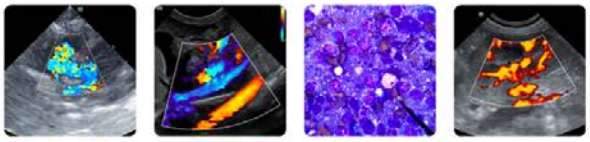


PATIENT

Pippa Sox

SPECIES

Canine

BREED

Boston Terrier

SEX

Spayed Female

AGE

14 Years 1 Month

WEIGHT

7.4 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

New Holland Veterinary Hospital

INVOICE

72463

DATE

12/10/25

PRESENTING CLINICAL SIGNS

AUS to further evaluate PU/PD/Panting, fur loss, urinary accidents in home, and a 2 lbs weight loss over 7 months. History of Cushings managed on Trilostane. Other PHx: Heart Murmur grade 3-4/6. Recent ACTH stim was WNL. Meds: Trilostane, Carprofen

Abnormal PE/Chem/CBC/UA Results: Nov 2025 rDVM Diagnostics - CBC: Hct 44.5%, Plts 702 H, remainder NSF - Chem: Alb 3.2-n, ALP 1098 H, ALT 86-n, normal renal values, normal SDMA, remainder NSF - T4: 0.8 L - ACTH Stim: Pre 1.4 ; Post 3.8 - WNL

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 4.3 cm. Right kidney measures 4.7 cm.

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. Left measures 1.2 cm at the cranial pole and 0.92 cm at the caudal pole. Right measures 1.2 cm at the cranial pole and 0.54 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). No focal nodules or masses are observed. Multifocal mineral foci are noted. Splenic vasculature appears normal.

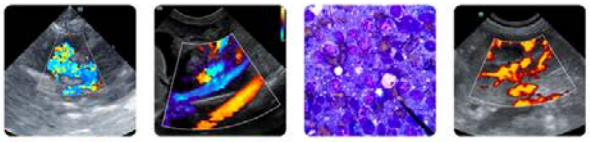
Liver

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

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 lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.



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The visible small intestines are normal in wall thickness and layering. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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

Pancreas

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules, primarily involving the right limb of the pancreas. 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

- Pancreatic nodular hyperplasia – Infiltrative neoplasia cannot be ruled out without tissue sampling. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Subtle mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- Bilateral adrenomegaly – Consistent with patient's reported history of medically managed hyperadrenocorticism.

SECONDARY FINDINGS

- Age related kidney changes.
- Spleen mineralization – This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism.
- Mild gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Given reported weight loss, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and

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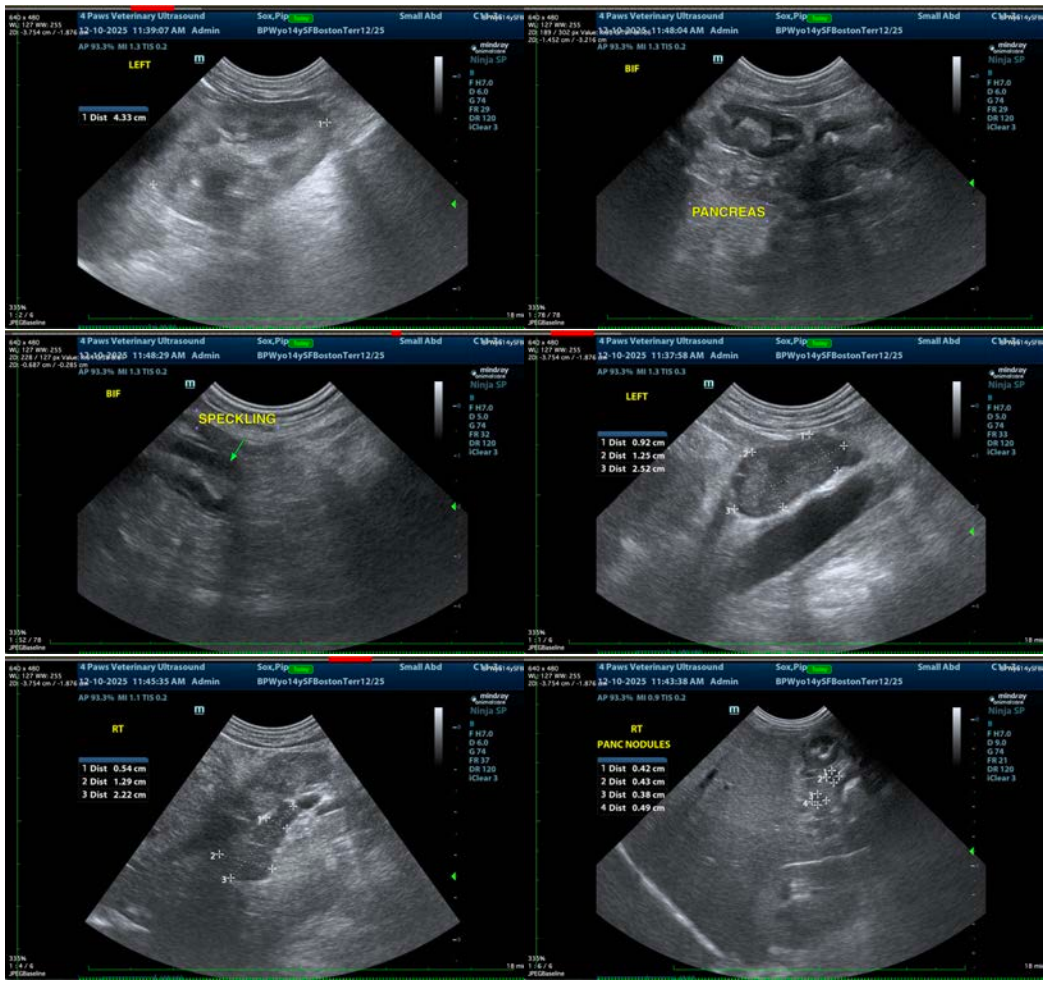
PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function, especially if weight loss is in the face of normal or even increased appetite.

Fine needle aspirates of the right limb of the pancreas could be considered if patient's coagulation status is appropriate.

If another contributing underlying cause of the PU/PD, weight loss, etc. is not diagnosed, it may be poor clinical regulation of the hyperadrenocorticism, even though cortisol levels are normal. Further recommendations depend in part on the dose and duration of Trilostane administration, as some patients respond better to the same or even decreased total daily dose but divided into twice daily dosing if patient is currently receiving it only once daily, and/or some patient's require an alternative medication.



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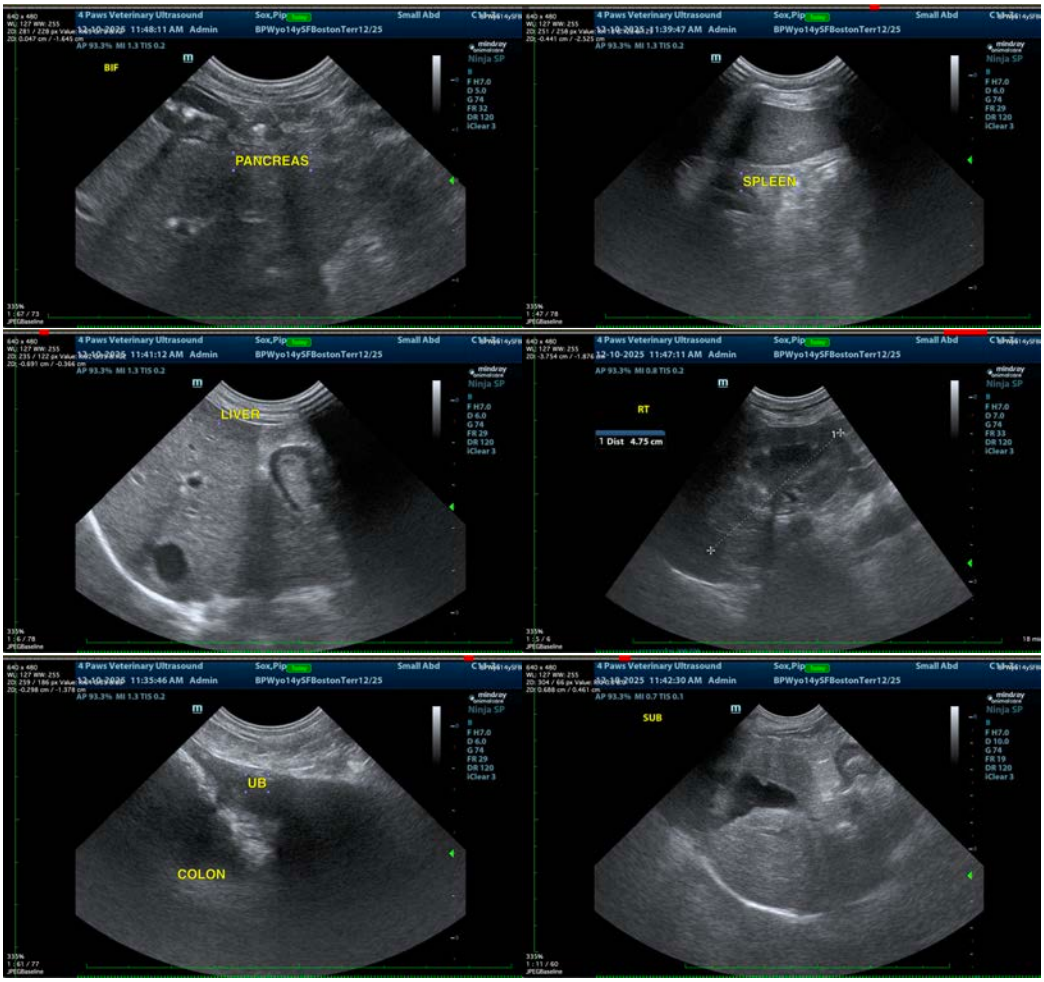

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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