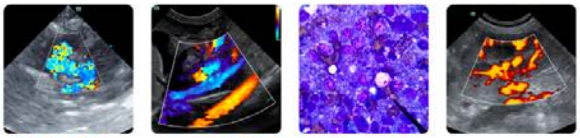




SonoPath www.animalsoundsnw.com info@animalsoundsnw.com 541.357.9423

**PATIENT**

Princess Contreras

**SPECIES**

Canine

**BREED**

Mixed

**SEX**

Spayed Female

**AGE**

13 Years

**WEIGHT**

13.79 kg

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Sara Hansen

**HOSPITAL NAME**

Banfield – Salem Lancaster

**REFERRING VET**

Dr. Marcberg

**INVOICE**

71536

**DATE**

11/4/25

## PRESENTING CLINICAL SIGNS

Clinical Exam Findings: nothing unusual with patient, severe dental calculus, gingivitis, halitosis patient presented for dental, unable to complete due to elevated liver enzymes and bile acid ABNORMAL Labwork Values 10/28/2025 CBC- WBC 4.82 (6-17), LYM 0.74 (1-4.8), MON 0.15 (0.2-1.5), MCH 26.1 (19.5-24.5) IOF- ALKP 445 (23-212), ALT 138 (10-125), BUN 28 (7-27), Na 161 (144-160) 4DX- negative Fecal- sent to ref lab UA- postponed Bile acids Pre 7.7 Post 42.4 Current Medications Simparica trio, Trazodone, Gabapentin Radiographic Findings none Notes to Specialist (if any) none

## 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 measured 5.67 cm. Right kidney measured 5.73 cm.

### *Adrenal Glands*

Adrenal glands are mildly “plump” for a small dog. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.54 cm at the cranial pole and 0.79 cm at the caudal pole. Right measures 0.91 cm at the cranial pole and 0.60 cm at the caudal pole.

### *Spleen*

The 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). No focal nodules or masses are observed. Splenic vasculature appears normal.

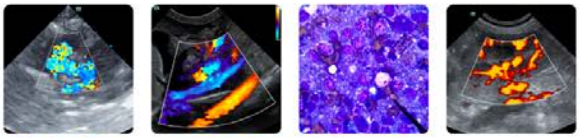
### *Liver*

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. 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.

### *Gastrointestinal*

The visible stomach wall is normal in thickness and layering. The stomach is mildly distended and contains an echogenic interface with distal progressively shadowing material consistent with hairball density (or similar fluid absorbing material) noted. Normal ingesta and gas cannot be definitively ruled out and should be considered especially without adequate fasting prior to the ultrasound.





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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

- Very mild subjective 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.

- Otherwise, an obvious cause for the reported increased liver enzymes 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

- Age related kidney changes.

- The gastric contents are most consistent with normal ingesta. However, given the shadowing, foreign material can't be definitively ruled out. Reassessment following an additional 12-24 hours of fasting could be considered if there is any concern for possible foreign material.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Testing for Leptospirosis is recommended.

The bile acid numbers reported should be interpreted in combination with patient's total bilirubin if not already evaluated, because if total bilirubin is increased, then bile acids don't add any additional diagnostic information.

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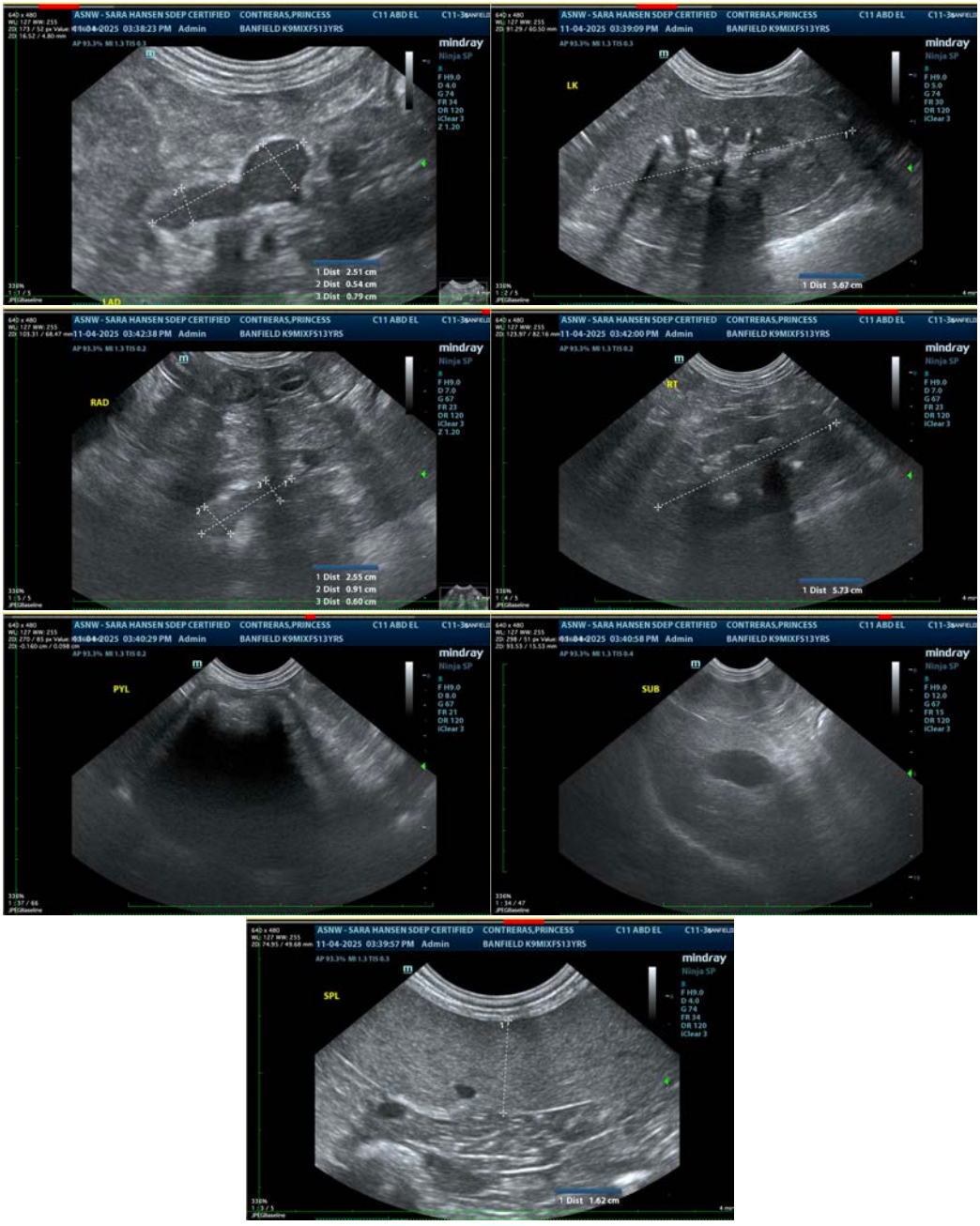
The mild adrenomegaly should be interpreted in combination with patient's clinical history. Early or emerging hyperadrenocorticism could be contributing to patient's reportedly increased ALP but doesn't match the other findings.

Given the cytopenias, pending results of above, additional comprehensiveinfectious disease evaluation could be considered, or ultimately bone marrow sampling.

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



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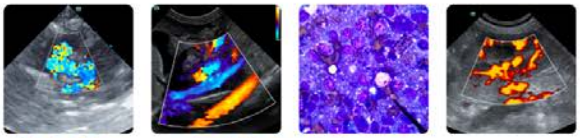

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Educational Teleconsultation Services™

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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