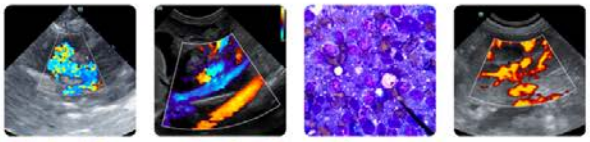


PATIENT

Stella McAdam

SPECIES

Canine

BREED

Brussels Griffon

SEX

Spayed Female

AGE

11 Years

WEIGHT

3.9 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Michelle DeMelo, RVT

HOSPITAL NAME

Woodstock Veterinary Hospital

REFERRING VET

Dr. Tasha Plummer

INVOICE

72728

DATE

2/4/26

PRESENTING CLINICAL SIGNS

Concern is that her general condition has not improved very much with control of her Cushing's, she continues to show a lot of alopecia and generalized muscle wasting. The owner has consulted with a Veterinary nutritionist and has been home cooking a low fat diet for Stella. Note that Stella does not show vomiting or significant anorexia, weight is stable overall. ACTH stim is being performed today. I will also be recommending that the owner reach back out the the Vet nutritionist. Looking for reason for the liver enzyme elevations, further tx recommendations. There are some cost concerns, so any empirical options appreciated.

Current medications: Vetoryl (Trilostane) 10 mg am, 5 mg pm, Apoquel 3.6 mg 1/2 tab SID, Ursodiol 250 mg 1/2 tab SID, Gabapentin 35 mg BID

Abnormal PE/Chem/CBC/UA Results: Patient has multiple co-morbidities, previously had an AUS by The Focal Zone Oct 15/24 - invoice # for AUS is 61523. Multiple health concerns are chronic low grade pancreatitis as elevations in spec CPL with min clinical signs, suspect abd pain (?) she is stoic, small renoliths, gall bladder sludge , chronic atopy and food allergy. Diagnosed with Cushing's in July 2025 based on marked overstimulation on ACTH stim - started on Vetoryl. Most recent ACTH stim November 10, 2025 - relatively good control: Pre cortisol = 93 (28-120 nmol/L) Post cortisol = 225 (220-550 nmol/L). Most recent blood work Jan 23,2026 showed mild anemia Hct =0.39 (0.41-0.6), moderate to severe liver value elevations - ALT=270 (18-121),ALP=2283 (5-160),GGT=29 (0-13) and a marked SpecCPL elevation=737 (0-200).

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.

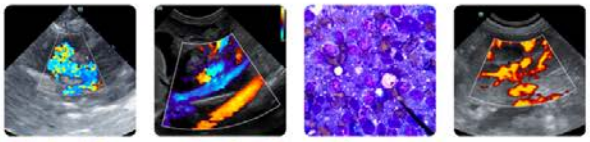
Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted. Punctate non-obstructive nephroliths are noted bilaterally. The left kidney is mildly small measuring 3.2 cm. The right kidney is normal in size at 4.2 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. A hyperechoic nodule is noted in the cranial pole of the left adrenal gland. Nodule does not disrupt normal shape and/or architecture. Visible surrounding vasculature appears normal. Left measures 1.4 cm at the cranial pole, the caudal pole is unable to be well visualized. Right measures 0.82 cm at the cranial pole and 1.1 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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.



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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. 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 empty with 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 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.

PRIMARY FINDINGS

- The bilateral adrenomegaly is consistent with this patient's reported history of medically managed hyperadrenocorticism.
- Hyperechoic adrenal nodule (cranial pole left 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.
- 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.

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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.

- Mild to moderate bilateral chronic kidney disease changes, most visibly significant in the left kidney, with punctate non-obstructive nephroliths bilaterally.

SECONDARY FINDINGS

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

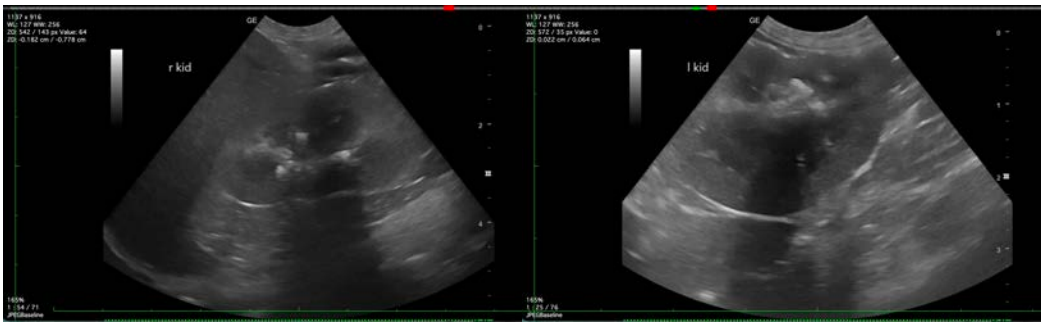
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of this study is largely static to the previous exam other than progressive adrenomegaly, which is expected with Trilostane-managed hyperadrenocorticism. There is not a definitive ultrasonographically visible intraabdominal explanation for patient's reported ongoing clinical signs and/or mild anemia, etc. Given the reported adequate cortisol level control but progressive non-specific clinical signs, further workup/evaluation for other underlying or concurrent diagnoses that could be contributing to the overall muscle wasting, anemia, etc. is recommended, beginning with:

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.

Additionally, if not recently evaluated, 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.

Ultimately, full consultation with and/or referral to a veterinary internist could be considered, if available.



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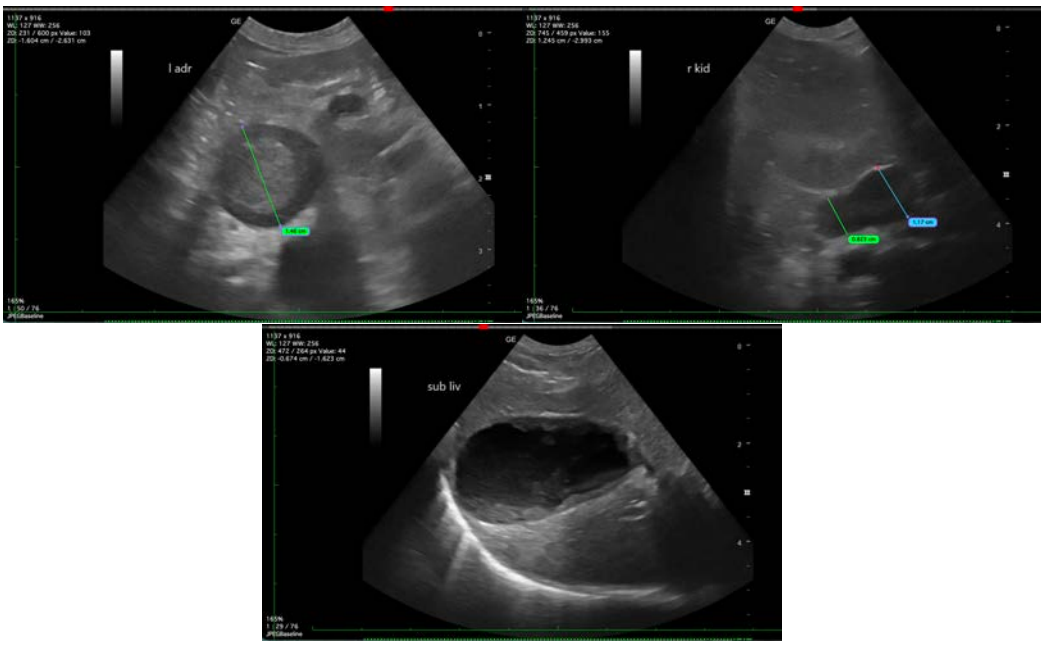

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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