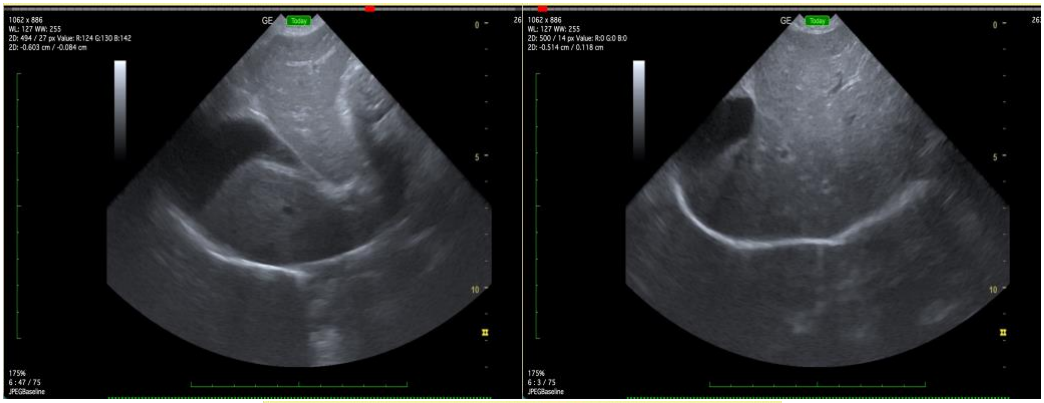

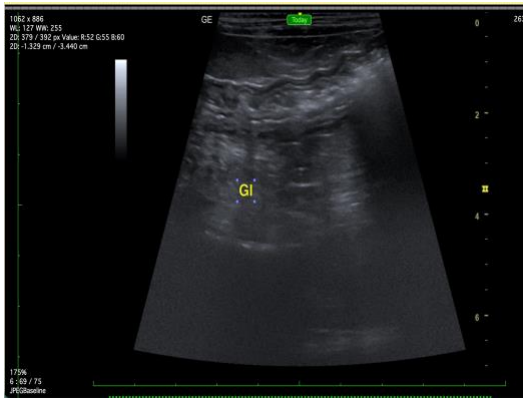

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@sonopath.com