



## PATIENT

McKenna Eyres

## SPECIES

Canine

## BREED

Westie

## SEX

SF

## AGE

10 year 5 months

## WEIGHT

8.1 kg

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Dr. Anthony Krawitz

## HOSPITAL NAME

Calusa Veterinary  
Center

## REFERRING VET

Dr. Anthony Krawitz

## INVOICE

11802

## DATE

4/28/2026

## PRESENTING CLINICAL SIGNS

Recently has had an increased appetite yet lost 1 pound of weight. Some panting, but no obvious PU/PD. BW showed mild hepatic enzyme elevation. ALT 177 and Alk phos 350, AST 132, otherwise WNL. Urine SG 1.022, UPC 0.4. A LDDS was WNL, pre 3.6, 4 hours 0.5, and 8m hours 0.3. Fecal PCR Keyscreen negative. She does have a history of chronic yeast and bacterial dermatitis due to allergies. Takes Apoquel and Simplicef at times and Douxo shampoo.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.5 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The right kidney is normal is size (4.92 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 (5.15 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 (0.53 cm at cranial pole and 0.77 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal. A hyperechoic nodule is noted in the caudal pole of the right adrenal. Nodule does not disrupt normal shape and/or architecture.

The left adrenal gland is normal in size (0.41 cm at cranial pole and 0.64 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal. A hyperechoic nodule is noted in the caudal pole of the left adrenal. Nodule does not disrupt normal shape and/or architecture.

### 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). No focal nodules or masses are observed. 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. Visible vasculature and biliary tree appear normal without distension or congestion.

The 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



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The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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**

- 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.
- Mild chronic cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- Hyperechoic adrenal nodules in the caudal poles bilaterally – 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**

Given patient's reported history, predominately, the liver enzymes, the very mild proteinuria, bilateral adrenal nodules, etc., emerging adrenal disease such as hyperadrenocorticism can't be ruled out and



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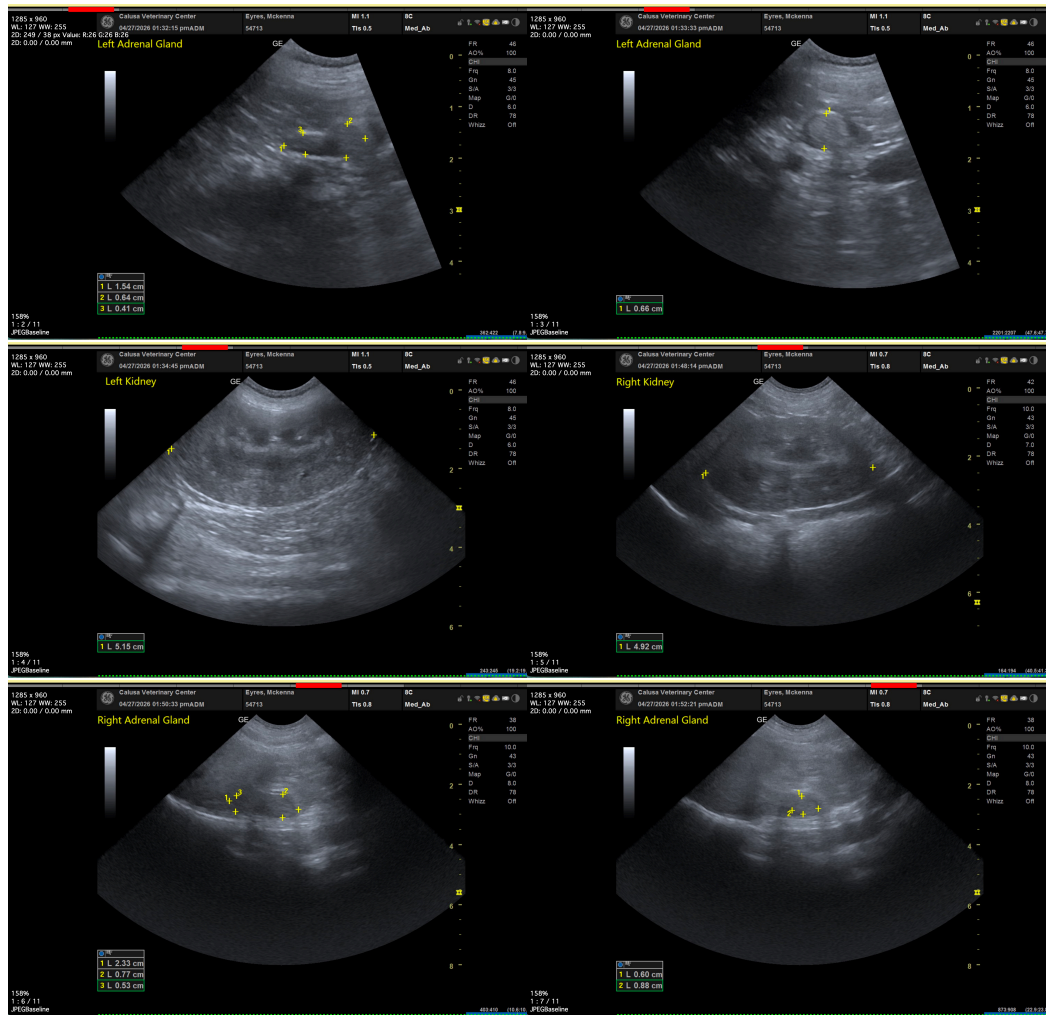
4/28/2026

may be too early for a positive low dose dexamethasone suppression test. Having said that, however, hyperadrenocorticism does not typically result in weight loss. Therefore, in my opinion, there's another underlying or potentially concurrent disease process that warrants primary investigation. If not recently evaluated, a thorough evaluation of daily caloric intake is recommended to assure an adequate daily caloric intake is occurring vs an inadvertent reduction in calories due to change in diet and/or feeding schedule, competitive eating environment, etc.

Further evaluation of digestion and absorption is recommended, therefore 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.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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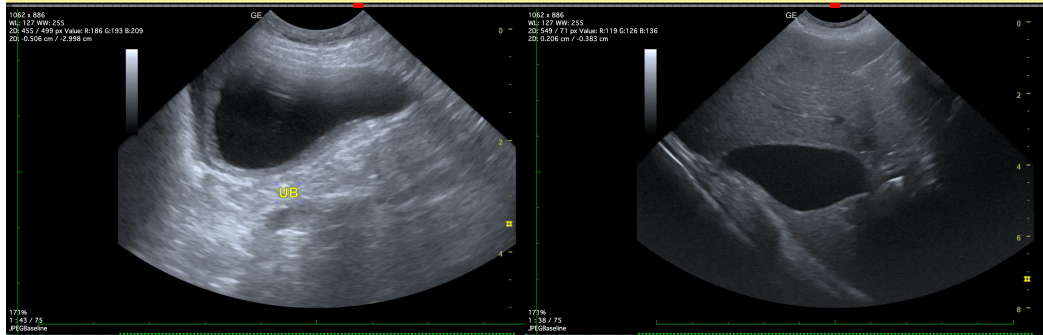
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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