



PATIENT

Brodie McHugh

SPECIES

Canine

BREED

Boston terrier

SEX

FS

AGE

10 years

WEIGHT

16.2 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Pamela Harrigan,
RDCS, Certified
Veterinary
Sonographer

HOSPITAL NAME

Sandwich Animal
Hospital

REFERRING VET

Dr. Laura Hussey

INVOICE

11949

DATE

5/13/2026

PRESENTING CLINICAL SIGNS

Pot-bellied appearance; PU/PD. Was treated for UTI but still having leaking symptoms. Crusty skin treated with doux shampoo.

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 overall normal in size 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. Left kidney measures 5.2 cm and the right kidney measures 5.7 cm.

Adrenal Glands

Adrenal glands are mildly plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Left adrenal measures 0.69 cm at the cranial pole and 0.86 cm at the caudal pole. The caudal pole of the left adrenal is mildly enlarged as a result of a hyperechoic nodule. Nodule does not disrupt normal shape and/or architecture.

Right adrenal measures 1.0 cm at the cranial pole and 0.81 cm at the caudal pole.

Spleen

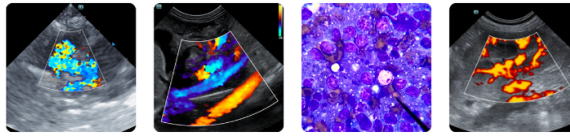
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion. Specifically, in the mid cranial liver, an approximately 0.9 cm x 1.3 cm mildly heterogenous, more hyperechoic nodule is noted.

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



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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.

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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.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

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The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no visible free peritoneal effusion noted in these images.

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There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

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- Mildly bilateral adrenomegaly with a hyperechoic adrenal nodule in the caudal pole of the left adrenal gland – 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.
- Moderately 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 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.
- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

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SECONDARY FINDINGS

- Mild age-related kidney changes.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's reported recent urinary tract infections, follow up recommendations depend in part on



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the treatment, course, duration, any follow up urine sampling, urine cultures, etc. as the first recommendation is to assure that the infection has fully cleared, instead of continuing to contribute to clinical signs.

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Therefore, 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 ration is recommended.

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A blood pressure is recommended if not recently evaluated.

If another cause for patient's reported ongoing urinary signs, potbelly, etc. is not found, hormone testing could be considered beginning with a low dose dexamethasone suppression test.

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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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