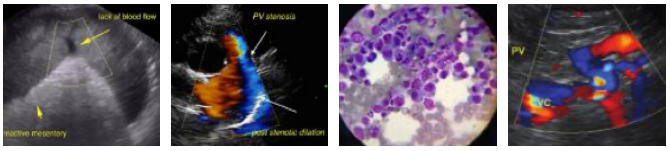
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Ruby Moore

SPECIES
Canine

BREED
Australian shepherd

SEX
Female, spayed

AGE
13 Yrs.

WEIGHT
22 kg.

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

IMAGING PERFORMED BY
Dr. Patti Mayfield

HOSPITAL NAME
Tumalo AH

REFERRING VET
Dr. Megan Kinnear

INVOICE
12978

DATE
2/8/22

PRESENTING CLINICAL SIGNS

History: Reason for Non-urgent Ultrasound: LDDST indicates likely Cushing's; does not reveal adrenal vs pituitary. Primary Problem(s): Recent PU/PD and worsening urinary incontinence that has been uncontrolled on Incurin or Proin. Pertinent Medical History: P has a 2 month history of non-responsive urinary incontinence. Recent UTI resolved after 2 courses of abx. Current Medication: Proin 50 mg PO BID
Abnormal PE/Chem/CBC/UA Results: Physical exam: NSF; lenticular sclerosis OU Diagnostic Tests Performed/Results: 1/21/22- CBC ok; elevated ALT (222), Alkphos (496) and Chol (454); USG = 1.022. 1/27/22- LDDST: Pre= 2.0; 4 hr post =1.3; 8 hr post = 2.0

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The majority of the wall is normal in thickness with a smooth mucosal surface. A 1.17 x 0.73 cm slightly irregular echogenic growth is observed along the caudodorsal wall, in the region of the trigone. No cystic calculi are observed. the visible portion of the proximal urethra is normal.

The left kidney is normal size (6.00 cm in length); normal shape and architecture with 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 hydroureter. Renal vasculature is normal.

The right kidney is normal size (6.63 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.92 cm at cranial pole) (0.80 cm at caudal pole) (2.88 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.

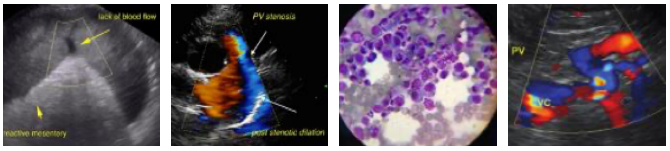
The right adrenal gland is borderline enlarged (1.47 cm at cranial pole) (0.77 cm at caudal pole) (3.03 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.76 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 normal in size with normal curvilinear peripheral contours. The parenchyma is slightly mottled in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The



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wall is normal in thickness. A 0.50 cm cholelith is suspected along with a small amount of echogenic to mineralized gravity-dependent debris. The cystic and common bile ducts are normal.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and 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 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 region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

- Mild bilateral adrenomegaly. These changes along with the bloodwork findings are suggestive of pituitary-dependent hyperadrenocorticism.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely, particularly in light of the patient's liver enzyme pattern.
- The urinary bladder growth in the region of the trigone could be consistent with a focus of polypoid cystitis or an emerging neoplastic process (i.e., transitional cell carcinoma). This lesion is not likely to be the sole cause of the patient's urinary incontinence but may be a contributing factor.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Mineralized gallbladder debris +/- distinct cholelith- incidental.
- Minor age-related renal changes.
- Although Cushing's disease is suspected, further testing (i.e., ACTH stimulation test) can be considered to help confirm the diagnosis. In addition, a baseline blood pressure and UPC (if proteinuria is present) should also be considered.
- Regarding the urinary bladder lesion, consider a urine BRAF test to further assess for a lower urinary tract neoplasia.

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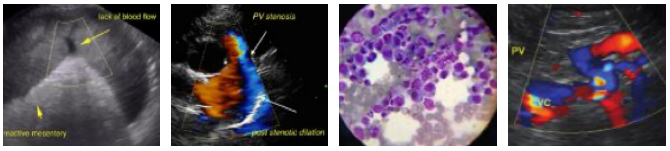

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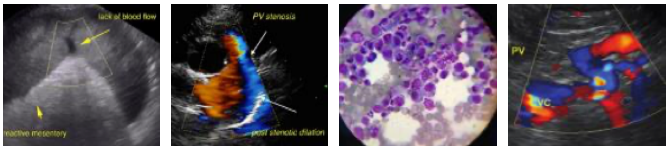

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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