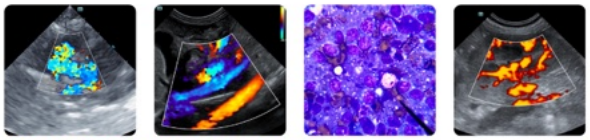


PATIENT

Timber Stewart

SPECIES

Canine

BREED

Mix

SEX

Spayed female

AGE

11 years

WEIGHT

54 lbs

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Dr. Brandon Holmes

HOSPITAL NAME

West Newton Animal Clinic

REFERRING VET

Dr. Hofmeister

INVOICE

71789

DATE

2/23/26

PRESENTING CLINICAL SIGNS

- The patient is presenting for a wellness examination, heartworm testing, and evaluation of chronic skin and coat issues. The owner reports that approximately two years ago (in 2024), the patient was diagnosed with Fanconi-like syndrome secondary to ingesting chicken jerky treats. Clinical signs at that time included polydipsia, polyuria, significant weight and muscle mass loss, and a poor hair coat. All signs resolved over a period of about 1.5 years after discontinuing the treats, with the exception of the hair coat. The coat has remained poor in quality, described as coarse and thin, and has changed color. A new, well-demarcated area of alopecia was recently noted on the shoulder. The owner also has concerns about a dark spot on the abdomen and a mass on the chest. The patient's appetite, thirst, and urination are currently normal. The owner also reports that the patient has significant situational anxiety and would like to discuss as-needed medication options. Past attempts to manage anxiety with a DAP collar and CBD oil were unsuccessful.
- Eyes: Bilateral incipient cataracts and lenticular sclerosis are present. Bilateral asteroid hyalosis was also noted. Integument: The hair coat is thin, coarse, and of poor quality. There is a well-circumscribed area of alopecia on the shoulder. The skin appears thin and crepey. A small area of hyperpigmentation is present on the abdomen. A small, fluid-filled cyst was noted under the right mandible, which resolved after aspiration. A soft, subcutaneous mass consistent with a lipoma is present on the ventral chest. Musculoskeletal: There is mild muscle atrophy, resulting in a prominent spine.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

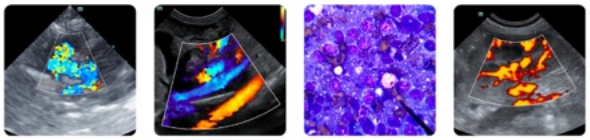
Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 6.8 cm, right measured 7.7 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

Adrenal Glands

The adrenal glands are bilaterally enlarged, but maintained normal shape, echogenic appearance, position and appearance of the visible periadrenal vasculature. Left adrenal gland measured 3.85 cm in length x 1.56 cm and 1.24 cm in width. The right adrenal gland measured 2.14 cm in length x 1.18 cm in width.



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Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. Incidental myelolipomas were present. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 1.5 cm in width.

Liver

Normal size with a diffuse, increased echogenic and coarse appearance, normal portal markings, and regular curvilinear capsule. Few, hypoechogenic, parenchymal nodules measuring up to 1.2 cm in size. A well circumscribed, hyperechogenic nodule/small mass in the caudal aspect of the left lobe measuring 2.2 x 2.4 cm in size. No additional masses are evident. Normal appearance of the hepatic and portal vasculature.

Gallbladder

The gallbladder is full containing a large amount of non-adhered, hyperechogenic sediment. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Normal appearance of the stomach, duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen. A small amount of ingesta is present within the stomach compatible with a recent meal.

Pancreas

The visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenomegaly.
- Hepatopathy.

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- Hepatic nodules.
- Gallbladder sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiolgies for the adrenomegaly would be disease, stress, age related reactive hyperplasia, and possibly emerging pituitary dependent Cushing's disease.

Etiologies for the hepatopathy would be reactive hyperplasia, nodular hyperplasia, vacuolar and metabolic with hepatitis and infiltrative neoplasia a less likely differential diagnosis.

The most likely etiology for the hepatic nodules would be incidental nodular hyperplasia.

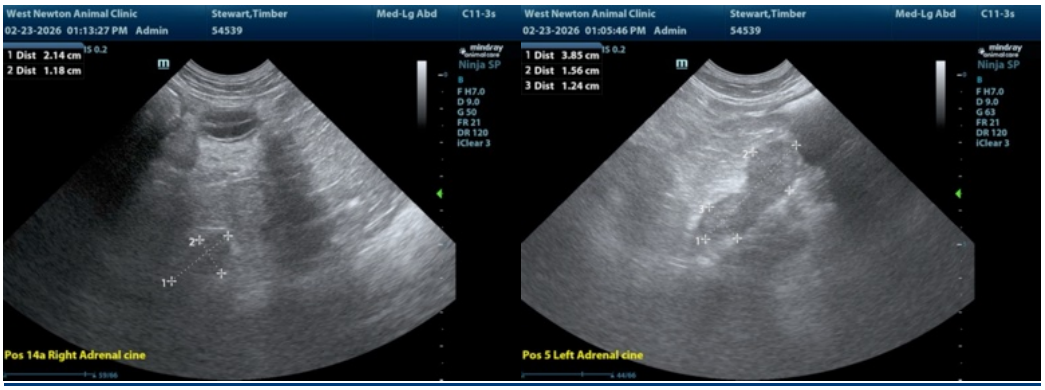
The most likely etiology for the hyperechogenic nodule/small mass would be nodular hyperplasia and an organized hematoma or granuloma.

Although the gallbladder sediment is most likely an incidental finding, monitoring for the development of a mucocele would be recommended.

Further assessment would be urine cortisol to creatinine ratio and if abnormal then adrenal function testing (ACTH stimulation/LDDST) would then be indicated.

If Cushing's disease has been excluded, then further assessment of the hepatopathy and hepatic nodules would be FNA cytology; however, a tru cut or wedge biopsy may be required for a final etiological diagnosis.

Specific therapy would be dependent on an etiological diagnosis.



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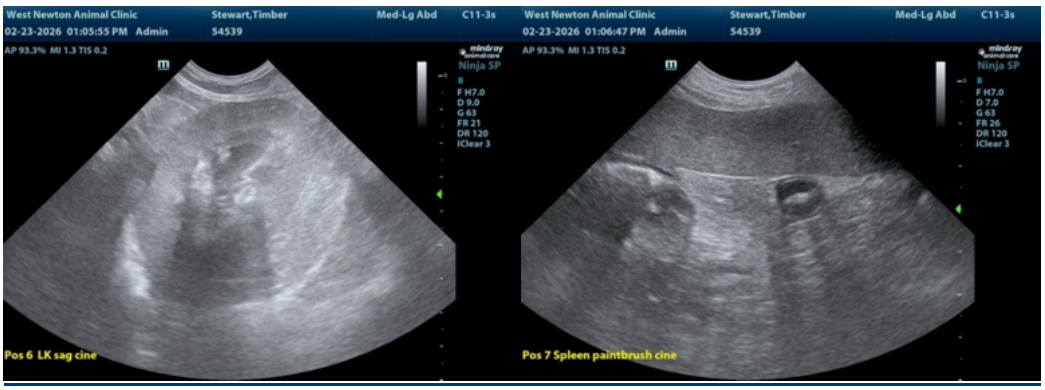

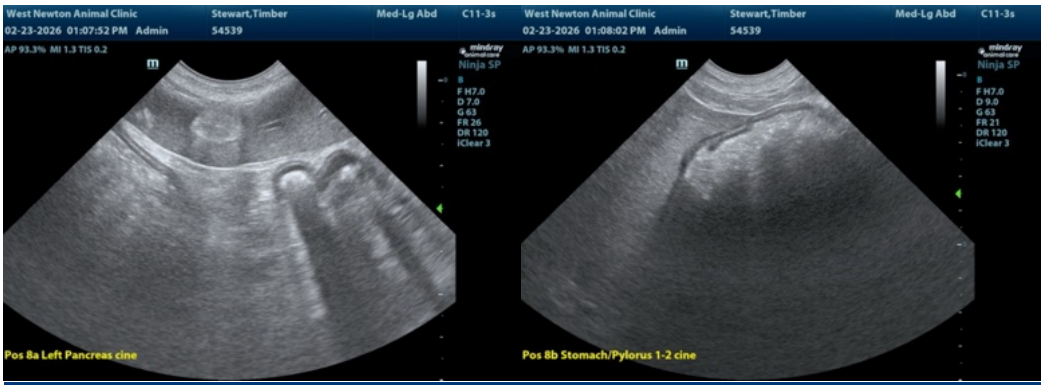

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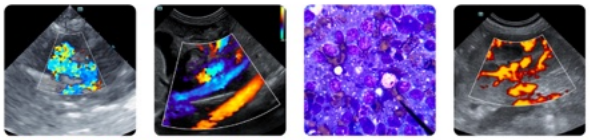

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

info@sonopath.com