


**DATE PRESENTING CLINICAL SIGNS**

2/10/26

**PATIENT**

Sadie Metrock

**SPECIES**

Canine

**BREED**

Alaskan Malamute

**SEX**

Spayed Female

**AGE**

7/14/15

**WEIGHT**

87.5 lbs

**INTERPRETED BY**

 Kathleen Sennello DVM,  
 MS, Diplomate ACVIM  
 (Small Animal Internal  
 Medicine)

**HOSPITAL NAME**

 Chadwell Animal  
 Hospital

**REFERRING VET**

Dr. Heydt

**INVOICE**

72863

**Patient History:** P presented on 12/31/25 for possible UTI and PU/PD. On examination, p was BAR MM-pink, moist CRT <2sec. P had mild-moderate tartar and gingivitis but otherwise PE WNL. A urinalysis was performed that revealed USG 1.006 and suspected rods. P was placed on a broad spectrum antibiotic. On 1/7/26, O notes that P was not improving on antibiotics so bloodwork and urine culture were performed. Bloodwork showed elevated ALP and urine culture was positive for *Pseudomonas aeruginosa*. Due to high antibiotic resistance of *Pseudomonas*, p was placed on a 7-day course of Amikacin. A LDDST was performed on 1/20/26 that came back inconclusive for Cushings. A repeat UA was performed on 2/2/25 which showed resolved UTI but USG 1.008. O notes p is still PU/PD. Discussed trial of proin for possible incontinence and abdominal ultrasound.

**Current Medications:** Thyroid tabs (0.4mg) - give 1 tab PO BID, Amikacin (250mg/ml) - 1.8cc SQ SID x 7d (course complete)

**Labwork Results:** Labwork attached, reported as: 12/31/25: Urinalysis: collect- free catch; color straw, clear; USG 1.006, pH 9, protein Neg, Glucose Neg; Ketone Neg; WBC 5/hpf, RBC < 1/hpf; Bacteria- rods; crystals none. 1/8/26: Bloodwork: WBC 5.6 K/uL (5.8-16.2); P 6.7 (2.5-6.1); K 6.0 (4-5.4); TP 7.6 (albumin 4; globulin 3.6); ALP 1,088. 1/8/26: Urinalysis: USG 1.006, pH 6.5, protein NEg, glucose- neg; WBC 0-2/hpf; RBC 2-5/hpf; bacteria -marked rods >40/hpf; crystals - none. 1/8/26: Urine culture: pseudomonas aeruginosa (50,000-100,000 CFU/ml). 1/20/26: LDDST: Pre 5.06 ug/dL; 4hr post 1.18; 8hr post 0.75. 2/2/26: Urinalysis: collection- free catch; color - straw, clear, USG 1.008, pH 5, protein - neg; glucose - neg; ketone - neg; WBC

**Date of Previous IntraPet Ultrasound:** No previous.

**Sedation:** Not required to complete full diagnostic ultrasound.

**Stat Report:** Not requested.

**Imaging Performed by:** Stephanie Warga RDCS, RVT.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**
**Urinary System**

The urinary bladder is moderately distended with anechoic urine. The majority of the bladder wall appears normal with a smooth mucosal surface. The apical region appears mildly thickened and irregular measuring at 0.64 cm. The trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (7.36 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (7.58 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is "plump" measuring 0.82 cm at the cranial pole and 0.86 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The exact margins of the right adrenal are difficult to clearly visualize (largely due to patient motion, etc.). General shape and size appear normal. The cranial pole measures 0.81 cm. The caudal pole measures 0.79 cm. It is visualized in its normal position between the right kidney and the caudal vena cava.

### ***Spleen***

The spleen is subjectively normal in size (2.38 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

### ***Liver***

The liver is borderline large in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

### ***Gastrointestinal***

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measures 0.28 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

### ***Pancreas***

The area of the pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

### ***Free Abdomen***

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

## **ULTRASONOGRAPHIC FINDINGS**

- Mildly thickened/irregular apical wall of the urinary bladder – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- “Plump” left adrenal gland and borderline “plump” right adrenal gland – Findings could be consistent with normal anatomic variation or early hyperplasia.

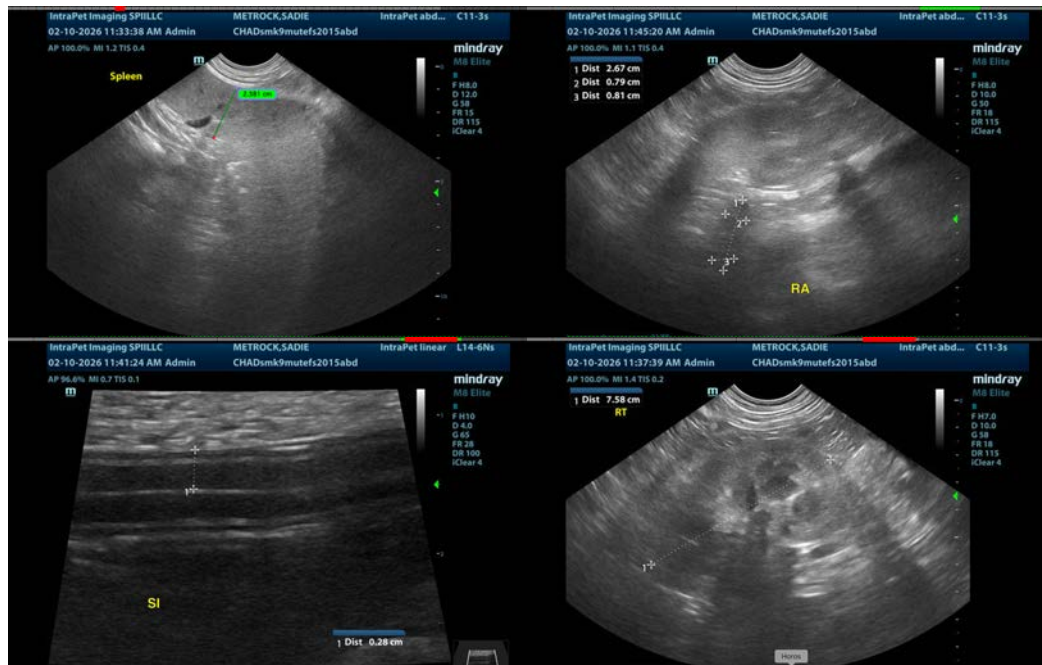
- Subjectively hyperechoic liver – The diffuse hepatic changes are non-specific and can be seen with vacuolar hepatopathy, reactive change, nodular hyperplasia or, less likely, inflammatory/immune-mediated disease, infiltrative neoplasia, or other hepatopathy.

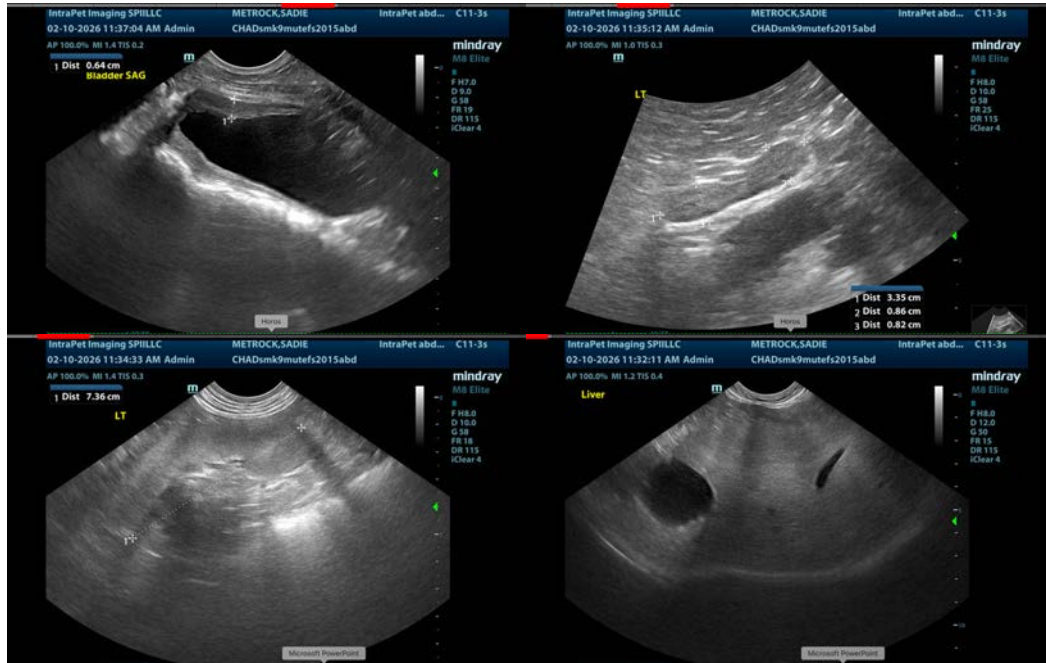
### INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver subjectively appears hyperechoic. This would be most consistent with a vacuolar hepatopathy, although other hepatopathies are possible. If further evaluation is desired, consider a liver function test and a fine needle aspirate (provided coagulation parameters are normal).

The left adrenal gland is “plump” and the right appears normal to borderline “plump” (likely requires sedation for more adequate evaluation). Findings could be normal for this individual or could be consistent with early Cushing’s.

In light of the resistant urinary tract infection identified and the hyposthenuria, consider re-culturing the urine despite a non-active urine sediment to confirm that the infection is gone. If other symptoms of Cushing’s are present, you could consider repeat evaluation, possibly a urine cortisol to creatinine ratio combined with an ACTH stimulation(?), or even an adrenal panel to the University of Tennessee’s endocrine lab combined with an ACTH stimulation test, looking for potential atypical Cushing’s. Additionally, a repeat low-dose Dexamethasone suppression test could be considered in the future if symptoms progress.





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.

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