SonoPath
Clinical Sonography & Telecytology
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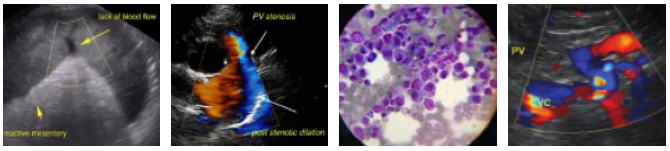

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Sydney Parr

SPECIES
Canine

BREED
Mixed breed

SEX
Female, spayed

AGE
11.5 years

WEIGHT
unknown

INTERPRETED BY
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY
Potomac Mobile Veterinary Ultrasound

HOSPITAL NAME
Silver Spring AH

REFERRING VET
Dr. Jarrett

INVOICE
12385

DATE
10/19/21

PRESENTING CLINICAL SIGNS

History: Was ultrasounded in July 2020. Found to have Cushings. Being treated with Vetoryl. ACTH showed some suppression but post was a little high. Having vomiting and diarrhea.
Abnormal PE/Chem/CBC/UA Results: acth pre 2.4 post 6.4 cbc plt 599 chem creat 2.0, bun 43, calcium 12, TP 7.7, ALB 4.0, ALT 533, AST 59, ALP 2834, Chol 471, Trigly 166

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (6.60 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. A 0.70 cm cortical cyst is observed at the medial aspect. Moderate pyelectasia is present (0.68 cm in the longitudinal plane). There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

The right kidney is small in size (3.34 cm in length) with an irregular shape. The cortex is variably thickened and hyperechoic to heterogeneous in appearance. There is poor corticomedullary distinction. Mineralized foci are visualized. Mild pyelectasia is present (0.29 cm in the longitudinal plane). There is no evidence of hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.90 cm at cranial pole) (0.85 cm at caudal pole) (2.69 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.57 cm at cranial pole) (0.64 cm at caudal pole) (1.80 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (2.09 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is enlarged with swollen, irregular peripheral contours. The parenchyma is hypoechoic relative to the spleen and heterogeneous in appearance with several large (>3 cm) swellings/masses. Vascular and biliary tracts are of normal volume with no evidence of congestion. The mesentery effacing the serosal surface is hyperechoic. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of echogenic mostly gravity-dependent debris is observed within the lumen. Some of the debris is stranding. In addition, a few small choleliths +/- mineralized sand are observed. The cystic and common bile ducts are normal/not seen.

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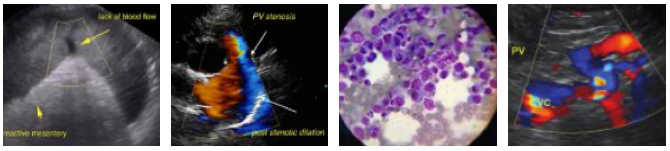

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Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal to mildly thickened (up to 0.67 cm) with a normal layering pattern and appropriate mural detail. The pyloric outflow tract is patent. The small intestinal lumen is segmentally dilated with gas and chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The left and right limbs of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

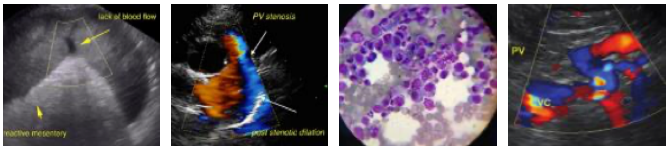
- The hepatic changes are concerning for infiltrative neoplasia. However, benign pathology (i.e., regenerative nodular hyperplasia, inflammatory disease) cannot be completely excluded. Regional peritonitis is present.
- Bilateral chronic nephropathy with dystrophic mineralization and pyelectasia. Renal changes are more severe on the right side.
- The mild gastric wall thickening is most consistent with inflammation with a lower possibility of emerging neoplasia.

Secondary Findings:

- Gallbladder debris, choleliths- incidental.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The mild left adrenomegaly is consistent with the previous diagnosis of Cushing's disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- A fine needle aspirate of the liver is recommended (if clotting status is appropriate). A 25-gauge needle should be used. If cytologic evaluation is inconclusive and an aggressive approach is desired, consider a surgical liver biopsy with aerobic and anaerobic bile cultures and acquisition of additional hepatic tissue samples for possible copper quantitation.
- Given the azotemia, consider the following diagnostics:



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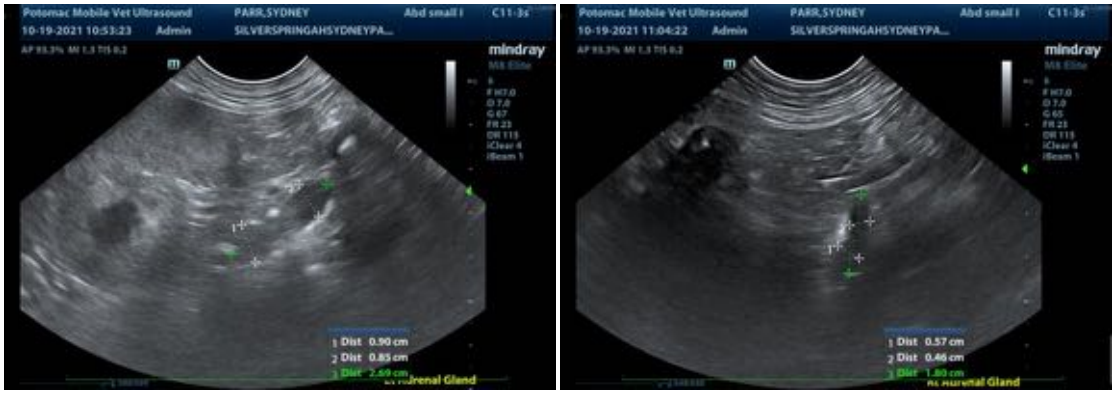
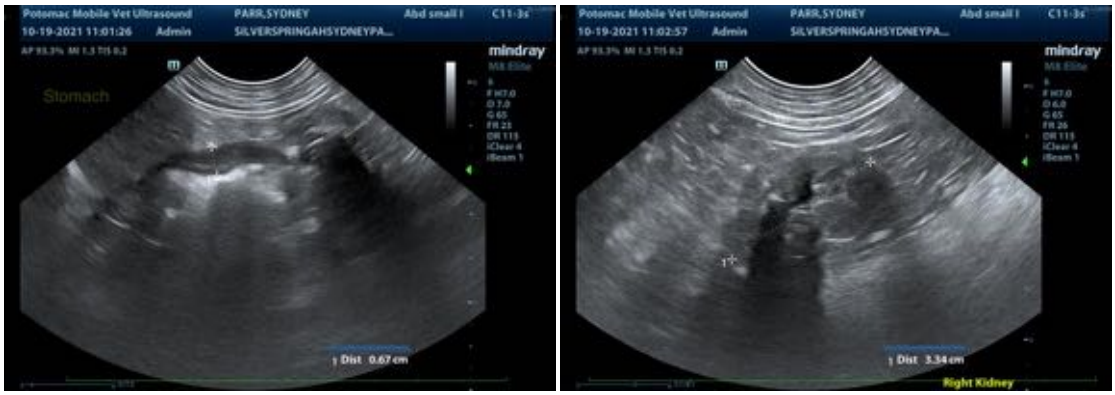
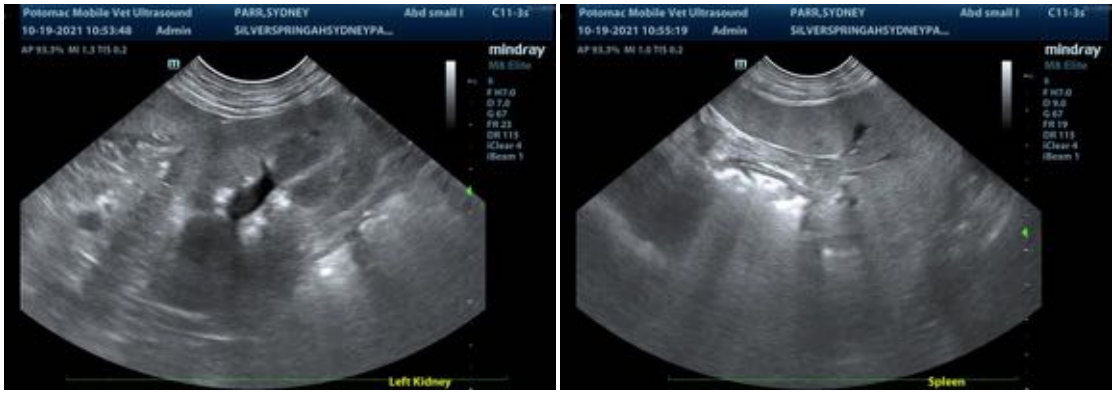
1. Urine culture and sensitivity.
2. UPC (if proteinuria is present).
3. Baseline blood pressure measurement.

- Further workup for the vomiting and diarrhea could include the following:
  1. GI panel including serum cobalamin, folate, TLI and PLI.
  2. A fecal evaluation for ova/Giardia.
  3. +/- endoscopic or surgical gastrointestinal biopsies.







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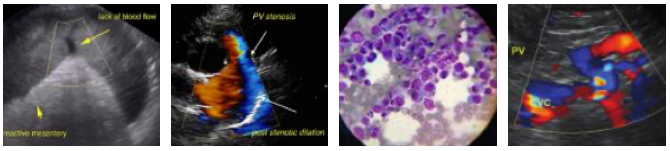

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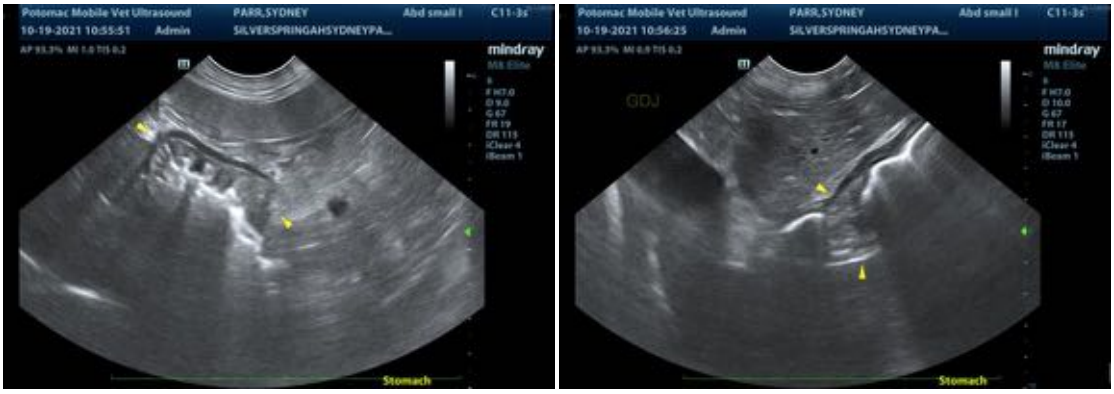

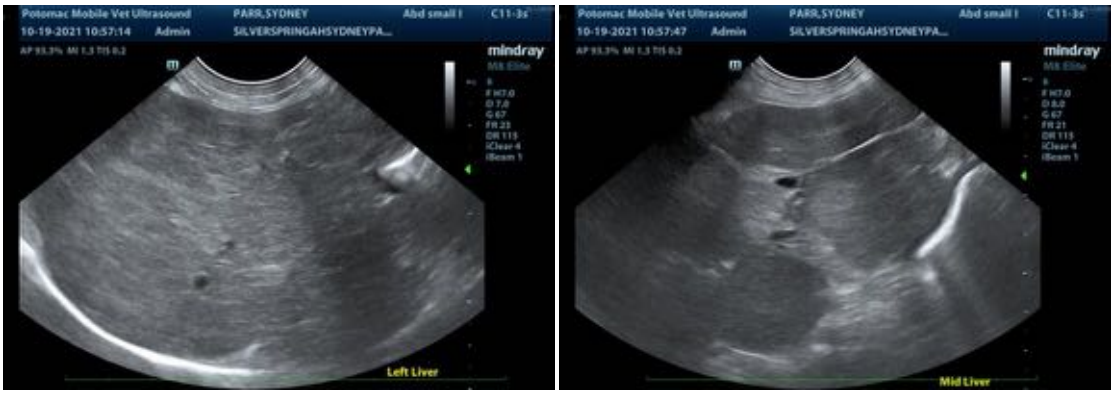

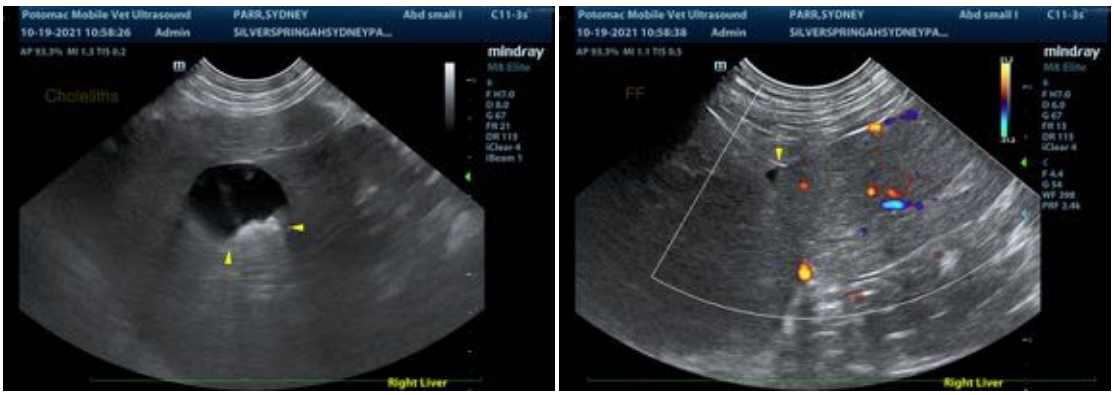

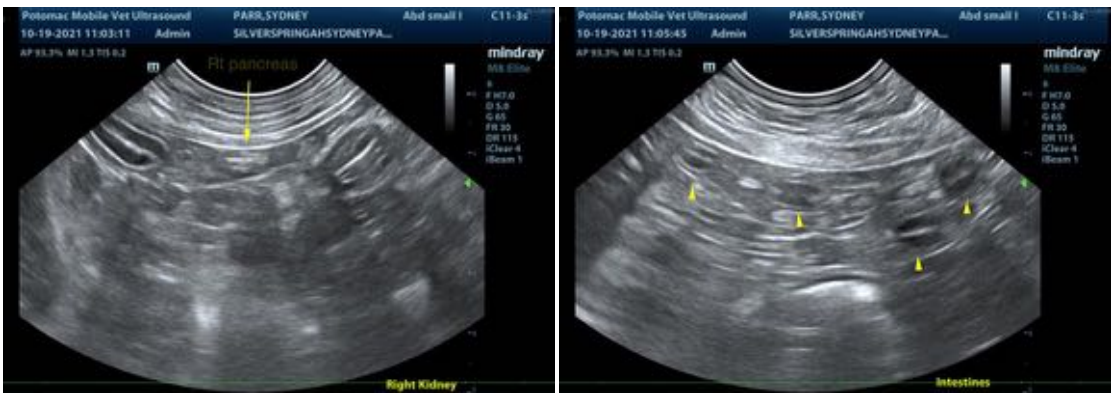

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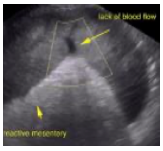
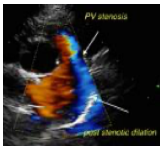
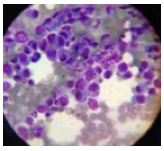
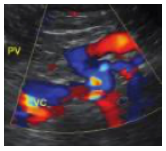

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

Andrea.nicastro@sonopath.com