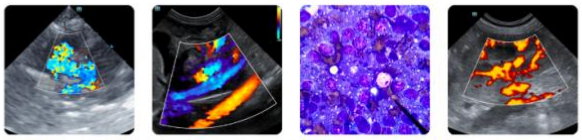

DATE

4-24-26

PATIENT

Max Meyers

SPECIES

Canine

BREED

Beagle Mix

SEX

Neutered Male

AGE

9/3/2015

WEIGHT

56.5lbs

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Hickory VH

REFERRING VET

Dr. Lyle

INVOICE

22927

PRESENTING CLINICAL SIGNS

Patient History: Patient has proteinuria and suspected Cushing's

Current Medications: Rimadyl 50mg BID, Gabapentin 200mg BID, Welactin
Labwork Results: Labwork attached, reported as: UPC = 3.9, ALP = 1445
Date of Previous IntraPet Ultrasound: 10/6/23. See attached.
Sedation: IV 0.3cc Torb and 0.3cc Domitor.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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 4.0 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 (6.53 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.27 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with 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 enlarged (0.76 cm at cranial pole) (0.91 cm at caudal pole) with a normal shape. A 0.72 x 0.56 cm isoechoic- to- to slightly hyperechoic nodule is observed at the caudal pole. The remaining glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.86 cm at cranial pole) (0.62 cm at caudal pole) with a normal shape and 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 (1.65 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few, small myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A moderate- to large amount of aggregated, echogenic, partially dependent- to suspended sludge is observed within the lumen. Some

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striations are observed at the periphery. The cystic and common bile ducts are normal/not seen. The duodenal papilla is normal-in-size (0.36 cm in width).

Gastrointestinal
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 is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is 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 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.

Lymph Nodes
The abdominal lymph nodes are normal/not visible.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.
- The gallbladder changes are consistent with a developing mucocele.
- Mild left adrenomegaly. The left adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.
- Bilateral nonspecific age-related renal changes. Given these findings, in conjunction with the proteinuria, a protein-losing nephropathy is suspected. Most protein-losing nephropathies are idiopathic. However, they can be secondary to infectious, inflammatory, immune-mediated, or neoplastic disease. Often, proteinuria can also occur in patients with hyperadrenocorticism.

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If the patient is exhibiting clinical signs of Cushing's disease, consider further testing (i.e., low-dose dexamethasone suppression test).
- Regarding the left adrenal nodule, consider a recheck ultrasound in 3-4 months to assess for growth.
- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.

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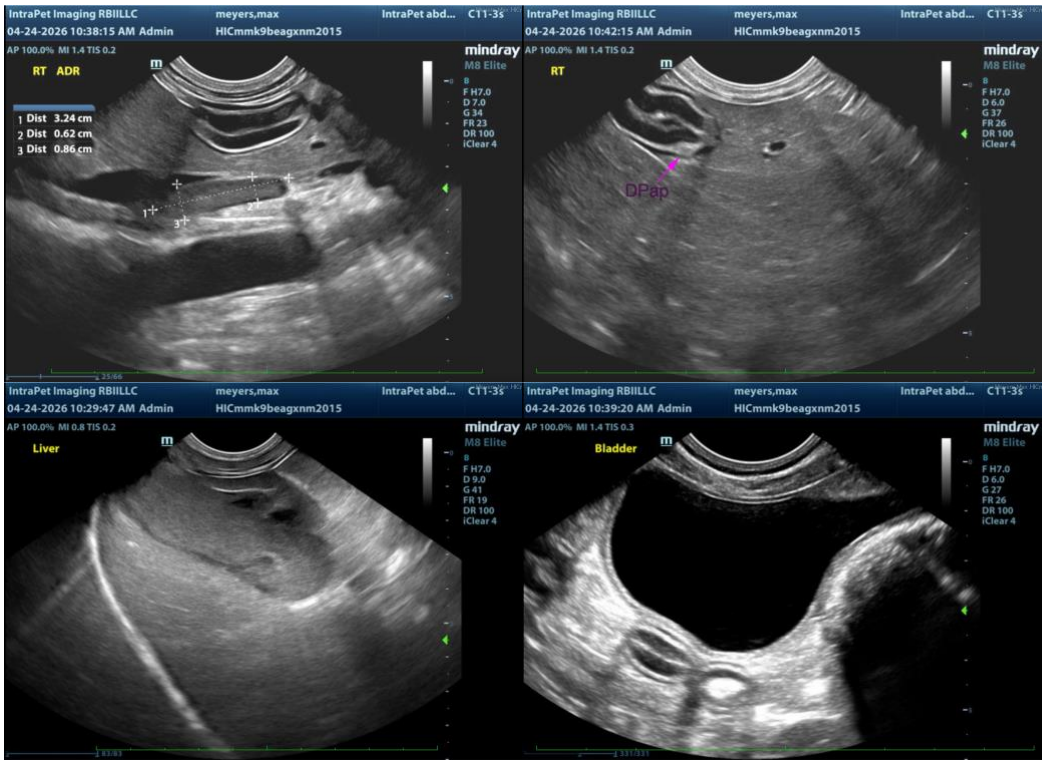
- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 4-6 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.

- Regarding the proteinuria, consider the following:

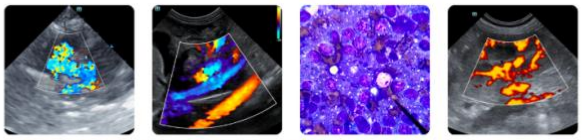
1. A search for an underlying cause is recommended.
2. Angiotensin II receptor blocker (e.g., telmisartan)
3. Antithrombotic (e.g., clopidogrel at 2.5 mg/kg PO q 24 hours)
4. Omega-3 fatty acids (65 mg/kg of DHA and EPA combined daily)
5. Prescription renal diet
6. Baseline blood pressure measurement with serial monitoring thereafter
7. Routine monitoring of UPC and bloodwork (CBC, chemistry panel) to assess for progressive disease



Imaging performed by

IntraPet Imaging

IntraPet.com



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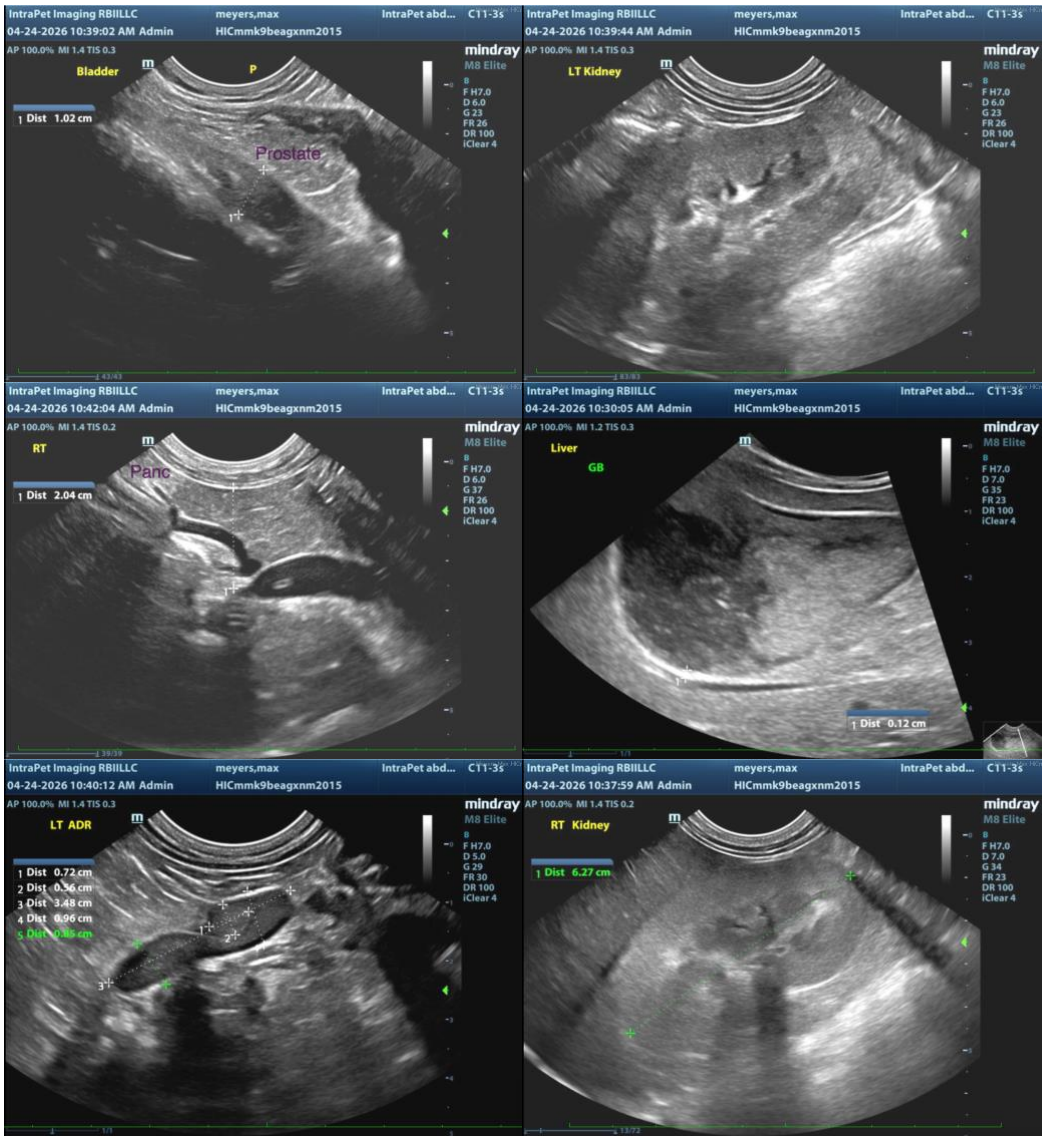

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com