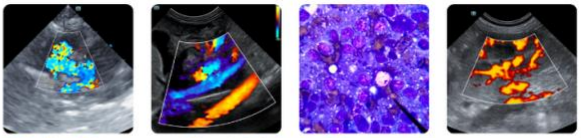




**PATIENT**

Oakley Carti

**SPECIES**

Canine

**BREED**

Labrador Retriever

**SEX**

Spayed Female

**AGE**

10 Years 6 Months

**WEIGHT**

70.8 Pounds

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Shari Reffi, CVT

**HOSPITAL NAME**

Bergen County VC

**REFERRING VET**

Dr. Santo

**INVOICE**

36804

**DATE**

12/8/25

## PRESENTING CLINICAL SIGNS

History: PU/PD, weight gain, inc. hunger. Clinical findings: overweight, BCS 7/9. Current Medications: Rimadyl; Gaba.

Abnormal PE/Chem/CBC/UA Results: LDD cortisol test 3.5 (1-6); 4hr post 1.1; 8hr 1.9; ALT 146 (H:121); ALP 855 (H:160); Lipase 297 (H:250); Total T4 0.5 (1-4).

## 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.

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. The left kidney measures 5.8 cm. The right kidney measures 5.7 cm.

### *Adrenal Glands*

The left adrenal gland is enlarged (2.6 cm at cranial and 2.2 cm at caudal pole) with moderate heterogenous parenchymal changes. Swollen capsular expansion is noted at both poles without evident capsular escape or vascular invasion.

Right adrenal gland is 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 right adrenal gland measures 1.1 cm at the cranial pole and 0.77 cm at the caudal pole.

### *Spleen*

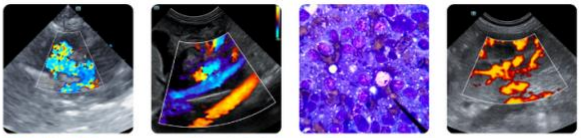
Spleen is subjectively normal in size (1.5 cm thick at the hilus) with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

### *Liver*

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately 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 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.

### *Gastrointestinal*





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The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out. If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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 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.

## ULTRASONOGRAPHIC FINDINGS

### Primary 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.
- Moderately heterogenous liver- These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Moderate 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.

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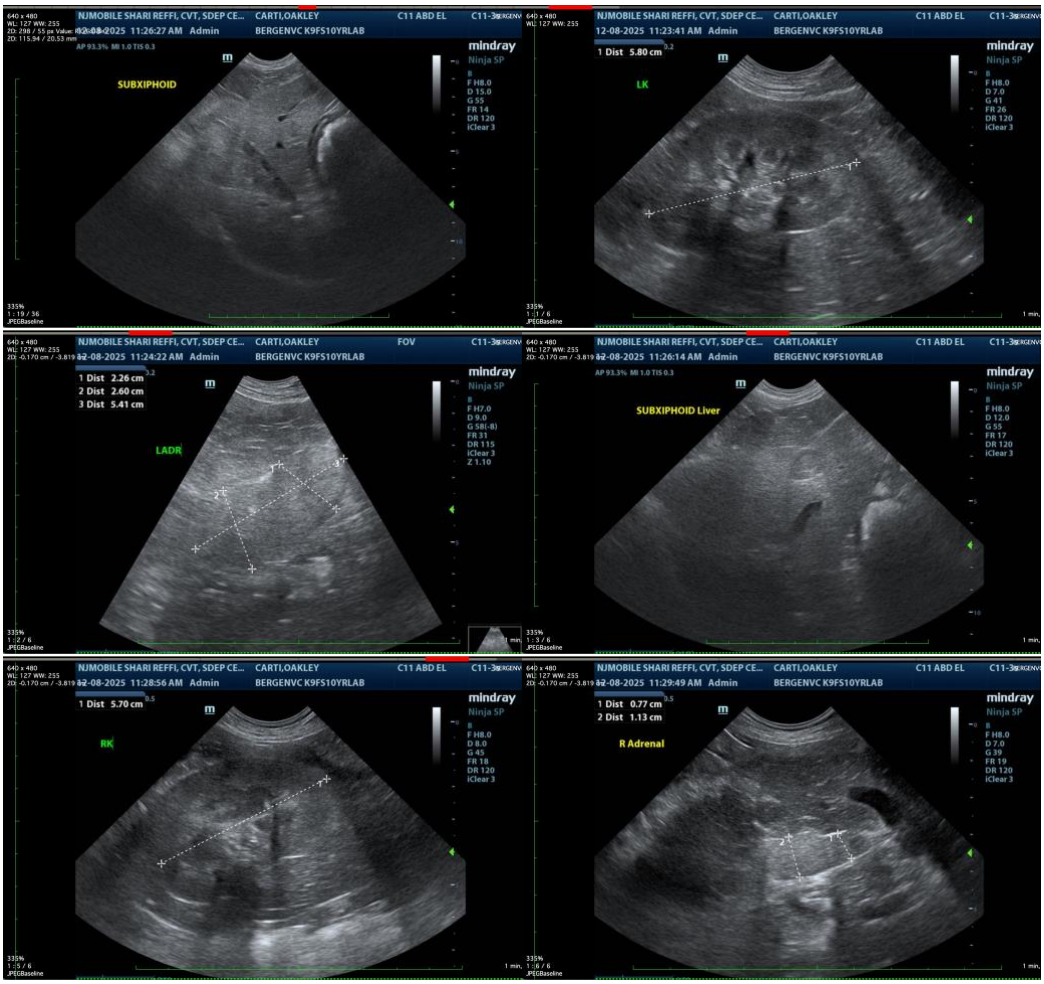
## Secondary Findings

- Age-related kidney changes

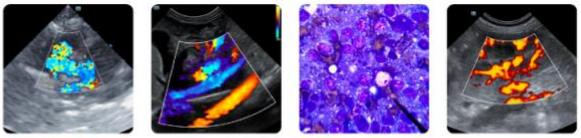
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left adrenal gland is more significantly enlarged and slightly more heterogenous, which based on appearance alone, wouldn't rule out primary adrenal dependent disease, however, given the reported low dose dexamethasone suppression test results, suppression was noted indicating most likely pituitary dependent. Therefore, if test results are consistent with patient's clinical history and not believed to be a false positive, etc., beginning medical management for pituitary dependent hyperadrenocorticism may be indicated.

In the meantime, if not recently evaluated, a blood pressure is recommended, as is 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 ration is recommended.



New Jersey Mobile
FUELED BY SONOPATH VETERINARY ULTRASOUND



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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