



PATIENT

Otis Kantorowski

SPECIES

Canine

BREED

Boston Terrier Mix

SEX

Neutered Male

AGE

11

WEIGHT

24 lbs

INTERPRETED BY

Andrea Nicastrò DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastrò DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Dunes VC

REFERRING VET

Dr Devin Soileau

INVOICE

22256

DATE

12-12-25

PRESENTING CLINICAL SIGNS

Presented for PU/PD, polyphagia, also wasting along the spine. Bloodwork from December 6 revealed and ALP of 1159. ALT 306. T4 2. UPC elevated at 4.1. Thrombocytosis. USG 1.007. Inactive sediment. 4dx negative. Low-dose dexamethasone suppression test consistent with Cushing's but does not distinguish adrenal vs pituitary.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.02 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (5.27 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (5.42 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (0.91 cm at cranial pole) (0.92 cm at caudal pole) with swollen peripheral contours. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (1.10 cm at cranial pole) (0.79 cm at caudal pole) with slightly swollen peripheral contours. The parenchyma is mildly heterogenous, with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

The spleen is normal in size (0.93 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 subjectively enlarged, with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen. A 0.59 cm parenchyma cyst is observed on the left side. The remaining parenchyma is homogenous. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is moderately distended. The wall is variably thickened (up to 0.19 cm) and hyperechoic. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with ingesta and irregular shadowing material. The gastric wall and



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pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

Trace free fluid is observed.

Other

A brief echocardiogram reveals no obvious evidence of right atrial or auricular mass. There is no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The bilateral adrenomegaly, in conjunction with the patient's clinical signs and bloodwork findings, is consistent with pituitary-dependent hyperadrenocorticism.
- The diffuse hepatic changes are most consistent with vacuolar hepatopathy (i.e., endocrine, idiopathic) with a lower possibility of inflammatory disease, infiltrative neoplasia, or other hepatopathy. Small left hepatic cyst, likely a benign lesion.
- The gallbladder wall changes are most consistent with cholecystitis with a low possibility of emerging neoplasia.
- Trace ascites, the cause of which is unclear. Broad considerations include increased hydrostatic pressure, increased vascular permeability, and low oncotic pressure.

Secondary Findings

- Bilateral nonspecific age-related renal changes
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The shadowing material within the gastric lumen may represent normal ingesta and/or foreign material. It appears nonobstructive at the time of this study.



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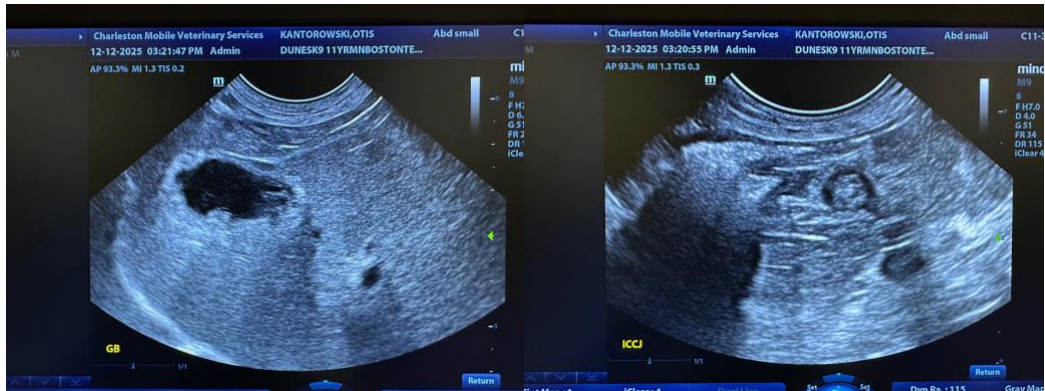
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider initiation of medical therapy for pituitary-dependent hyperadrenocorticism (i.e., trilostane).
- A baseline blood pressure measurement is recommended to evaluate for systemic hypertension, particularly in light of the patient's Cushing's disease and proteinuria.
- Regarding the significant proteinuria, consider initiation of an angiotensin receptor blocker (i.e., telmisartan). Serial monitoring of the patient's UPC, renal values, and blood pressure is recommended to assess progression.





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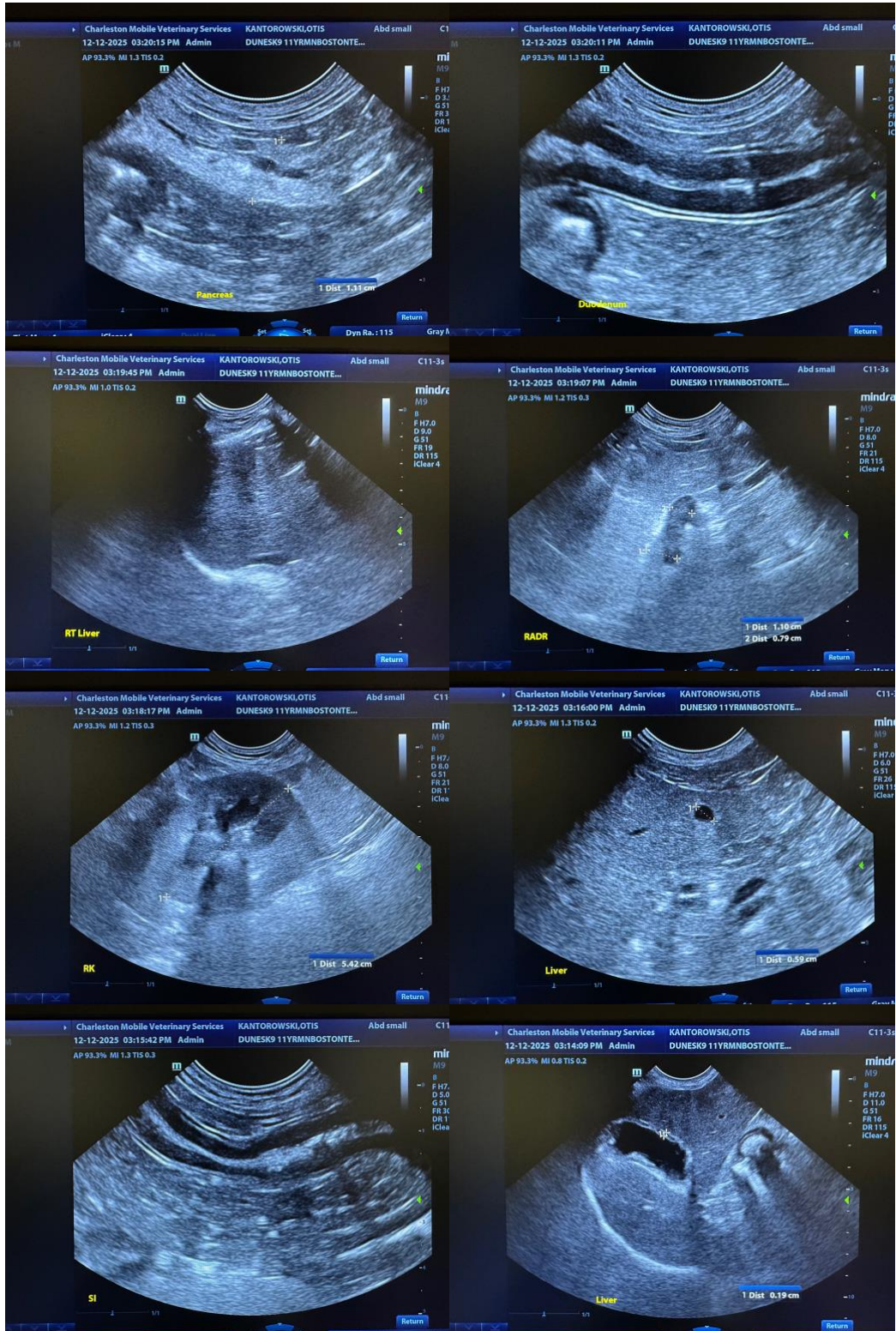
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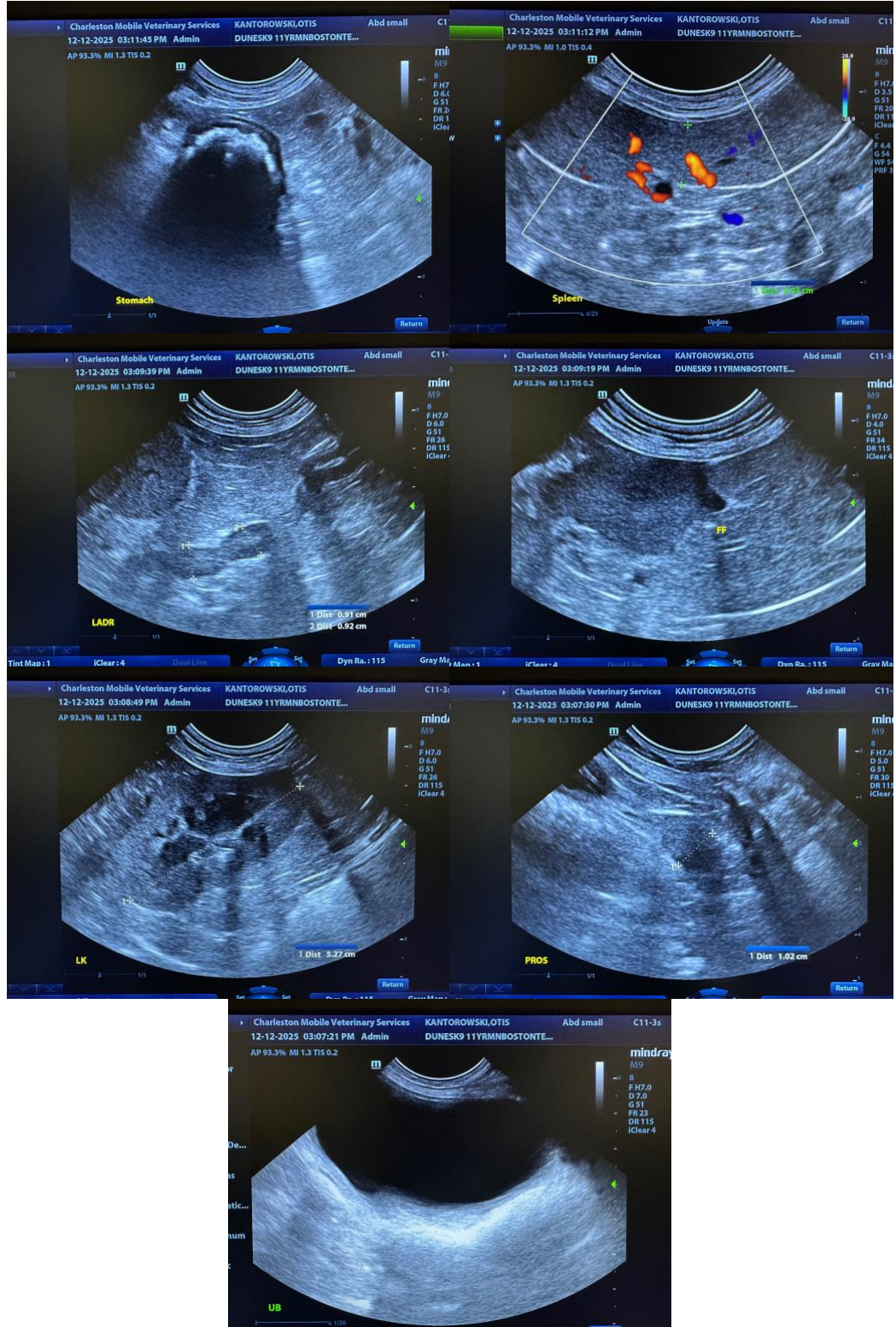
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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