



PATIENT

Spock Crotsley

SPECIES

Canine

BREED

Pitbull

SEX

Neutered Male

AGE

12 Years

WEIGHT

85.3 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Mary Pearce

HOSPITAL NAME

Chambersburg AH

REFERRING VET

Dr. Tanya Miller

INVOICE

36340

DATE

3/23/26

PRESENTING CLINICAL SIGNS

- Presented for concerns of PU/PD 3/3/26, basic ultrasound at that time found NSF.
- Had been drinking much more at night over the last year, recently worsened per o.
- Cushings testing recommended, which was not consistent.
- Full abdominal ultrasound recommended with specialist review, o elected to proceed.
- Full adrenal panel pending with ACTH stim.
- Hx anal gland infection, resolved.
- Abnormal PE/Chem/CBC/UA Results: 3/10/26: LDDST resting cortisol 3.4, 4hr post 1.3, 8 hour post 1.5. Not consistent with Cushings. 12/12/25: CBC: HCT 52%, WBC 10.5, PLT 488, normal. Chem: normal other than ALP 177 (5-160). TT4 normal. UA: USG 1.010, noncrystalline debris present, otherwise quiet sediment.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Prostate is normal in size (1.6 cm wide, sagittal view), echotexture and echogenicity for a neutered male. Except for a very subtle non-expansive, non-disrupting hypoechoic density/nodule noted, measuring 1.4 cm x 1.6 cm in size.

Kidneys are bilaterally normal in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney measures 6.25 cm. The right kidney measures 5.39 cm. The abnormal shape is secondary to stable chronic infarcts bilaterally.

Adrenal Glands

Left adrenal gland is normal in size (0.55 cm at cranial pole and 0.58 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is unable to be visualized in these images.

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. Splenic vasculature appears normal.

Liver



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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 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.

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 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.

ULTRASONOGRAPHIC FINDINGS

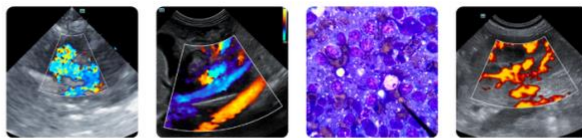
- Mild bilateral chronic kidney disease changes, characterized by stable bilateral chronic infarcts.
- The prostatic nodule could represent a benign process, including a cyst, hematoma, or even chronic inflammatory lesion. Although an early infiltrative neoplastic nodule, while thought less likely, can't be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Differentials for PU/PD are vast and include, but are not limited to:

Primary polyuria caused by chronic kidney disease, pyelonephritis, liver disease, diabetes mellitus, hyperthyroidism, hypercalcemia, hyperadrenocorticism, hypoadrenocorticism, E.coli infections ie) pyometra in females, polycythemia, central diabetes insipidus or primary nephrogenic diabetes insipidus

Primary polydipsia caused by psychogenic polydipsia, fever, pain, or central nervous system disease



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Most causes of PU/PD can be diagnosed with a comprehensive history and physical exam, a first AM urine specific gravity to see if urine concentration is possible (as most animals naturally consume less water overnight) followed by a comprehensive CBC, serum chemistry panel, electrolytes, and urinalysis.

If not, next step(s) may include a urine culture, low dose dexamethasone suppression test, T4, bile acids, Leptospirosis testing and/or an empirical course of antibiotics.

If a diagnosis is still not obtained, a more advanced work-up is indicated and consultation with an internist may be warranted.

If a diagnosis is not obtained, as false negative hormone testing can occur, then follow up or recheck hormone testing could be considered in 3-6 months.

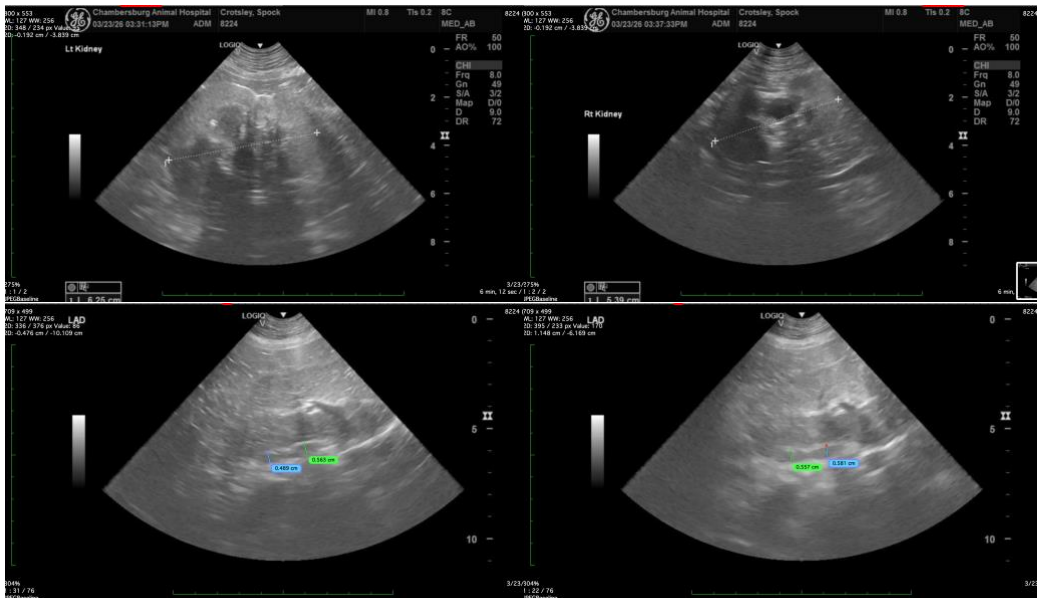
In the meantime, if possible, to further visualize the right adrenal gland, that too may be helpful.

Addendum:

The kidney changes are subtle with infarcts appearing stable and are of unknown contribution to patients reported PU/PD. These changes should be interpreted in combination with laboratory workup, urinalysis results, etc. Having said that, if not recently evaluated, a blood pressure is recommended.

Similarly, the prostatic nodule is of unknown contribution, submission of urine to look for BRAF gene mutation could be considered to further investigate possible uroepithelial neoplasia, or if it can safely be reached and patient's coagulation status is appropriate, a fine needle aspirate of the nodule could be considered.

Dr. Johnson would appreciate any follow-up available from further workup of the prostatic nodule.
Beth.johnson@sonopath.com





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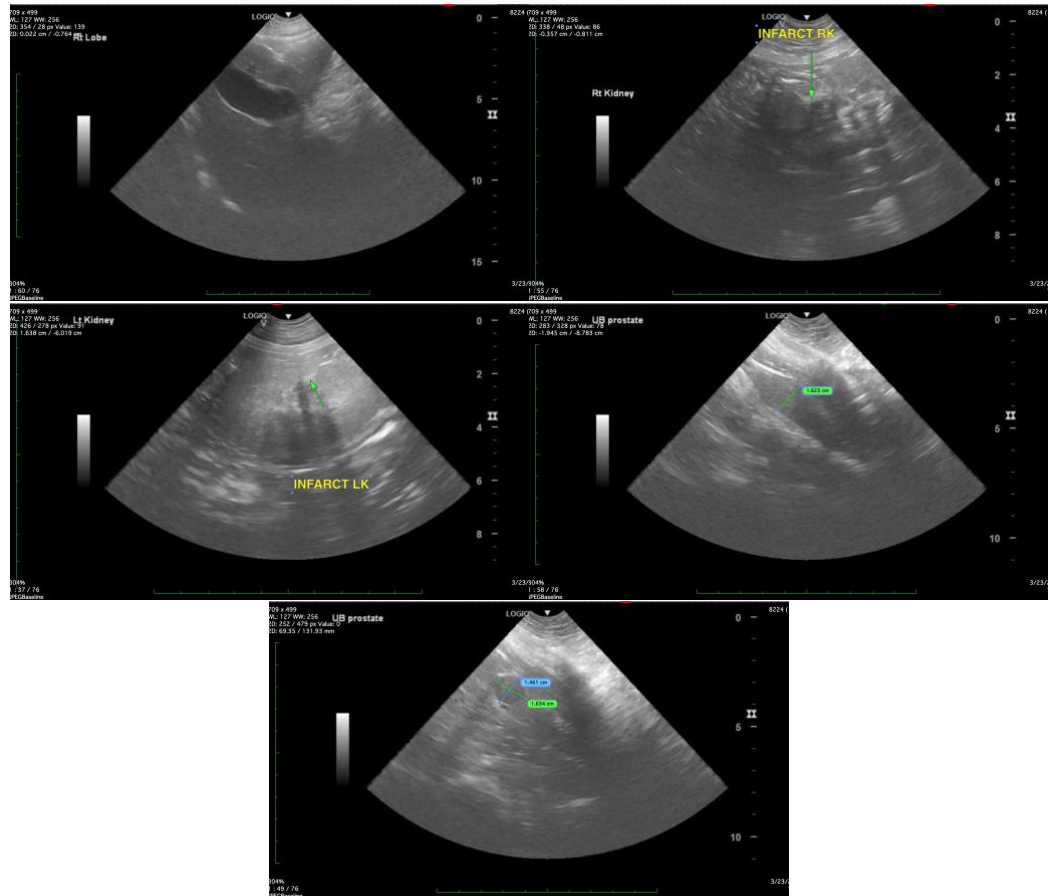
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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