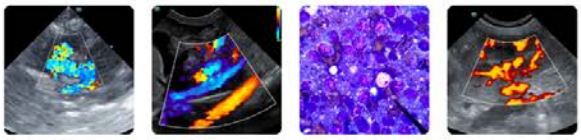


DATE

2/26/26

PATIENT

Memphis Hunt

SPECIES

Canine

BREED

Shepherd x

SEX

Neutered Male

AGE

6/26/14

WEIGHT

28.39 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Banfield Towson

REFERRING VET

Dr. Washington

INVOICE

73315

PRESENTING CLINICAL SIGNS

Patient History: Recently diagnosed with hypothyroidism. History of ALKP elevation. Cushing's disease ruled out with low dose dexamethasone suppression testing.

Current Medications: Levothyroxine 0.6 mg tabs, Galliprant 60 mg tabs, Gabapentin 300 mg caps PRN, Dasuquin advanced.
Labwork Results: Labwork not submitted. Reported as cardioBNP 1590 (0-900), ALKP 384 (23-212).
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Trazadone, Torb & Midaz.
Stat Report: Not requested.
Imaging Performed by: Andi Parkinson, BS, RDMS.

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.

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

The right kidney is normal is size (6.72 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.

The left kidney is normal is size (6.41 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

The right adrenal gland is normal in size (1.4 cm at cranial pole and 0.83 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. A hyperechoic nodule is noted in the cranial pole, measuring approximately 1.4 cm x 1.6 cm. Nodule does not disrupt normal shape and/or architecture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.53 cm at cranial pole and 0.49 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The 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), except for an approximately 0.80 cm x 1.0 cm mildly heterogeneous, largely hypo- to anechoic non-capsule disrupting nodule in the mid spleen. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Additionally, multiple small anechoic densities/suspect cysts are noted throughout the 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 debris has a mineral/sand appearance with no visible shadowing or obstruction. 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 a small to moderate amount of 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.

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

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.

In the cranial mid to left abdomen is a non-discrete subtle focal area of enhanced, almost clumped appearing hyperechoic mesentery/fat.

ULTRASONOGRAPHIC FINDINGS

- The subtle focally enhanced fat described could indicate some focal enteritis in the area, emerging pancreatitis versus other.

- Mildly 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.

- Multiple suspect incidental hepatic cysts.

- 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. Some mineral/sand debris is noted with no visible evidence of obstruction.

- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

- Hyperechoic adrenal nodule (cranial pole right adrenal gland) – Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further recommendations regarding the changes described depend in part on patient's clinical signs but could include:

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.

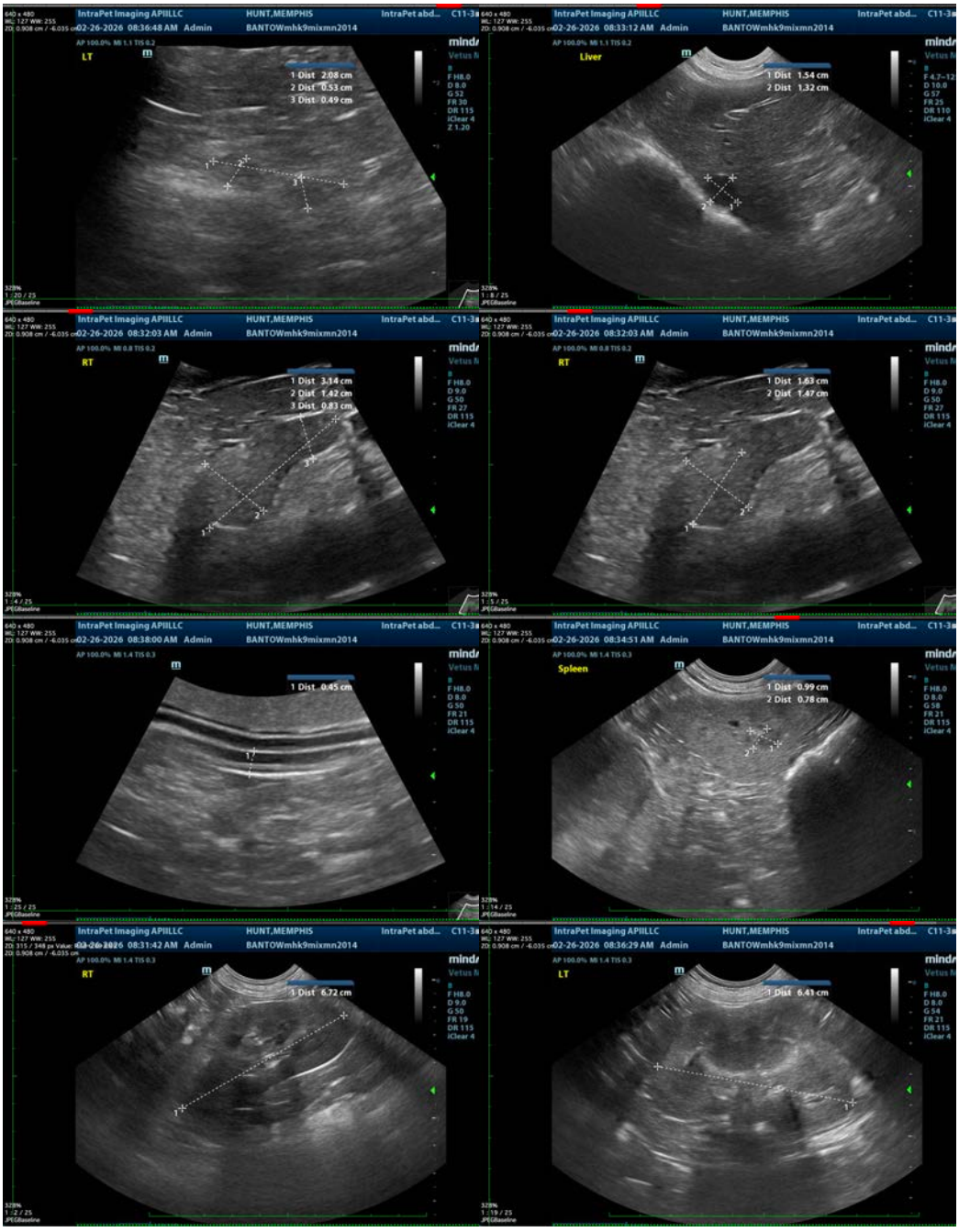
Fine needle aspirates of the non-specific hyperechoic tissue in the mid to left cranial abdomen as well as potentially the splenic nodule +/- liver could be considered if patient's coagulation status is appropriate.

If there is any gastrointestinal history, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Additionally, a routine fecal/giardia exam could be considered.

Otherwise, given the reportedly increased ALP, empirical hepatic nutraceuticals including Ursodiol could be considered, given the gallbladder debris noted above, while monitoring for improvement.

The adrenal nodule could indicate emerging adrenal disease, although given the lack of consistent clinical history and normal hormone testing, this is less likely than an incidental finding or normal patient variant. Having said that, monitoring of clinical signs and the appearance of the adrenal nodule is warranted.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HUNT,MEMPHIS
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LT
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2 Dist 0.53 cm
3 Dist 0.49 cm
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Liver
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RT
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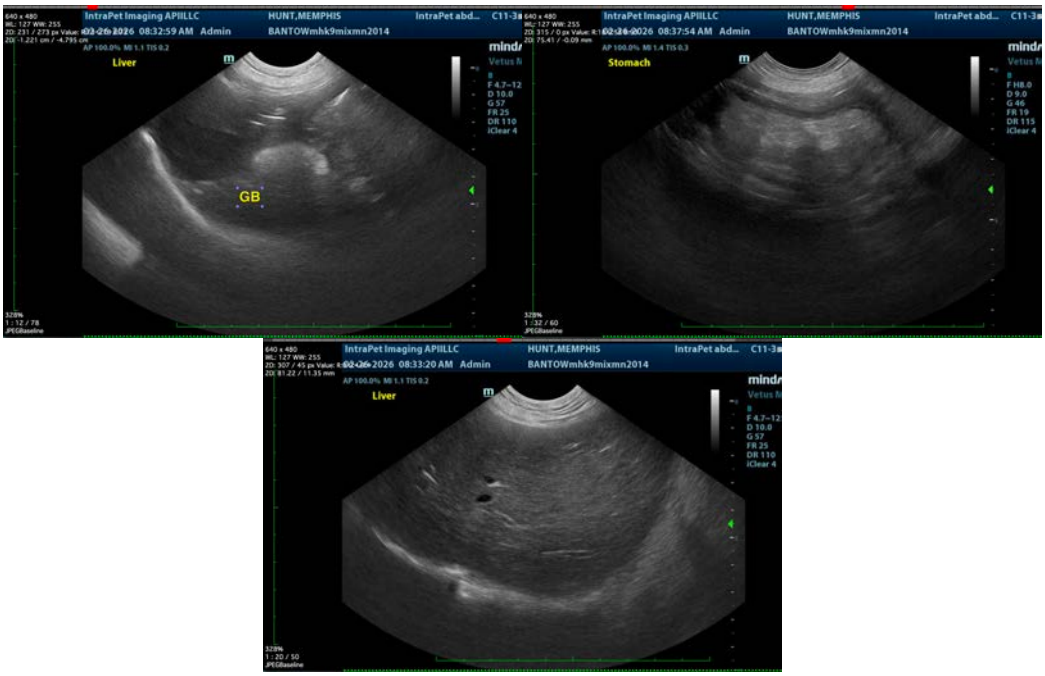
LT
1 Dist 6.41 cm



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