

**DATE PRESENTING CLINICAL SIGNS**

4/19/22

Increase in water intake. Alopecia on tail. Elevated ALP (320), ALT (127)- 4/2021. Bile acid normal. Weight loss 9/2021. Mild increase ALT and ALP. USG 1.029 10/1/2021. Recheck AUS 9/2021- splenic nodule, left adrenal gland prominent at cranial aspect, irregular shape. Gained weight since September- 32.2lbs 9/2021, 41lbs 4/2022.

PATIENT

Cody Popomaronis

Current Medications: Cobalequin, RC HP food.

Lab Results: Thyroid profile normal MSU 10/2021. GI Panel: B12 282, Folate 8.68, TLI 37.5, PLI 176. LDDST 4/13/22 Pre 5.2, 4hr 4.6, 8hr 3.7. 3/8/22- ALP 1128, GGT 21, Chol 718, Triglyceride 1022. O&P Giardia negative 10/13/21.

SPECIES

Canine

Date of Previous IntraPet Ultrasound: 4/27/21 and 9/30/21. See attached.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

BREED

Labradoodle

Imaging Performed By: Andi Parkinson, RDMS.

SEX

Male, neutered

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder is mildly to moderately distended with mostly anechoic urine. The wall in the region of the apex is mildly thickened (up to 0.44 cm) with a slightly irregular mucosal surface. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

AGE

7/3/2011

The prostate is not definitively visualized due to its pelvic location.

WEIGHT

41 lbs.

The left kidney is normal in size (6.07 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is minimal loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

INTERPRETED BY

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

The right kidney is normal size (5.67 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is minimal loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

HOSPITAL NAME

Jacksonville VH

Adrenal Glands

The left adrenal gland is prominent in size at the cranial pole and normal in size at the caudal pole (0.91 cm at cranial pole) (0.62 cm at caudal pole) (2.65 cm in length). The parenchyma at the cranial aspect is slightly heterogeneous with mild loss of glandular detail. The glandular echogenicity and detail at the caudal pole are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

REFERRING VET

Dr. Burk

The right adrenal gland is mildly enlarged (1.11 cm at cranial pole) (0.87 cm at caudal pole) (4.27 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.

INVOICE

13233

Spleen

The spleen is normal in size (1.86 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.21 x 0.91 cm hypoechoic to slightly heterogeneous nodule is observed at the caudolateral aspect. The lesion causes minor capsular expansion. A few small, irregular myelolipomas are observed in the region of the hilus. A 0.58 cm hyperechoic nodule is also seen at the lateral aspect. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous 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 wall is thin and smooth. A moderate amount of aggregated echogenic partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 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.

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

Primary Findings:

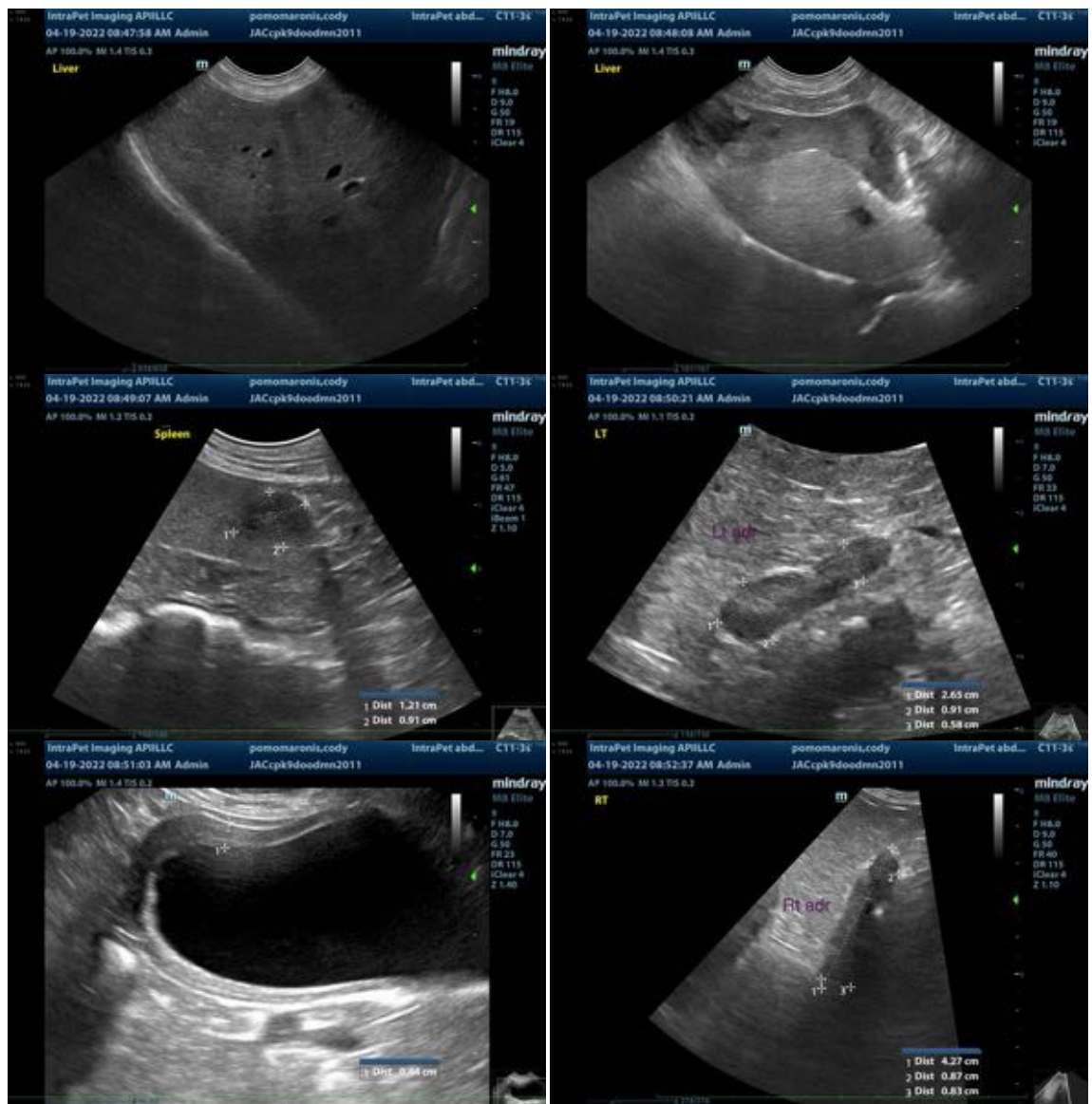
- Suspected benign diffuse hepatopathy. Vacuolar hepatopathy and regenerative nodular hyperplasia are the top differentials.
- Mild bilateral adrenomegaly. In light of the patient's clinical history, this finding is suggestive of pituitary-dependent hyperadrenocorticism.
- Gallbladder debris/sludge, non-mucocele.
- The splenic nodule is similar in size compared to the previous sonogram and may represent an emerging tumor or a benign focus of lymphoid hyperplasia, extramedullary hematopoiesis or splenitis.

Secondary Findings:

- Age-related pancreatic remodeling/fibrosis. Low-grade pancreatitis may also be present, particularly if the patient exhibits a positive Murphy's sign.
- Minor age-related renal changes with dystrophic mineralization.
- The urinary bladder wall changes could be consistent with cystitis or may be artifactual due to lack of full repletion. Correlation with the patient's clinical history is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A urinalysis is recommended to assess for isosthenuria. If present and if the patient is overtly clinical for Cushing's disease, medical therapy (i.e., Trilostane) can be considered.
- Also consider a baseline blood pressure measurement and UPC (if proteinuria is present).
- Consider a fine needle aspirate of the splenic nodule if clotting status is appropriate.





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.

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