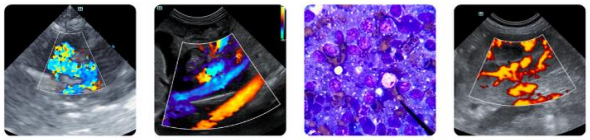


PATIENT

Geordie Burchert

SPECIES

Canine

BREED

Terrier Mix

SEX

MN

AGE

10Y

WEIGHT

25lbs

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

All Creatures Great and Small (Denville)

REFERRING VET

Dr. Ashmore

INVOICE

74476

DATE

4-6-26

PRESENTING CLINICAL SIGNS

- BCS 3/9
- PU/PD/Wt. loss of 2 lbs recently.
- Appetite normal, no c/s/v/d
- Current Meds: (Torb sed for scan)

Abnormal PE/Chem/CBC/UA Results: Alb-2.2; ALT-251; USG: 1.010

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

Kidneys are overall normal in size (Left 5.2 cm; Right 5.2 cm) and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Adrenal glands are mildly plump in size (Left cranial pole 0.7 cm, caudal pole 0.8 cm; Right cranial pole 0.9 cm, caudal pole 0.6 cm) for a small to medium sized dog. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

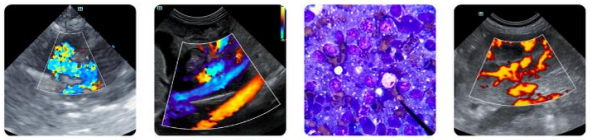
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The 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 mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal



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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

Primary

- Subjectively mild bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.
- Emerging gallbladder mucocele – 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.

Secondary

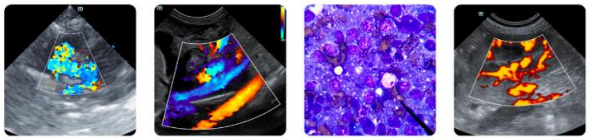
- Mild to moderate age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's reported weight loss in the face of a normal appetite, ruling out diabetes mellitus is recommended if not already evaluated.

Evaluation of digestion and absorption is recommended via a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

A routine fecal/giardia exam is recommended.



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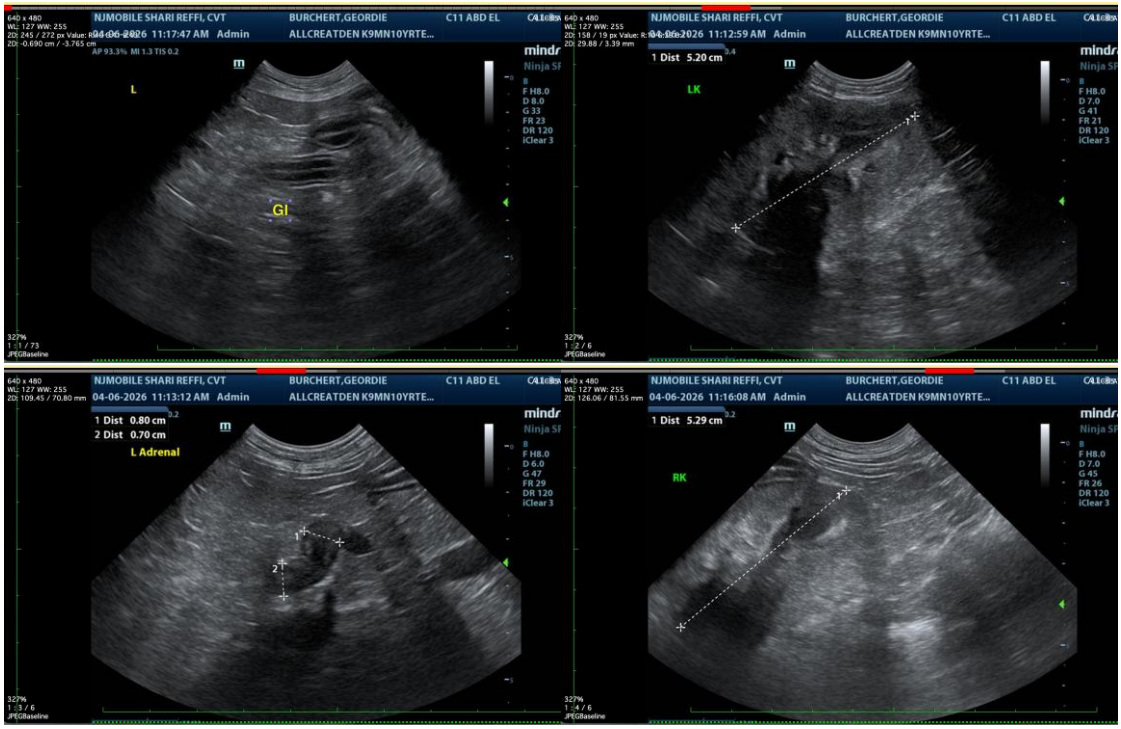
If patient is hypoalbuminemic, then additionally further evaluation for hypoalbuminemia is recommended to also include urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Given the patient's mild adrenomegaly, some of the reported PU/PD could be secondary to underlying or emerging adrenal disease. Although hyperadrenocorticism does not typically result in weight loss. Therefore, further evaluation of the weight loss and the albumen etc. is recommended with management of that concurrent process prior to further workup of possible adrenal disease, which could be considered only if clinical signs persist.

Having said that, a BP is recommended if not recently evaluated.



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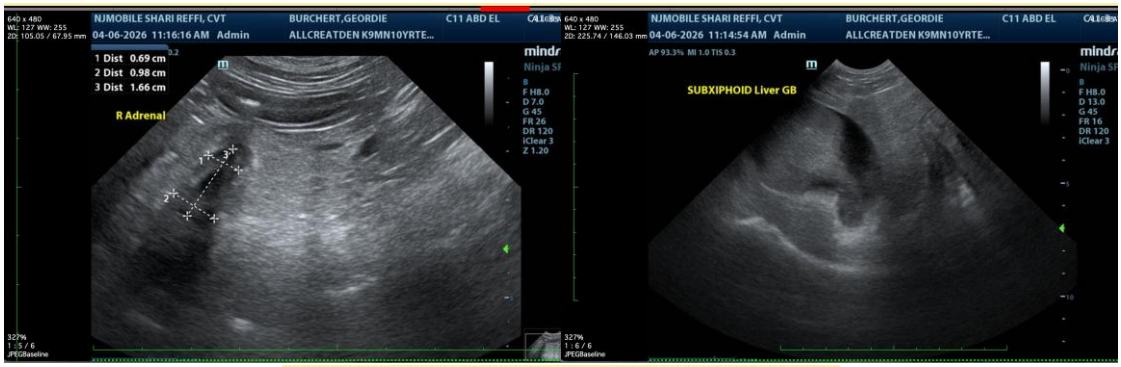

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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