



<b>PATIENT</b>	<b>PRESENTING CLINICAL SIGNS</b>
Franklin Blumenthal	PU/PD, no weight loss, eating well Abnormal PE/Chem/CBC/UA Results: USG low ALT 238, ALP 301 (as of August)
<b>SPECIES</b>	<b>ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN</b>
Canine	<b>Urinary System</b>
<b>BREED</b>	Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.50 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.
Bichon X	
<b>SEX</b>	The right kidney is normal in size (4.8 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Mild pyelectasia noted. There is no evidence of mineral or infarcts observed.
Spayed Female	
<b>AGE</b>	The left kidney is normal in size (4.2 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.
9 Years	
<b>WEIGHT</b>	<b>Adrenal Glands</b>
15 Pounds	The right adrenal gland is normal in size (0.96 cm at the cranial pole and 0.58 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.
<b>INTERPRETED BY</b>	The caudal pole of the left adrenal gland is normal at 0.69 cm. The cranial pole is not fully visualized in these images, but no apparent pathology noted in the area.
Beth Johnson, DVM DACVIM	<b>Spleen</b>
<b>IMAGING PERFORMED BY</b>	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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.
Dr. Scott	<b>Liver</b>
<b>HOSPITAL NAME</b>	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. A 3.6 cm x 4.0 cm mass is noted in the deep liver, adjacent to the gallbladder. The mass is of mixed echogenicity, primarily hyperechoic but containing multiple cysts of varying size. Visible vasculature and biliary tree appear normal without distension or congestion.
Ho-Ho-Kus VH	
<b>REFERRING VET</b>	Gallbladder is moderately distended with anechoic bile as well as moderate suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.
Dr. Scott	
<b>INVOICE</b>	<b>Gastrointestinal</b>
43700	The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.
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<b>PATIENT</b>	The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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.
Franklin Blumenthal	
<b>SPECIES</b>	The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.
Canine	
<b>BREED</b>	<b>Pancreas</b>
Bichon X	The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.
<b>SEX</b>	<b>Free Abdomen</b>
Spayed Female	There is no evidence of free peritoneal effusion noted in these images.
	There is no apparent lymphadenopathy noted in these images.
<b>AGE</b>	<b>PRIMARY FINDINGS</b>
9 Years	<ul style="list-style-type: none"> <li><b>Cystic Liver Mass</b> – Most consistent with a benign biliary cystadenoma – Malignancy cannot be ruled out but is considered less likely.</li> </ul>
<b>WEIGHT</b>	<ul style="list-style-type: none"> <li><b>Moderate gallbladder debris</b> - 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.</li> </ul>
15 Pounds	
<b>INTERPRETED BY</b>	<ul style="list-style-type: none"> <li>The adrenal glands are normal in shape and size but subjectively considered near the upper end of normal limits for a small breed dog. Therefore, considerations should include adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism vs stress or normal variant. Interpret in combination with clinical signs of hyperadrenocorticism.</li> </ul>
Beth Johnson, DVM DACVIM	
<b>IMAGING PERFORMED BY</b>	<b>SECONDARY FINDINGS</b>
Dr. Scott	<ul style="list-style-type: none"> <li><b>Chronic Cystitis</b> - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.</li> <li><b>Hyperechoic splenic nodules</b> – 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.</li> </ul>
<b>HOSPITAL NAME</b>	
Ho-Ho-Kus VH	
<b>REFERRING VET</b>	<b>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</b>
Dr. Scott	The described adrenal gland, liver and gallbladder changes are all suggestive of hyperadrenocorticism. Given the reported clinical signs of If clinical signs of PU/PD, etc., testing for hyperadrenocorticism with a LDDS test is warranted. If a LDDS test has been evaluated with a normal result, investigation of possible atypical hyperadrenocorticism with a full ACTH stimulation adrenal panel to the University of Tennessee could be considered. If clinicals signs are not present, monitoring is recommended with testing pursued when/if clinical signs develop. If not recently evaluated, blood pressure is recommended. If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine
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culture are also recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

**SPECIES**

Canine

A fine needle aspirate of the cystic liver mass could be considered if patient's coagulation status is appropriate, or alternatively, given the trending towards benign appearance, monitoring could be considered, beginning with a recheck ultrasound of the area in approximately 3 months.

**BREED**

Bichon X

**SEX**

Spayed Female

**AGE**

9 Years

**WEIGHT**

15 Pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Dr. Scott

**HOSPITAL NAME**

Ho-Ho-Kus VH

**REFERRING VET**

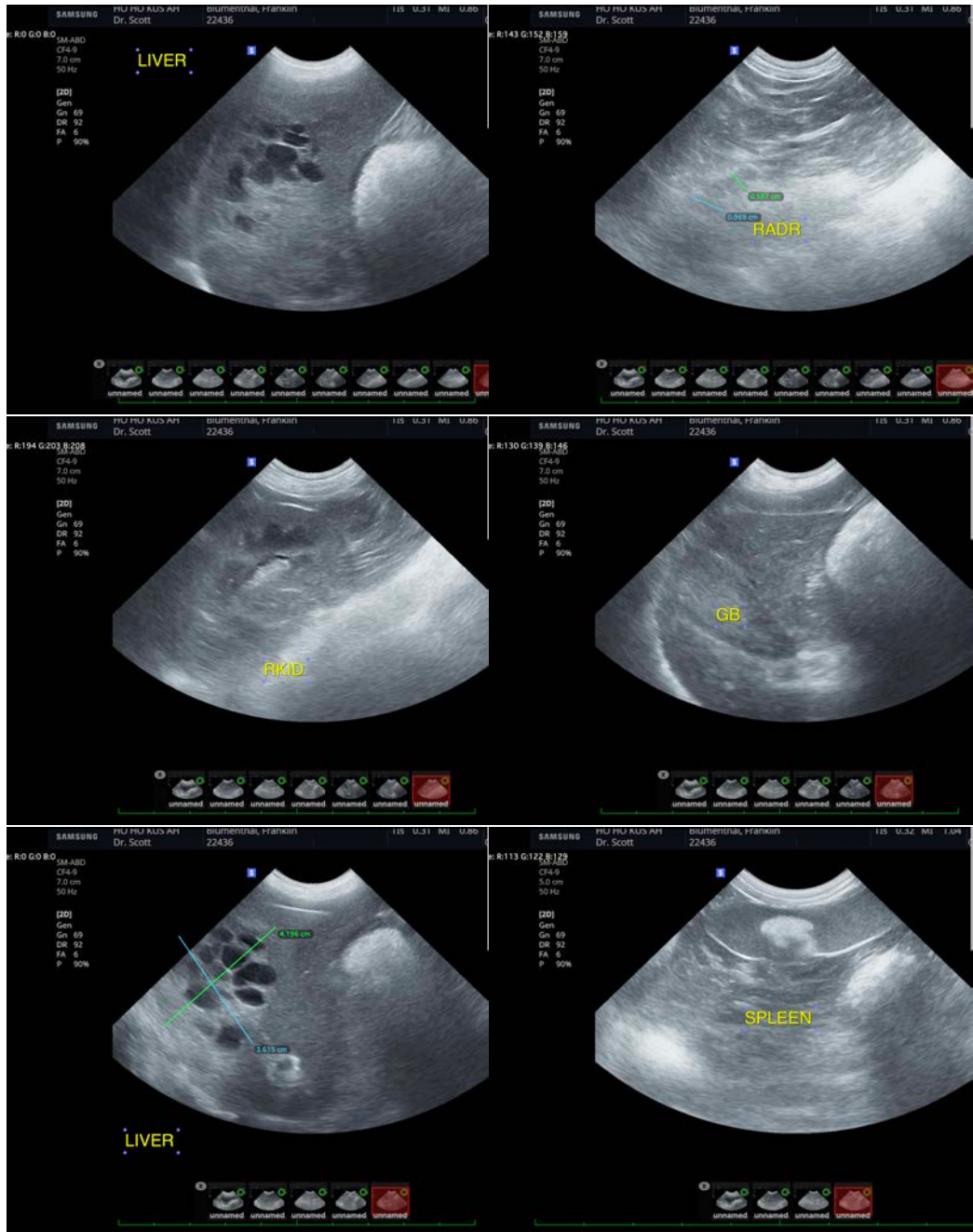
Dr. Scott

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**SPECIES**

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**BREED**

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**SEX**

Spayed Female

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**HOSPITAL NAME**

Ho-Ho-Kus VH

**REFERRING VET**

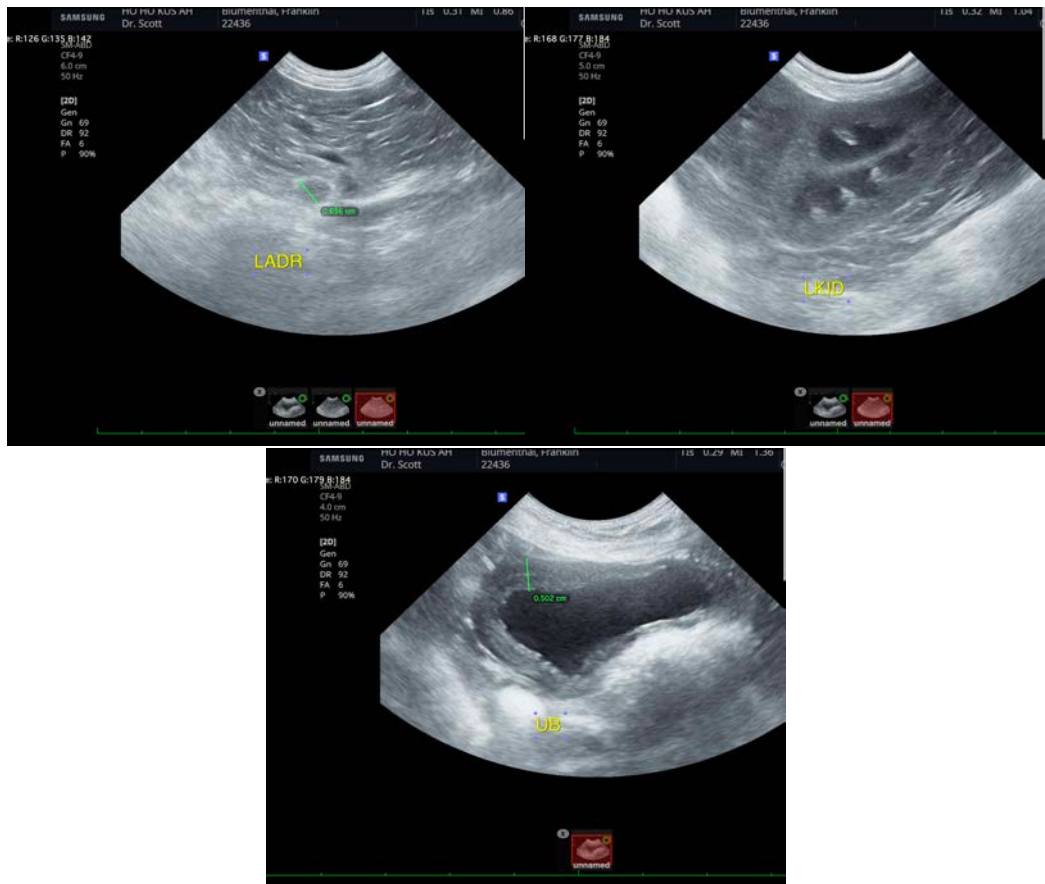
Dr. Scott

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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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