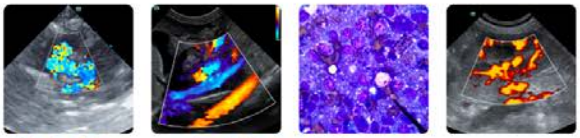

SonoPath www.carolinavetmobile.com
info@carolinavetmobile.com 800.808.5948

PATIENT

Belle Johnson

SPECIES

Canine

BREED

Lab x

SEX

Spayed Female

AGE

14 Years 3 Months

WEIGHT

62.6 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Pet Care Clinic of the High Country

REFERRING VET

Dr. Sturgill

INVOICE

72647

DATE

12/17/25

PRESENTING CLINICAL SIGNS

P presented for ultrasound due to progressive weight loss despite polyphagia with concurrent PU/PD and geriatric decline. P has Cushing's dz and is managed on Trilostant. Last Stim well managed. P is weaker in the back end. P tense on abdominal palpation On Trilostane, Galliprant, Gabapentin, Amantadine recently added in.

Abnormal PE/Chem/CBC/UA Results: CBC mild low WBC 5.5, and Neu 2.5 Chem ALT 353 ACH stim pre 1.5, Post 1.6, T4 2.6

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 6.6 cm. Right kidney measures 7.2 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 0.95 cm at the cranial pole and 0.93 cm at the caudal pole. Right measures 1.5 cm at the cranial pole and 1.0 cm at the caudal pole.

Spleen

The 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). An approximately 2.8 cm x 4.1 cm, mildly heterogeneous, hypo- to anechoic, non-capsule disrupting nodule/mass is noted in the cranial to mid aspect of the spleen. Splenic vasculature appears normal.

Liver

The liver is normal to subjectively large in size with moderately undulating or scalloped capsular contour or margins as a result of multifocal rounded, hypoechoic, emerging nodule type lesions of varying sizes. The remaining parenchyma is diffusely heterogeneous in appearance. 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 a small to moderate amount of echogenic non-shadowing luminal contents and gas

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consistent with normal ingesta. There is 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 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.

Medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

PRIMARY FINDINGS

- The appearance of the liver is non-specific, with differentials for a microscopic hepatopathy including benign, infectious or inflammatory disease such as Leptospirosis or bacterial cholangiohepatitis, other inflammatory disease such as chronic active hepatitis, copper associated hepatotoxicity, other hepatotoxicity, as well as infiltrative neoplasia, which is unable to be ruled out without tissue sampling.
- Similarly, the splenic nodule/mass could represent a benign lesion such as a hematoma, extramedullary hematopoiesis, etc., or infiltrative neoplasia, which can't be ruled out without tissue sampling.
- Mildly reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

SECONDARY FINDINGS

- The bilateral adrenomegaly is consistent with patient's reported history of medically managed hyperadrenocorticism.
- Age related kidney changes.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

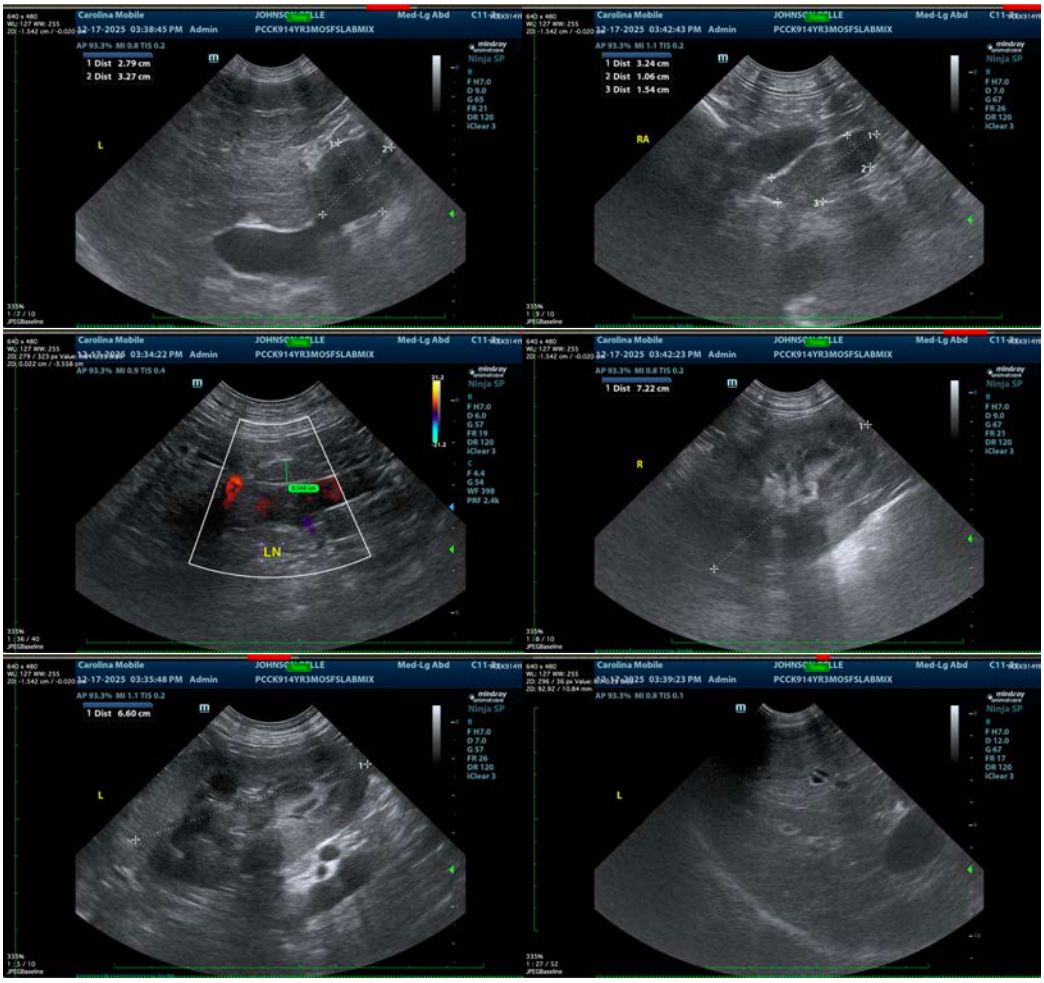
Fine needle aspirates of the liver and spleen are recommended if patient's coagulation status is appropriate.

Bile acids are recommended if patient's total bilirubin is not increased.

Pending results of above, testing for Leptospirosis could be considered.

Differentials for the concurrent neutropenia include infectious disease, neoplastic disease, autoimmune disease, etc., and if a diagnosis is not made, bone marrow cytology could be considered.

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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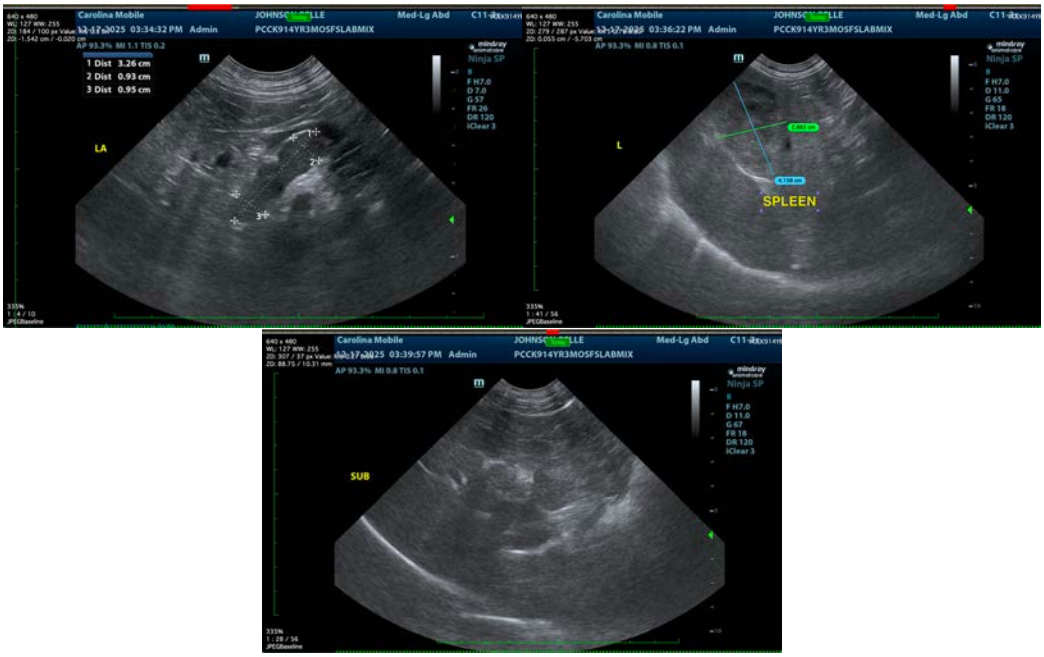

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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