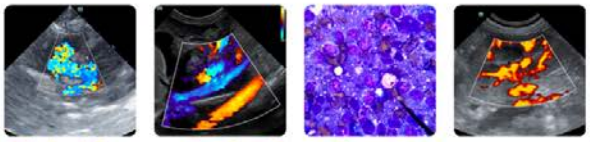




**PATIENT**

Leo Fritchey

**SPECIES**

Canine

**BREED**

Shih Tzu

**SEX**

Neutered Male

**AGE**

6 Years

**WEIGHT**

8.5

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Justin Freeby

**HOSPITAL NAME**

Abby Road Veterinary Hospital

**REFERRING VET**

Dr. Justin Freeby

**INVOICE**

73972

**DATE**

3/24/26

## PRESENTING CLINICAL SIGNS

P has history of irritable bowel/allergic bowel which is managed on Purina HA - based on previous ultrasound and response to therapy.

Abnormal PE/Chem/CBC/UA Results: P has had persistent proteinuria with UPCR consistently above 0.5 (no hematuria/pyuria/uti) present during readings. Last labwork showed elevated cystating B (100) but creat 0.8 and bun 22, upcr was 0.7. screening ultrasound

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, 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 prostate is normal in size (0.67 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (4.32 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 (4.29 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 normal in size measuring 0.69 cm at the cranial pole and 0.93 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.

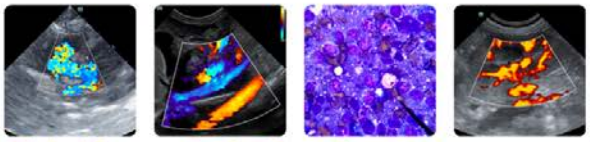
The right adrenal gland is large, measuring 0.71 cm at the cranial pole and 0.90 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

### *Spleen*

The spleen is subjectively normal in size (0.94 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 large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.





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The gall bladder lumen is moderately distended. There is a moderate amount of non-organized echogenic debris. There is some irregularity at the gallbladder wall, consistent with small polypoid lesions or adhered debris. The cystic and common bile ducts are normal/not visible.

### *Gastrointestinal*

The stomach contains moderate fluid and shadowing ingesta. 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. In some areas shadowing ingesta interferes with full evaluation of the stomach.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to moderate fluid/chyme distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.39 cm. Jejunum wall measures 0.32 cm. Visualized peristalsis appears appropriate. Fluid and gas visualized within the small intestine is potentially indicative of a non-fasted patient.

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 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

- Bilateral adrenomegaly – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.

- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

- Moderate gallbladder debris with a slightly irregular gallbladder wall – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring. The bladder wall irregularity is mild but could be consistent with mild cholecystitis. Correlate with current lab work.

- Fluid and shadowing ingesta visualized within the stomach and some areas of the small intestine – Findings are most consistent with a post-prandial patient. If the patient was adequately fasted, this could represent delayed gastric emptying.

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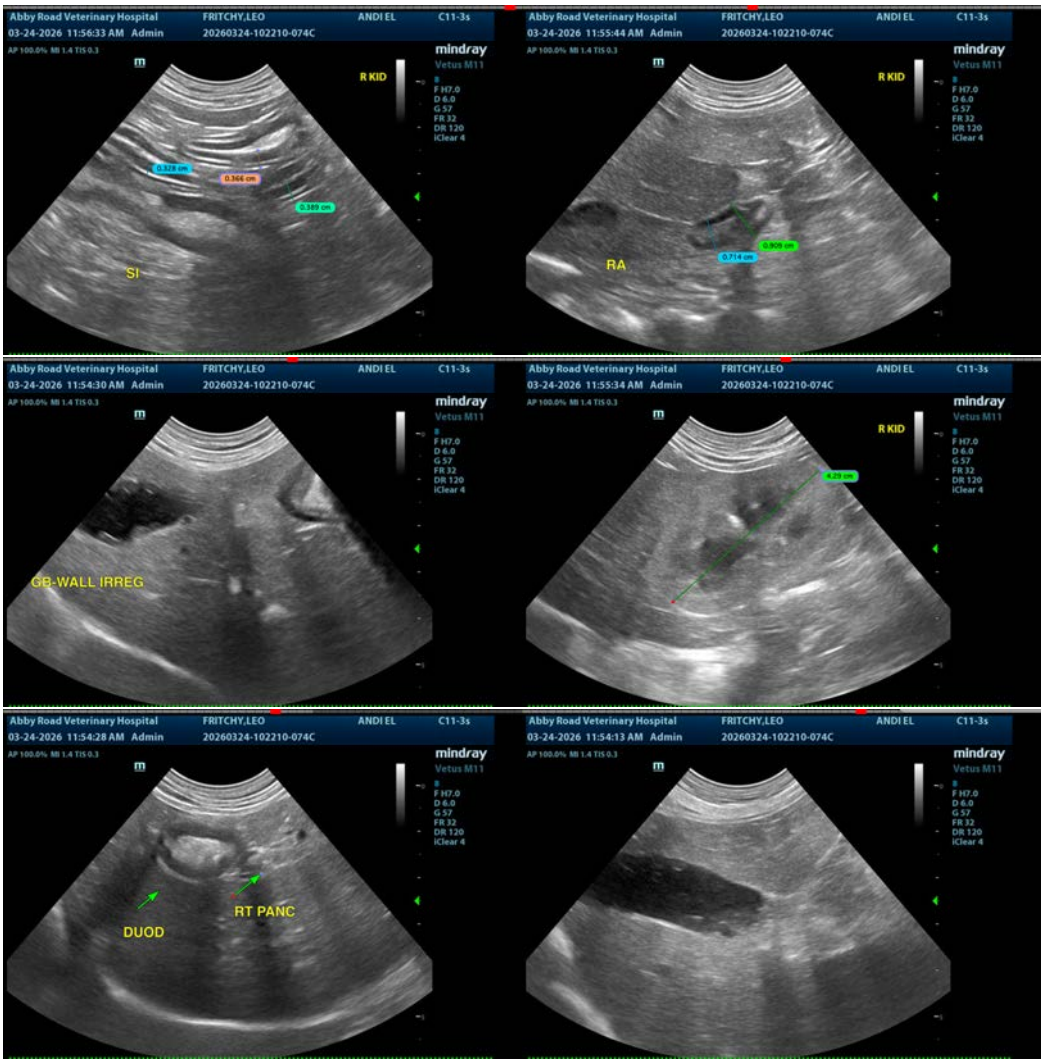
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The combination of the adrenal gland enlargement and the large, heterogeneous liver is concerning for possible pituitary dependent hyperadrenocorticism. If clinical signs consistent with this are present, consider adrenal function testing. Additionally recommend a blood pressure, as this can be associated with proteinuria.

There is a moderate amount of debris visualized within the gallbladder and some irregularity to the gallbladder wall. Consider starting chronic Ursodiol therapy and continued monitoring of the gallbladder. If liver enzyme elevations are significant and/or progressively rising, treatment for cholecystitis could be considered.



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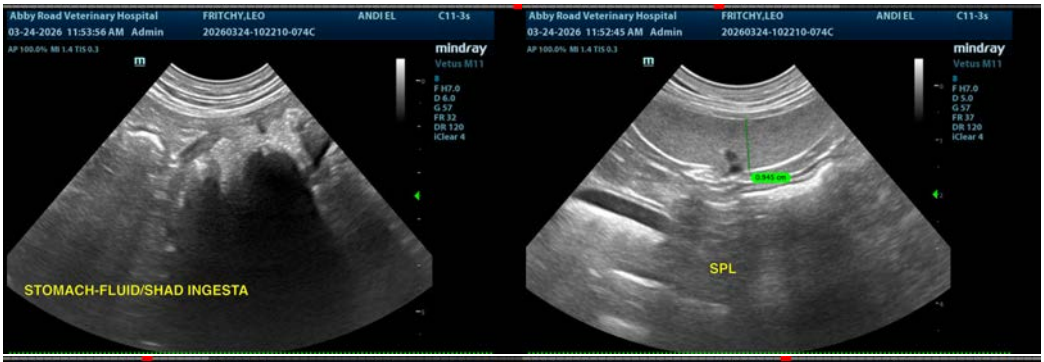


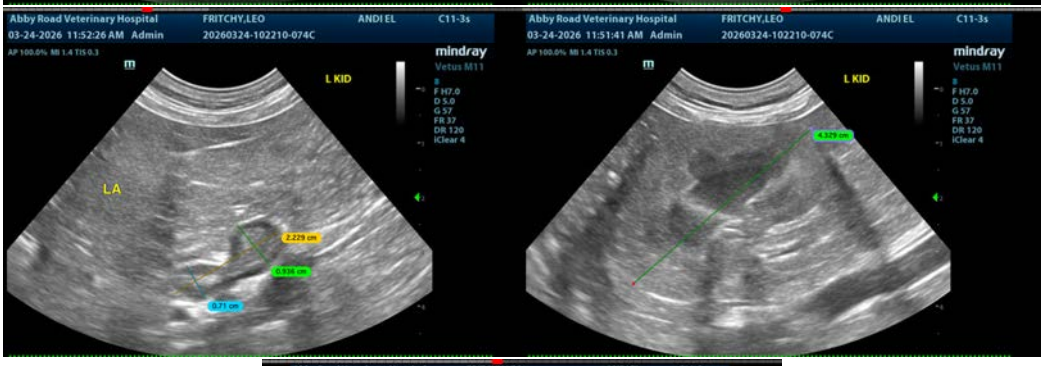


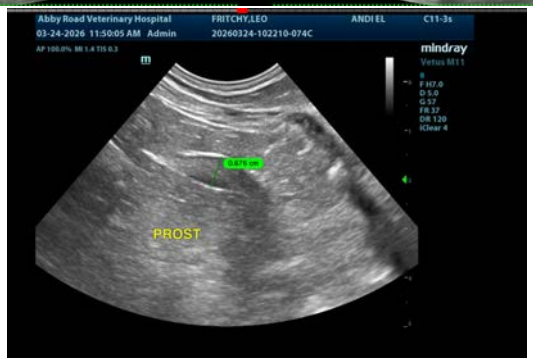


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

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

info@sonopath.com