



PATIENT

Sophie Anglestein

SPECIES

Canine

BREED

Beagle

SEX

Spayed female

AGE

10 years

WEIGHT

13.3 kg

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Abby Gerenser

HOSPITAL NAME

Abby Road VH

REFERRING VET

Dr. Gerenser

INVOICE

68360

DATE

11/5/25

PRESENTING CLINICAL SIGNS

History: Patient has a hx of hypothyroid and Cushing's (managed on levothyroxine and veteryl). Also has a heart murmur. Has had issues with appetite since last ultrasound. Seemed to improve when on Metoclopramide. Patient last ate at 11:30 pm last night (confirmed twice with owner).
Abnormal PE/Chem/CBC/UA Results: Seems mildly uncomfortable overall, slightly in cranial to mid abdomen, tail tucked, not as bright as usual.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, presented normal thicknesses. The urethra revealed subjectively poor tone visualized up to 3.0 cm beyond the cystourethral junction. If any evidence of recurrent UTI is present then underlying occult incontinence may be an issue. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 5.3 cm. The right kidney measured 5.6 cm.

Adrenal Glands

The **adrenal glands** appeared slightly enlarged and swollen. No evidence of focal capsular expansion or invasion into the phrenic veins was noted. No overt suspicion of neoplasia was noted. This is considered likely a hyperplastic change associated with stress or adrenal endocrinopathy (PDH). If isosthenuria is persistently present and the patient morphologically suggests Cushing's disease then ACTH testing would be indicated. The left adrenal gland measured 0.8 cm at the caudal pole and 0.67 cm at the cranial pole. The right adrenal gland measured 1.6 cm at the cranial pole and 0.8 cm at the caudal pole.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.



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Liver

The **liver** revealed uniform, mild enlargement. Minor coalescing gallbladder bile was noted. This is not pathological.

Gastrointestinal

There was some residual chyme and gas was noted in the **stomach**, yet not pathological. This is consistent with post prandial presentation. Transit of chyme into the small intestine was normal. Curvilinear patterns were maintained throughout the GI tract. No evidence of pathology. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The **pancreas** revealed minor, heterogenous parenchymal changes, yet this is not likely a clinical issue at this time.

ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenal hypertrophy, consistent with PDH/Cushing's.
- Subjectively poor urethral tone.
- Coalescing gallbladder sludge, physiological.
- Otherwise unremarkable abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinalysis is warranted as well as assessment for potential history of incontinence or recurrent UTI. Full CNS examination and assessment for systemic hypertension is warranted given the vague clinical signs in this patient. Orthopedic pain may also be playing a role. There was no evidence of visceral disease that would explain any abdominal pain.



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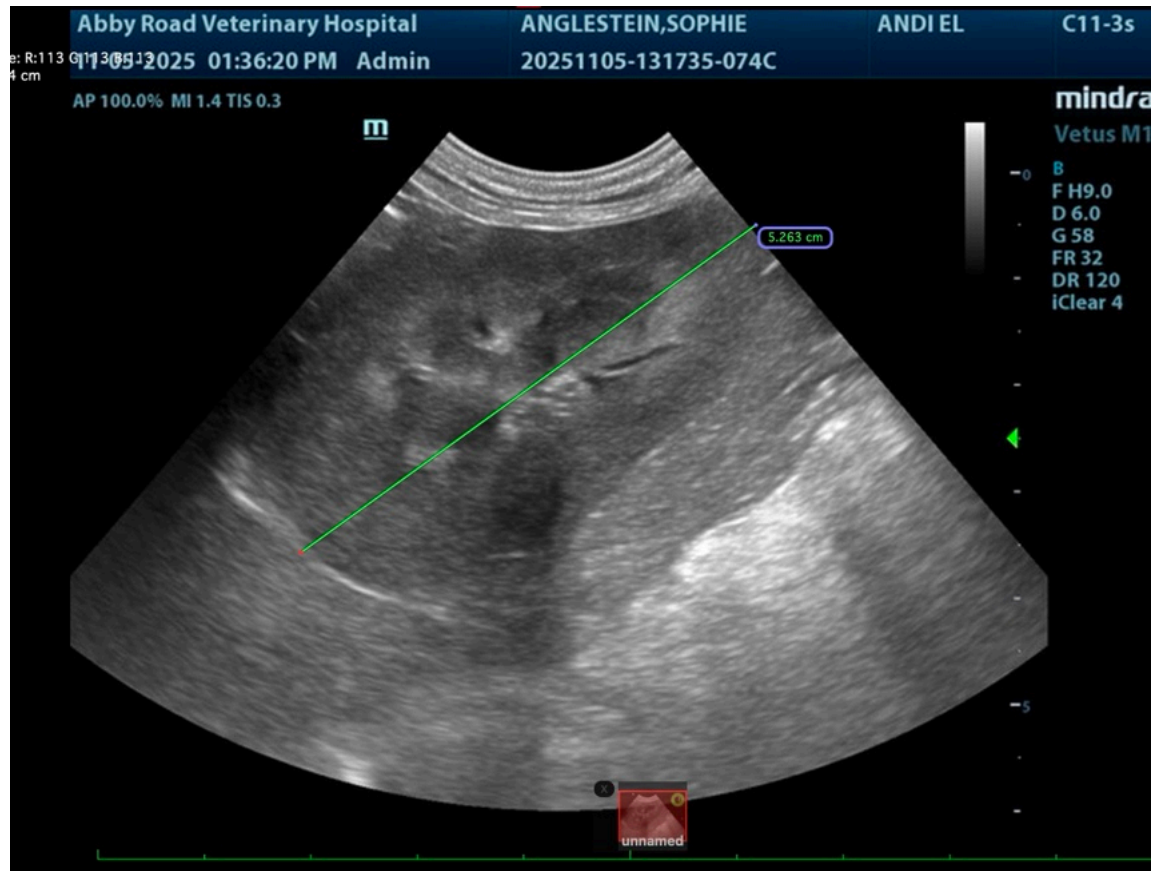
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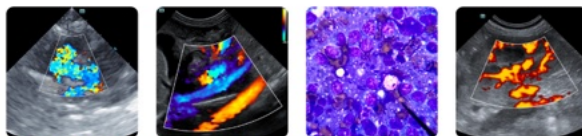
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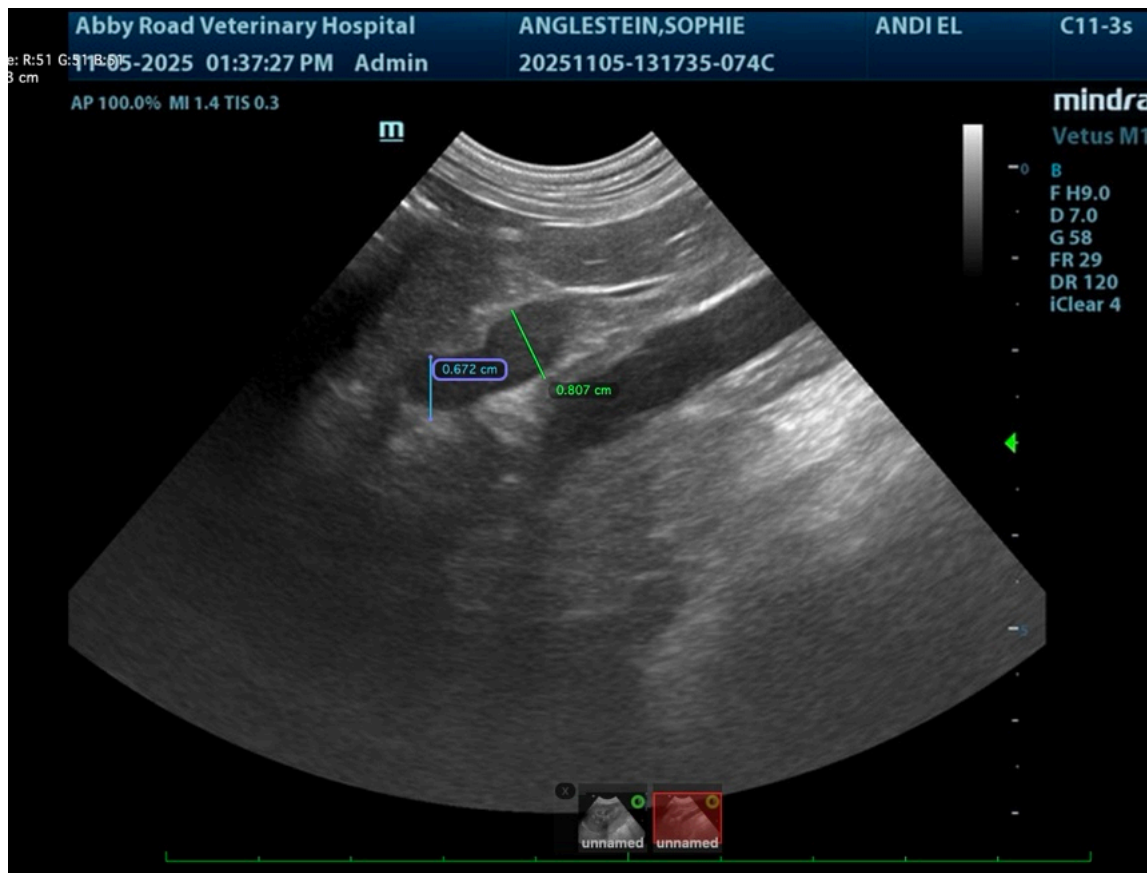
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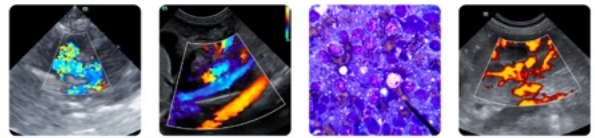
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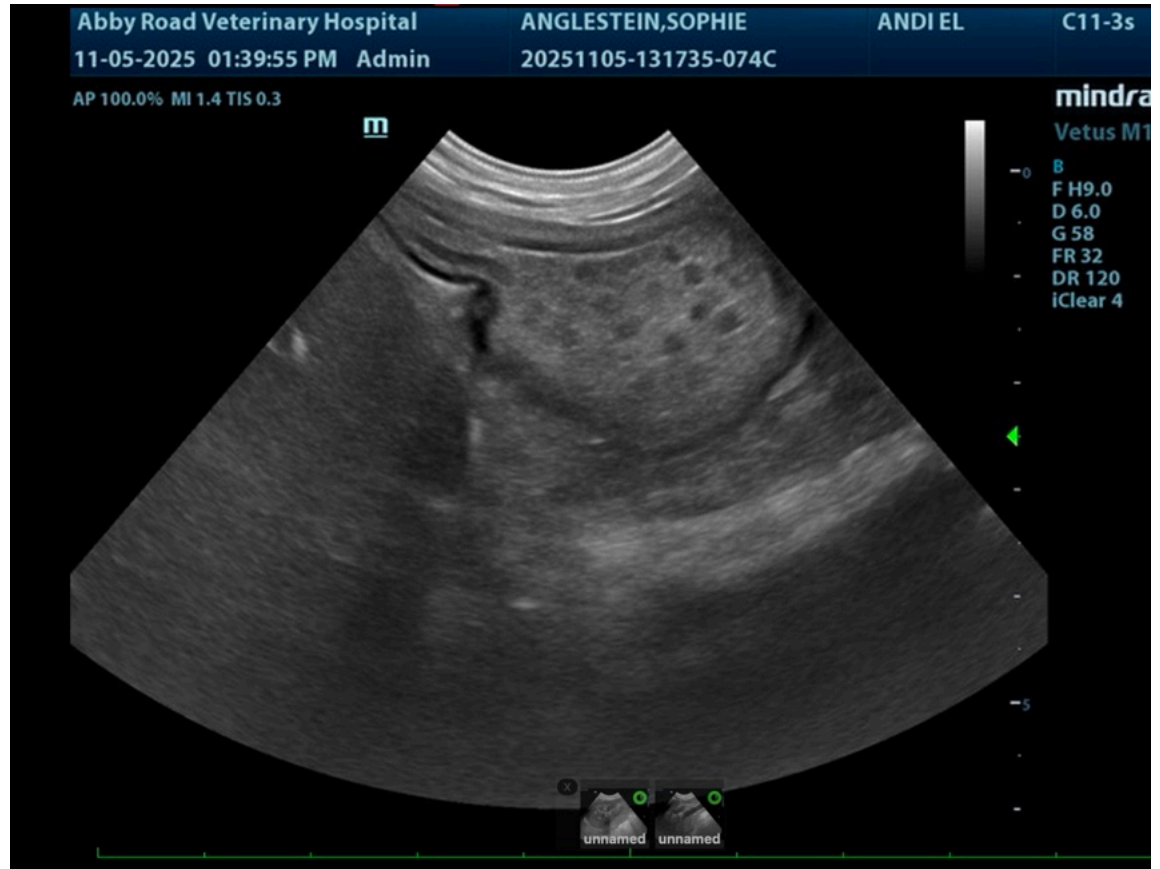
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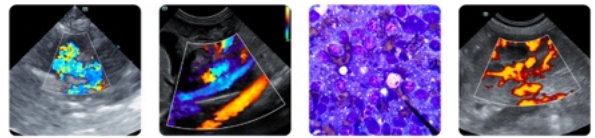
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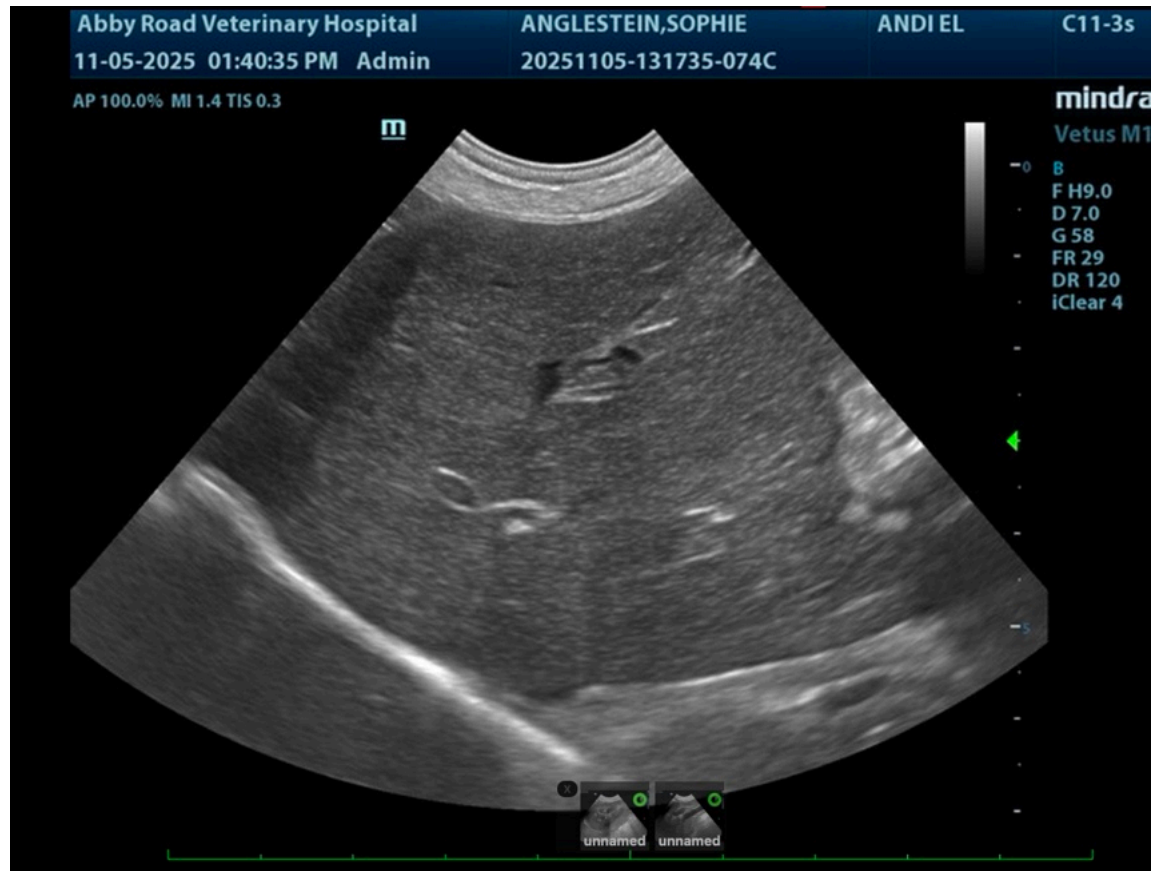
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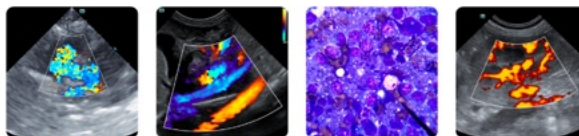
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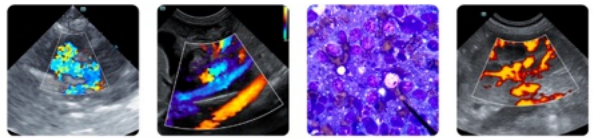
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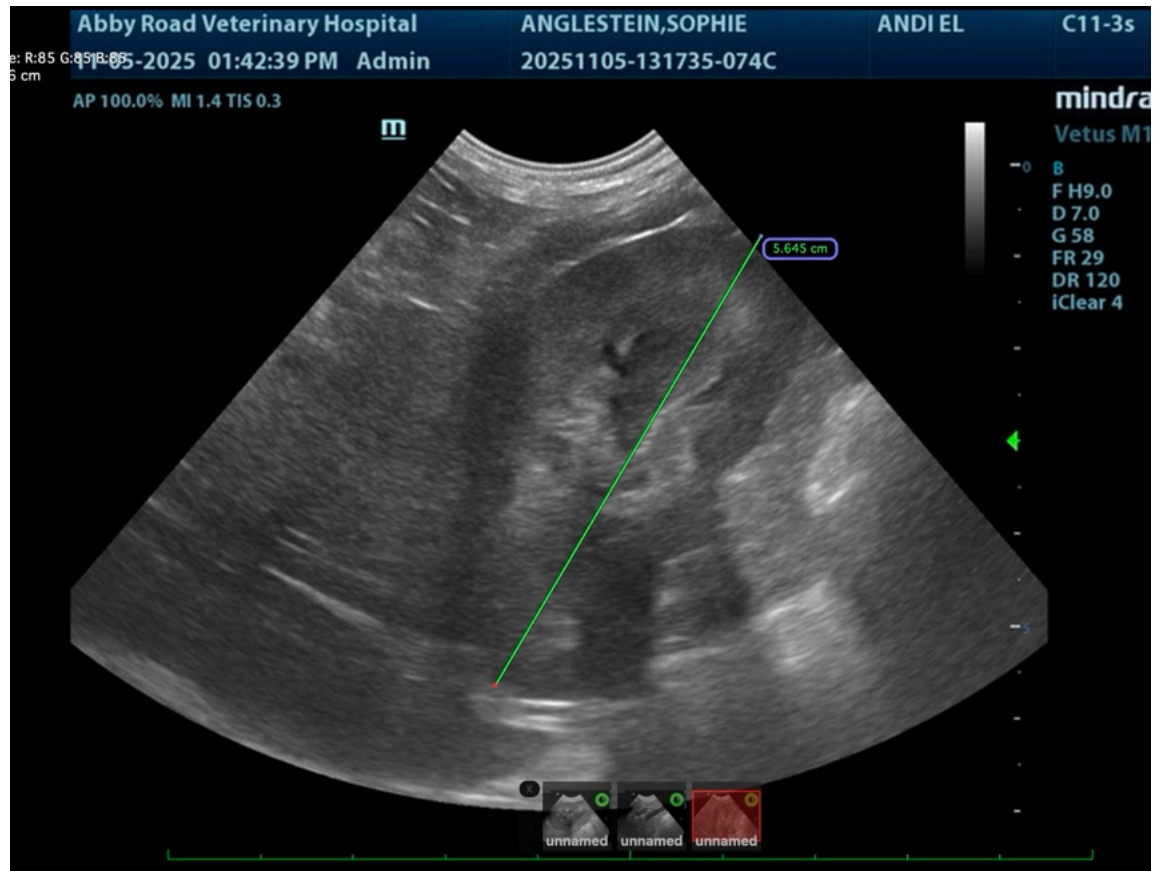
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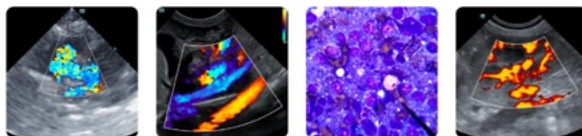
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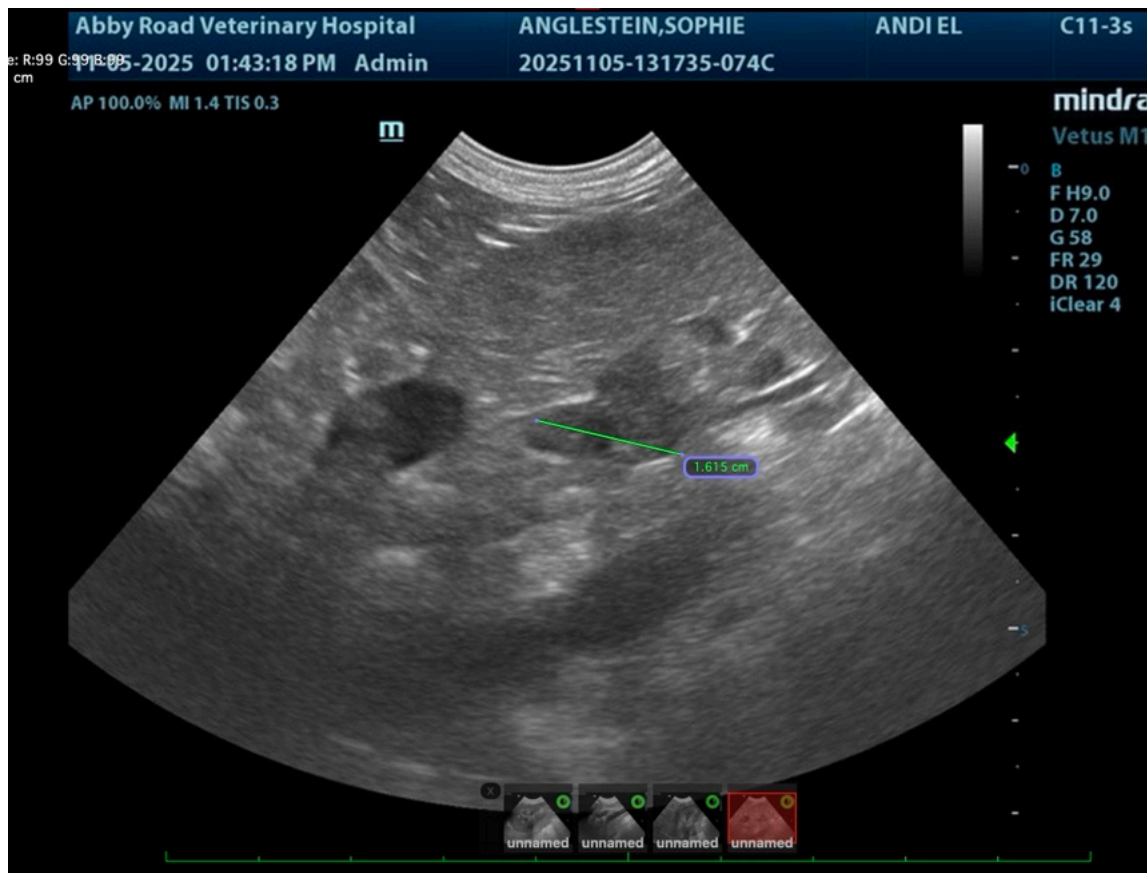
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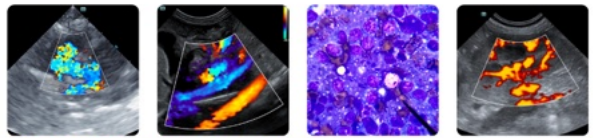
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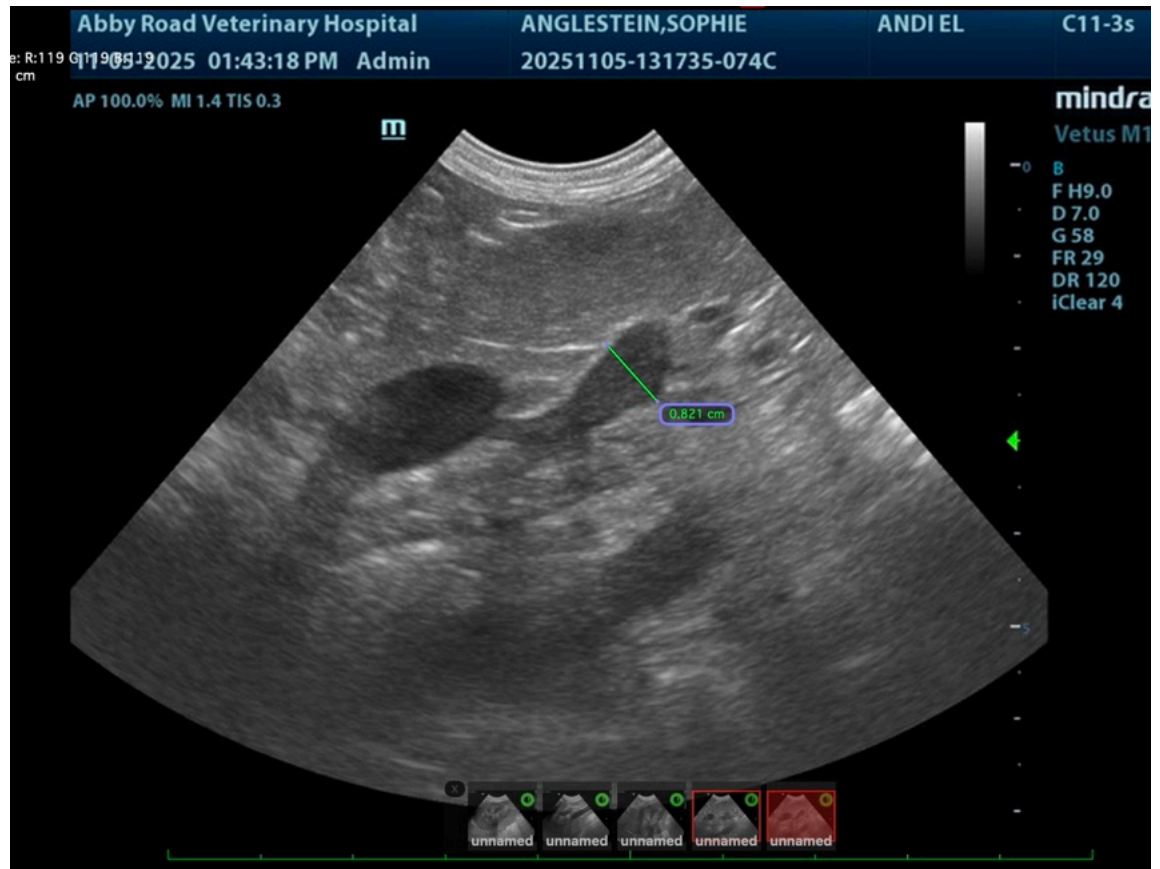
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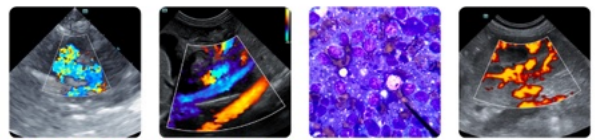
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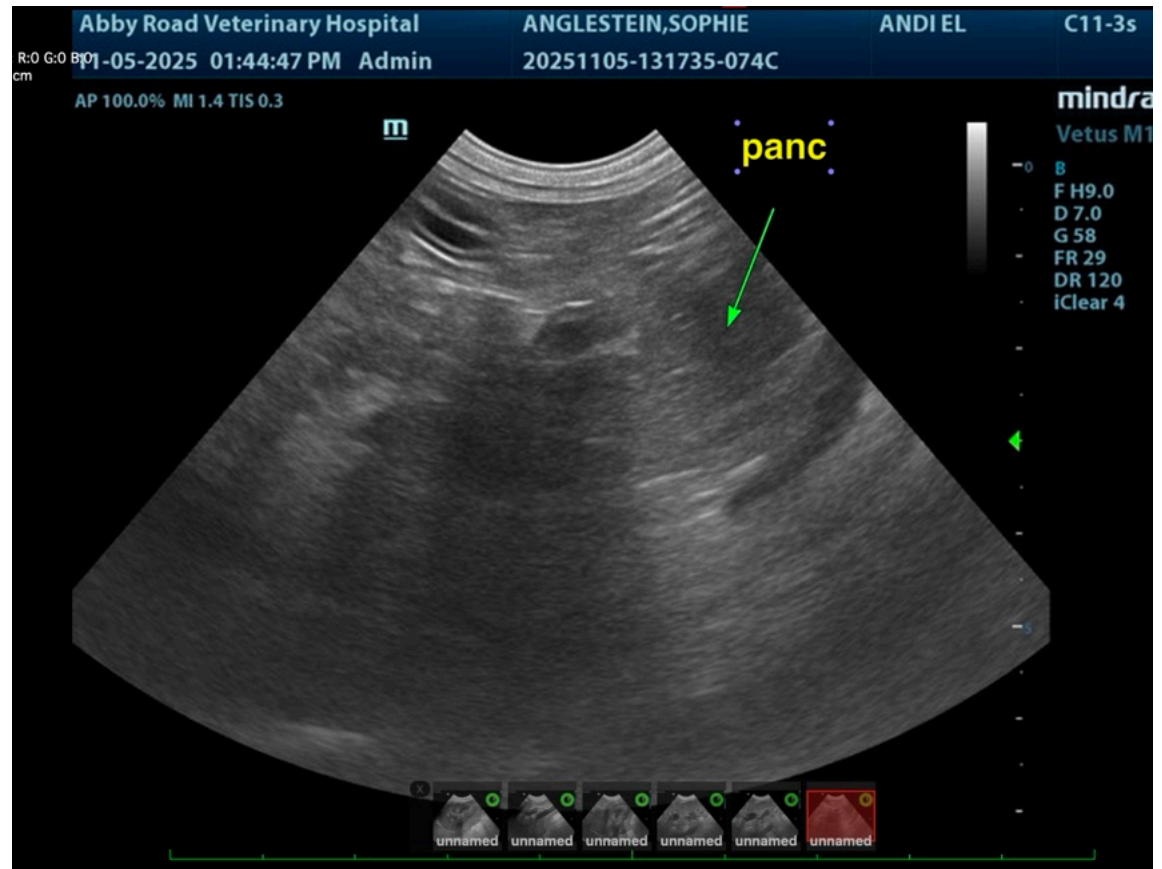
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

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