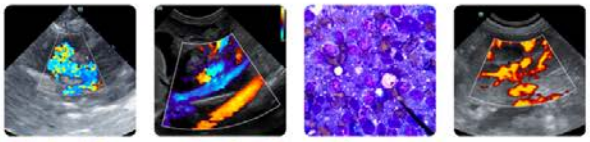


PATIENT

Jack Brida

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

12 Years 10 Months

WEIGHT

71

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jessica Green

HOSPITAL NAME

Stanglein Veterinary Clinic

REFERRING VET

Dr. Nathaniel Stanglein

INVOICE

73062

DATE

2/18/26

PRESENTING CLINICAL SIGNS

Some increased orthopedic pain, a little lethargy and slight reduction of appetite. No other GI signs, History of Cushings disease managed holistically currently. BW showed marked increase in both ALP/ALT where as previously had just been mild-mod elevation in ALP

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, except for an echogenic density measuring 1.3 cm x 1.0 cm in size originating from or attached to the inner mid dorsal wall of the urinary bladder.

The area of the prostate is examined without evident prostatic pathology.

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 7.19 cm. Right kidney measured 7.13 cm.

Adrenal Glands

The right adrenal gland is enlarged (3.7 cm long x 2.4 cm wide) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted. Adjacent to the right adrenal gland there appears to be some echogenic densities potentially within the vena cava, although it is difficult to determine whether this comes from the right or left side if it's definitively originating from an adrenal gland, as a clot or thrombus is another differential. Similarly, it could be tissue overlying the vena cava versus truly within it, and color doppler would help to further assess blood flow in the area.

The left adrenal gland is plump/swollen in size, measuring 0.78 cm at the cranial pole and 0.98 cm at the caudal pole. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

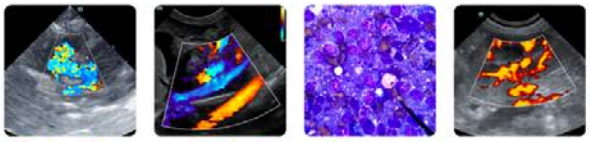
Spleen

Spleen is generally normal in size and shape with a smooth capsular contour. Parenchyma is diffusely nodular in appearance characterized by small discrete hypoechoic nodules. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mottled by multifocal discrete hypoechoic nodules of varying sizes "moth-eaten". 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.



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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.

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 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.

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

- The liver changes could represent a benign process such as marked nodular hyperplasia, steroid or vacuolar hepatopathy, extramedullary hematopoiesis, or even chronic inflammatory disease. However, given the degree of nodular change, infiltrative neoplasia such as round cell neoplasia, metastatic disease, other can't be ruled out without tissue sampling.

- Splenic micronodular hyperplasia pattern – This nodular change is often associated with benign aging nodular hyperplasia. Infiltrative neoplasia, however, including both early hemangiosarcoma as well as round cell neoplasia cannot be ruled out.

- Bilateral adrenomegaly – Consistent with patient's reported history of suspected hyperadrenocorticism. However, the right adrenal gland has a mass-like appearance, with differentials still including hyperplasia versus a benign adenoma, although a malignant adenocarcinoma or pheochromocytoma or other can't be ruled out, especially if there truly is vascular invasion as described above.

- The echogenic urinary bladder density described above could represent settled debris, mucus, sludge, other, although tissue can't be ruled out, with both benign cystitis or polypoid change as well as infiltrative neoplasia possible.

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.

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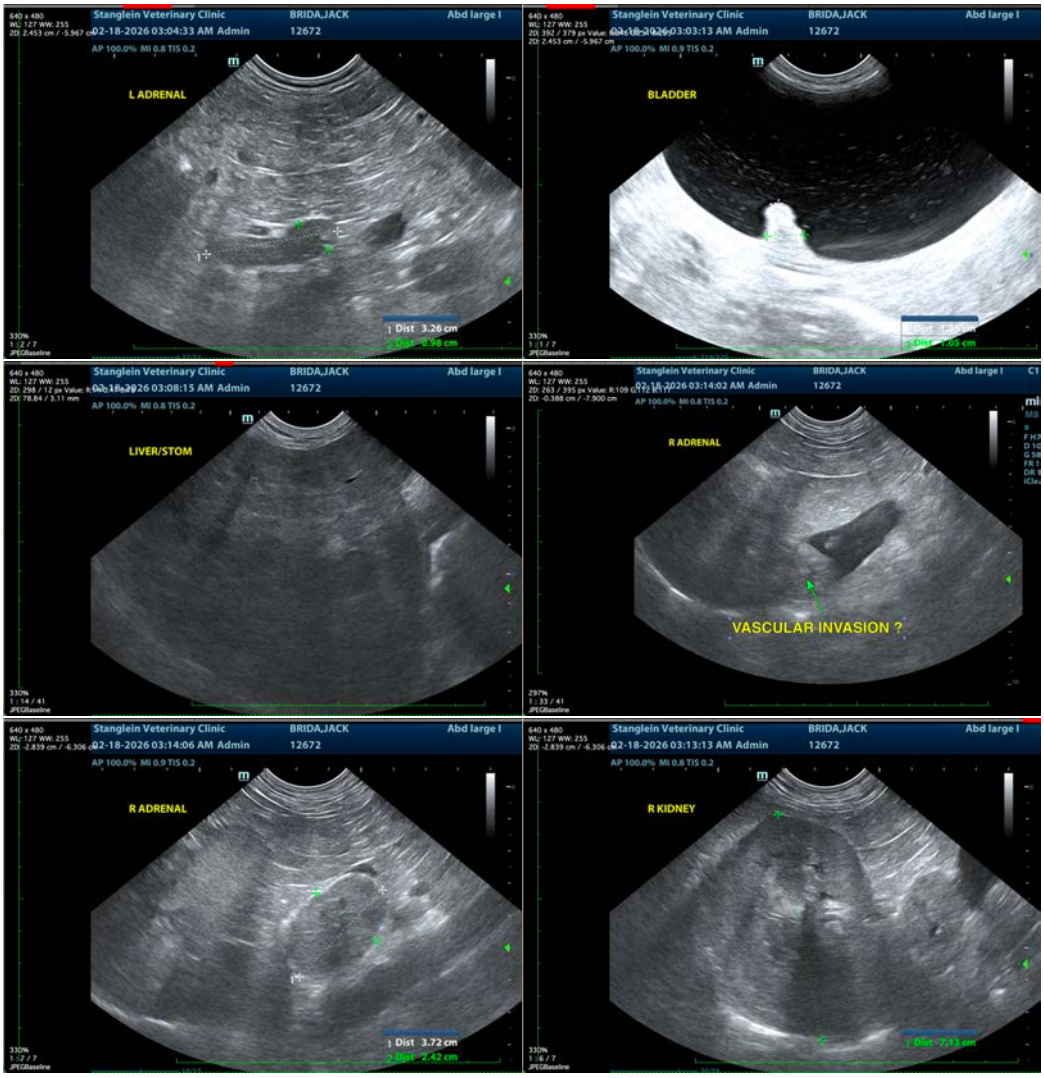
Fine needle aspirates of the liver +/- spleen are recommended if patient's coagulation status is appropriate.

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.

Additionally, submission of urine to look for BRAF gene mutation could be considered.

Pending results of above, given the concern for possible vascular invasion in the right cranial abdomen, advanced imaging of the adrenal glands in that area via abdominal contrast CT scan may be helpful.

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



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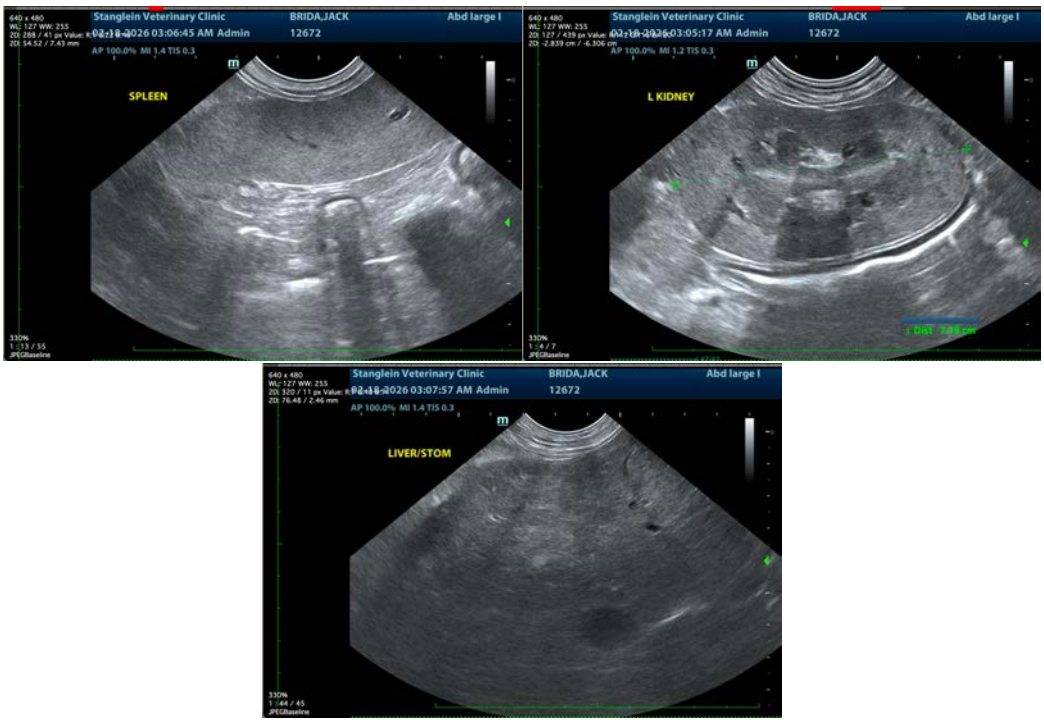

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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