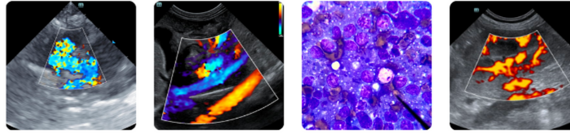


DATE

2/2/2026

PATIENT

Hercules Brown

SPECIES

Canine

BREED

Dachshund

SEX

MN

AGE

8 years

WEIGHT

18 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

HOSPITAL NAME

VCA Columbia at
Centre Parke

REFERRING VET

Dr. Stefan

INVOICE

11231

PRESENTING CLINICAL SIGNS

Patient History: Patient has severe periodontal disease and Cushing's disease. On preop labwork he has marked
elevations in ALT, Alp, and GGT. PSL. Cholesterol and Triglycerides are also elevated. Ultrasound recommended to r/o gall bladder pathology and/or pancreatitis, hepatitis before procedure.

Current Medications: Vetoryl 10mg PO BID since Sept 2025, Dasuquin EOD, Omega FA supplement (eicosa caps) SID.

Labwork Results: Labwork attached, reported as: ALT 314 (12-118), Alp 7539 (5-131), GGTP 195 (1-12), Cholesterol 974 (92-324), Triglycerides 462 (29291), PSL 157 (24-140), WBC 3.2 (4-15.5).

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment is observed. At least two urinary cystoliths are visible measuring approximately 0.9 cm in diameter. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture, and echogenicity for a neutered male.

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 or infarcts observed. Small, non-obstructive nephroliths are noted bilaterally. Left kidney measures 5.16 cm, and right kidney measures 5.6 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 adrenal measures 1.1 cm at the cranial pole and 1.4 cm at the caudal pole. Right adrenal measures 1.0 cm at the cranial pole and 0.97 cm at the caudal pole.

Spleen

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). 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 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 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

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. 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 of the small intestine is empty with 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

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

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

- 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.
- 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.
- 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.

- Spleen mineralization – This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

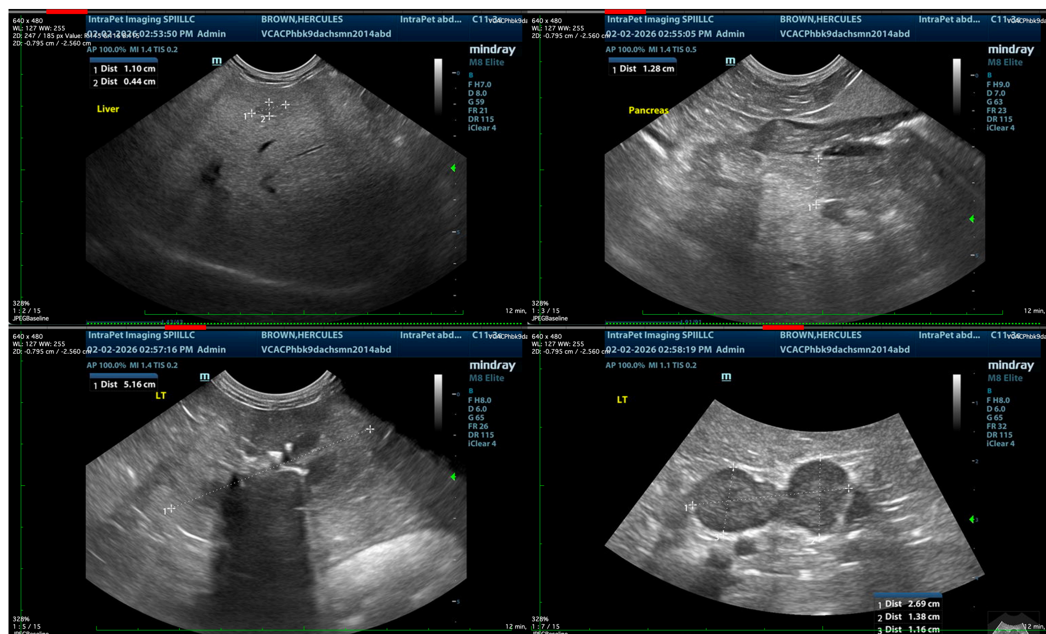
SECONDARY FINDINGS

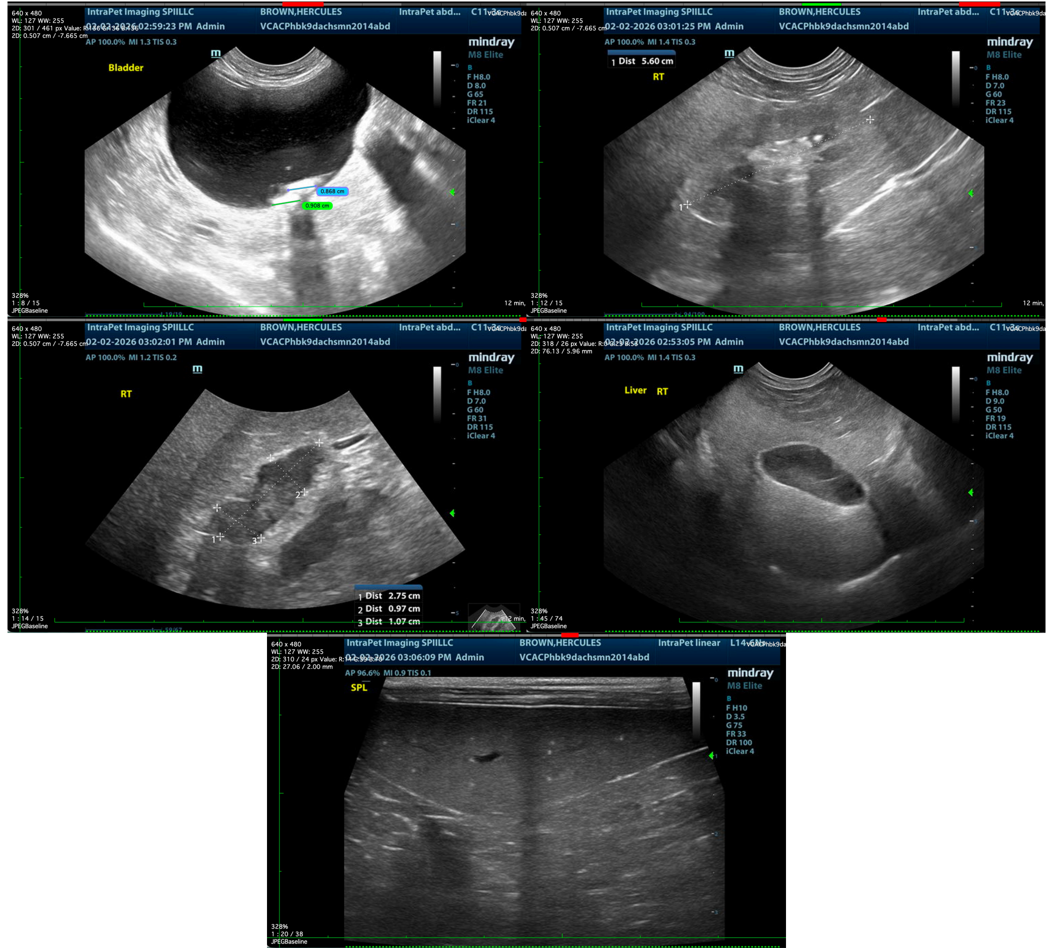
- Age related kidney changes with small non-obstructive nephroliths bilaterally.
- Suspect, at least two urinary bladder cystoliths.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes described above are largely mild/subtle and consistent with patient's history of hyperadrenocorticism. They, and the lab work, should therefore be interpreted largely in combination with patient's clinical history, that may further indicate whether or not hyperadrenocorticism is well controlled. Having said that, infiltrative disease affecting the liver resulting in the subtle nodules, including infiltrative neoplasia, while considered less likely can't be definitively ruled out. A fine needle aspirates could be considered if patient's coagulation status is appropriate.

Patient's concurrent leukopenia is of unknown relation but concerning and may warrant further workup as well for possibly infectious disease, autoimmune disease, even infiltrative neoplasia not visible in the abdomen versus other.





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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