



PATIENT

Gunny Wire

SPECIES

Canine

BREED

Pitbull

SEX

Spayed Female

AGE

11 Years

WEIGHT

62 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Newton VH

REFERRING VET

Dr. Wyman-Greenwald

INVOICE

21213

DATE

2/20/23

PRESENTING CLINICAL SIGNS

History: Increased liver values

Abnormal PE/Chem/CBC/UA Results: Alt 225, Alp 5718, GGT 75, Chol 1024, Trig 887, PSL 396, T4 0.5.
U/A-cysto pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (6.88 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.

Right kidney is normal is size (7.82 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.

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. Dystrophic mineralization is noted bilaterally. The right adrenal gland measures 3.55 cm long x 1.62 cm at the cranial pole and 1.03 cm at the caudal pole. The left adrenal gland measures 3.53 cm long x 1.15 cm at the cranial pole and 1.93 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.

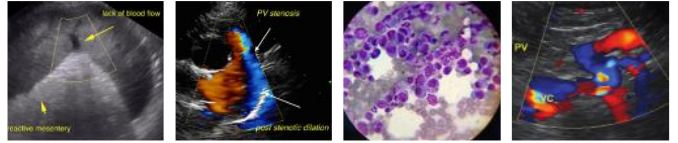
Liver

Liver is subjectively 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. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as mild 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 primarily empty/nondistended, except for a small curvilinear interface with strong acoustic shadowing that



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could represent nonobstructive foreign material/foreign body. Normal ingesta/kibble and gas can't be ruled out and this finding should be interpreted in combination with supporting clinical signs and/or monitoring.

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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.

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

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Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

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- Bilateral adrenomegaly with incidental dystrophic mineralization noted bilaterally- consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism vs stress or normal variant. Interpret in combination with clinical signs of hyperadrenocorticism.

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- Spleen mineralization - This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism.
- Suspected nonobstructive gastric foreign body, as described above.

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Secondary Findings

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- 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.

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- Pancreatic age-related remodeling - Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Urinary bladder debris

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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As is reportedly already pending, 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.



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A blood pressure is also recommended if not recently evaluated.

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Beyond that, the changes described above are all consistent with/suggestive of possible hyperadrenocorticism, however, hyperadrenocorticism is only recommended to be pursued in the presence of supporting clinical signs, such as PU/PD, polyphagia, etc. Without supporting clinical signs, comorbidities, such as urinary tract infections, hypertension, etc., should be managed with specific hormone testing only pursued when/if clinical signs develop.

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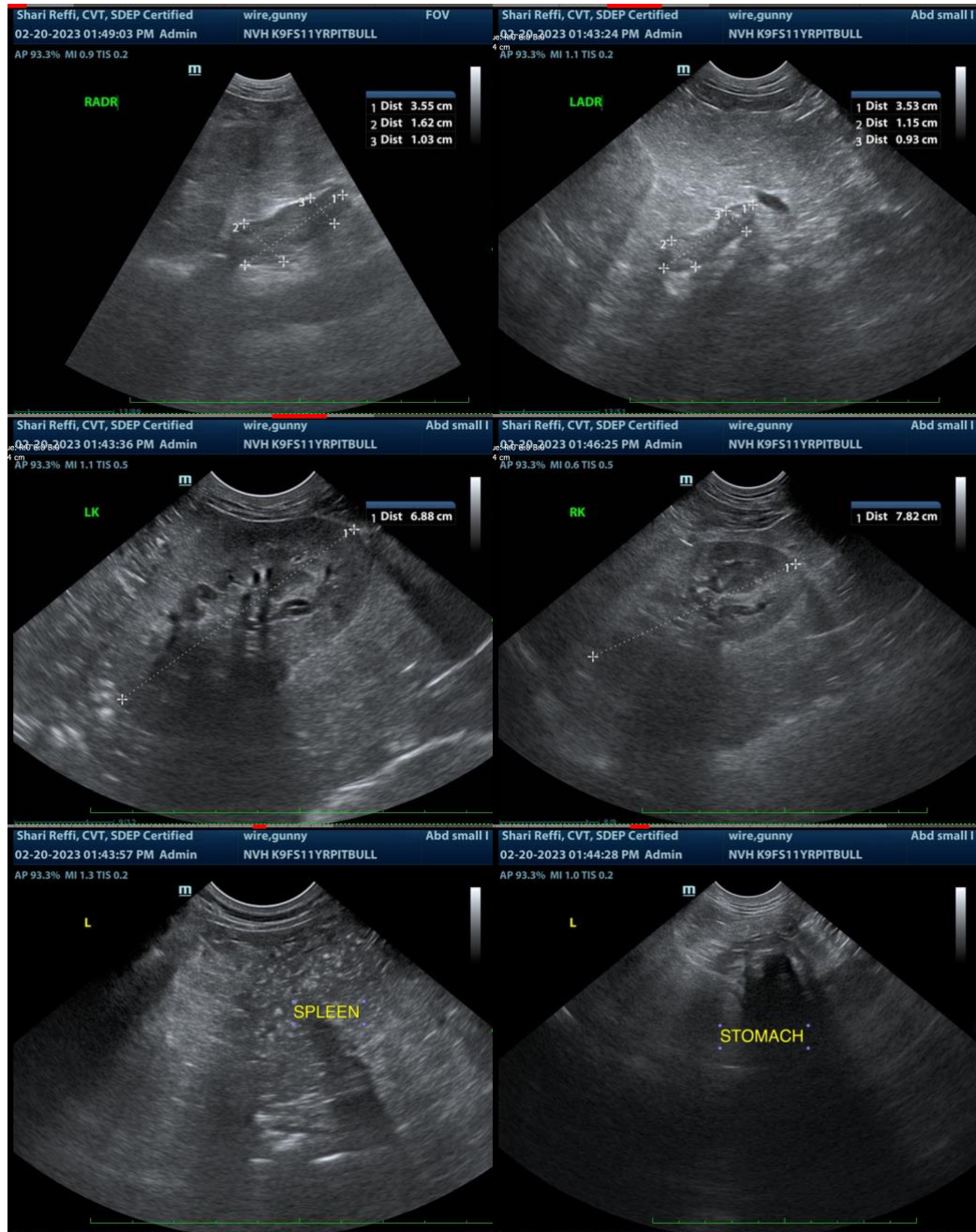
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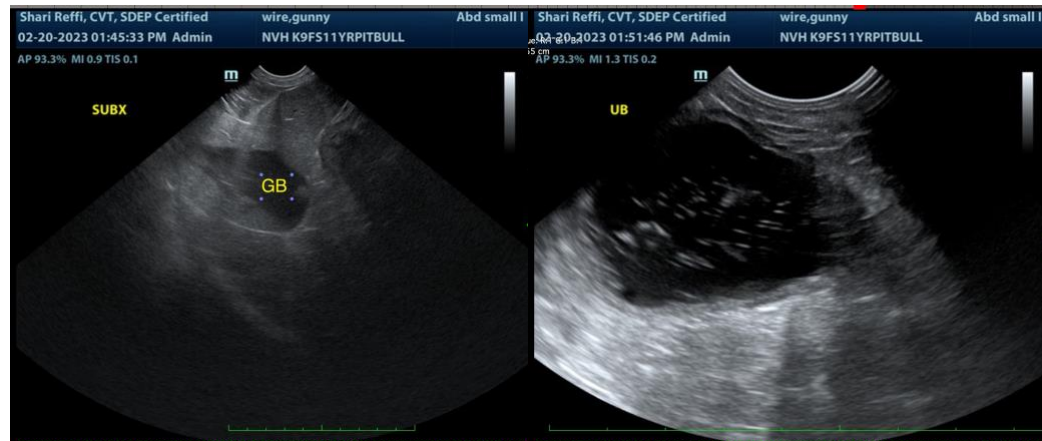
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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