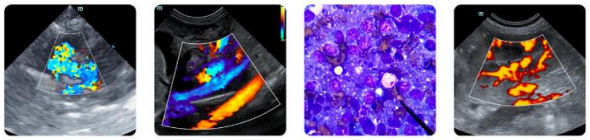




**PATIENT**

Lucy Nahar

**SPECIES**

Canine

**BREED**

Labrador Retriever Mix

**SEX**

FS

**AGE**

11

**WEIGHT**

46 lbs.

**INTERPRETED BY**

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

**IMAGING PERFORMED BY**

Shane Stafford

**HOSPITAL NAME**

West Newton AC

**REFERRING VET**

Shane Stafford

**INVOICE**

10848

**DATE**

4/30/26

## PRESENTING CLINICAL SIGNS

Lucy is a 11 year old FS labrador retriever mixed breed dog. That is having an abdominal ultrasound to look for more evidence of suspected Hyperadrenocorticism (Cushings disease). Came in for a yearly exam and pulled labwork for dental procedure.

Lucy's labs showed that the one white blood cell called monocytes was elevated which can be due to chronic inflammation (from the dental disease) or other things like endocrine disease (an imbalance in the hormones) called Cushings disease. The reason why I brought up Cushings disease (a disease that affects the adrenal glands) is that Lucy's chemistry showed signs that are suggestive of Cushing's disease (slight elevation of in our glucose (due to the cortisol being a stressed hormone), her liver values being slightly elevated, her cholesterol being up, and her urine was dilute with some significant protein loss in the urine. Is the owner noticing any one of the following signs at home: eating alot more recently, drinking more, peeing more, panting, weight gain, skin issues, and etc. The owner is only noticing a increase in drinking more (based on USG I suspect polyuria as well.)

Abnormal PE/Chem/CBC/UA Results: Polydypsia Slight weight gain Labwork abnormalities Mild hyperglycemia Mild hypophophatemia Mild hypochloremia Cholestasis liver pattern Hypercholesterolemia Monocytosis Inadequate concentrating urine (USG: 1.017) with proteinuria of 0.6

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

No evidence of pathology in the area of the aortic trifurcation.

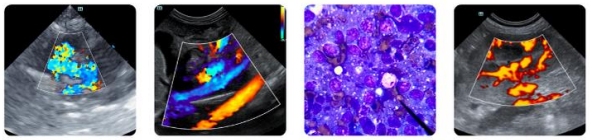
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.6 cm in length. The right kidney measured 6.0 cm in length.

### *Adrenal Glands*

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.50 cm width at the caudal pole. The right adrenal gland was indistinctly visualized yet overtly normal in size, position, and shape. The right adrenal gland subjectively measured 0.58 cm width at the caudal pole.

### *Spleen*

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.





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### *Liver/ Gallbladder*

The liver was subjectively normal in size and contour. Normal hepatic vascular volume was present. Primarily homogeneous, mildly increased hepatic parenchyma echogenicity was noted, exhibiting mild coarse echotexture. A solitary, discreet, nonhomogeneous, nondisruptive hepatic nodule was present in the caudal liver, measuring 1.2 cm in diameter. The gallbladder was non-distended in size, containing primarily anechoic content with mild, non-organized gallbladder debris. The cystic and common bile ducts were normal.

### *Gastrointestinal*

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild, nonshadowing ingesta, consistent with food echogenicity without signs of obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material.

Normal visible colon wall layers were present with formed feces in lumen.

### *Pancreas*

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

### *Free Abdomen*

No overt lymphadenopathy or peritoneal effusion was present.

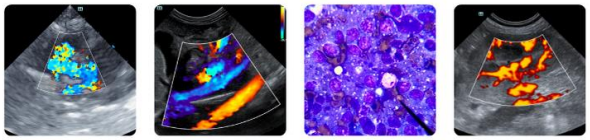
## ULTRASONOGRAPHIC FINDINGS

### *Primary Findings*

- Hepatopathy with discreet intraparenchymal nodule
- Mild, nonorganized gallbladder debris (non mucocele)
- Normal bilateral adrenal glands
- Mild age-related renal changes

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Vacuolar / cholestatic hepatopathy, inflammatory disease, suspect discreet nodular hyperplasia or lipogranuloma are possible with emerging nodular hepatic neoplasia thought less likely yet not definitively excluded. Sonographic monitoring of the liver nodule for evidence of progression is indicated. There is no sonographic evidence of adrenal pathology, i.e., hyperplasia or tumors, although underlying adrenal disease is not excluded. Correlation with full adrenal workup is warranted if strong clinical signs suggestive of adrenal disease are present. Monitoring of proteinuria is recommended. Hepatosupportive medications may prove beneficial.





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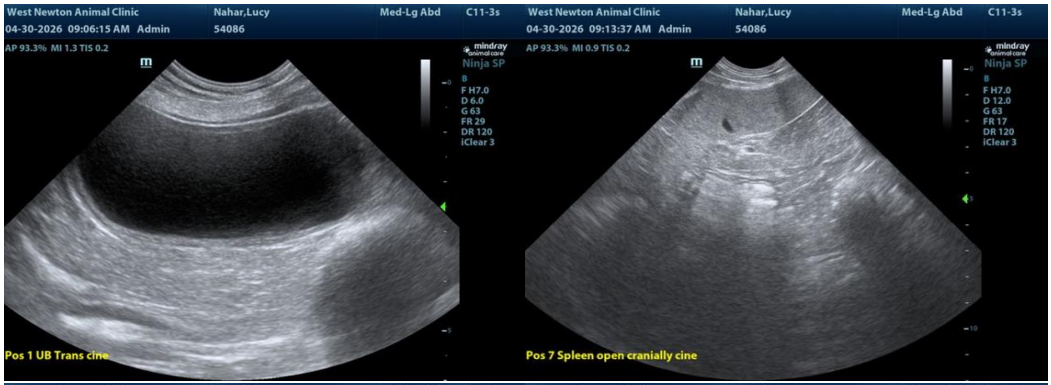


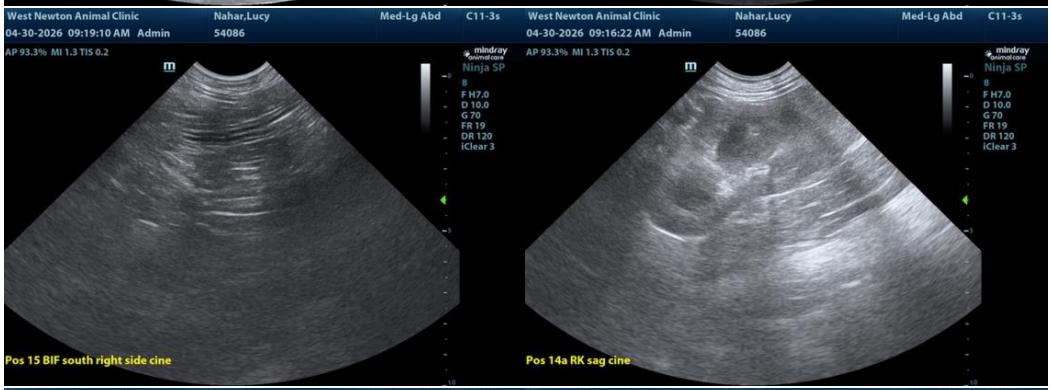


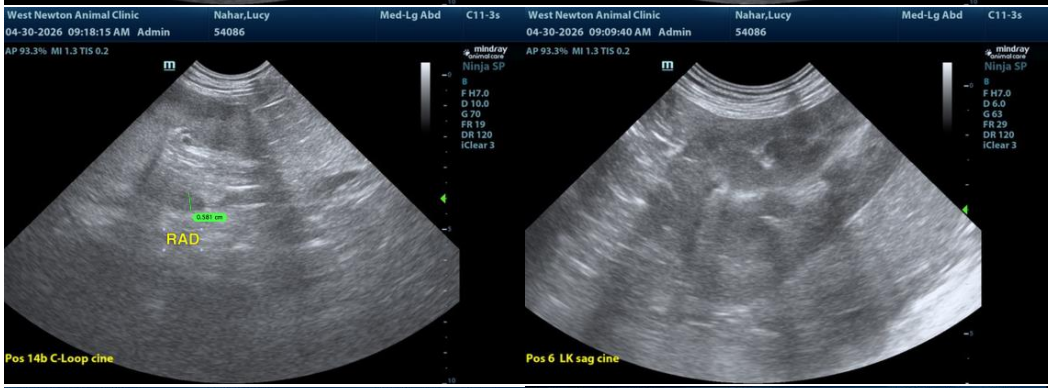


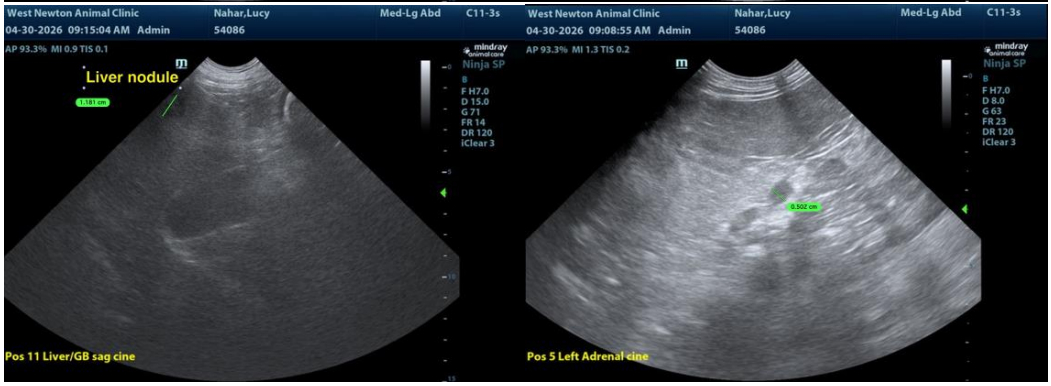

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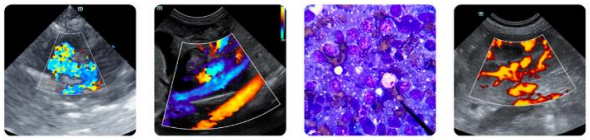

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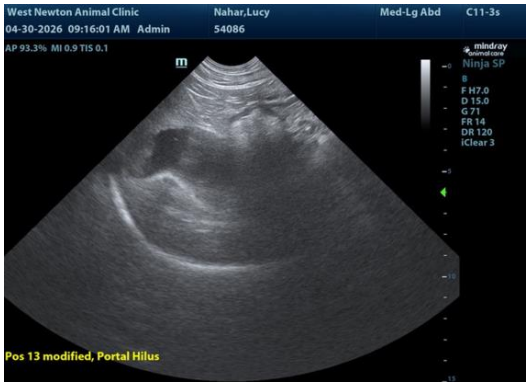


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)**
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