Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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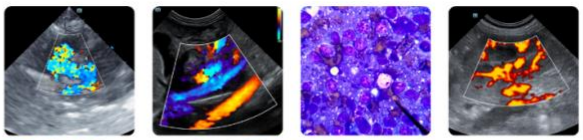

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Teigen Mills

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Female Spayed

AGE

8/28/2017

WEIGHT

15.8 lbs

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

VC Myrtle Beach

REFERRING VET

Dr Boland

INVOICE

22812

DATE

4-3-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings:
- Main concerns: History of PU/PD, waking owner up 5-6 times per night, nocturia
- Diagnosed with Cushing's (PDH) 9/10/24 with LDDST and started on Vetoryl
- Hypothyroidism - diagnosed 5/15/24 (pre-HAC)
- Gallbladder sludge/mucous - diagnosed 10/13/25 (on ursodiol)
- Vetoryl dosage increased multiple times (by another vet as owner moved away) due to continued pu/pd. Dosage was adjusted by that vet based on resting cortisol levels, not full ACTH stim
- Polydipsia improved but pet still waking owner 3-4 times per night to urinate.
- ACTH stim 3/17/26 (on 30mg Vetoryl BID): Pre = 2.1, Post = 1.4
- Vetoryl discontinued 3/18/26, but within a few days pu/pd returned. Pet is not currently on Vetoryl 10mg po BID

Exam: BAR, potbellied appearance, hyperpigmentation of skin along abdomen, thin haircoat. No other significant findings.

Abnormal lab-work values:
- T4 (3/17/26) on 0.2mg levothyroxine bid = 1.1
- ACTH stim 3/17/26 Pre = 2.1, Post = 1.4
- Chems last run 12/6/25: ALP = 640, GGT = 55, Lipase = 559
- Urine last run 12/6/25: proteinuria, no wbc or bacteria

Current Medications: Vetoryl 10mg po BID, Ursodiol 250mg 1/2-tab po once daily, Levothyroxine 0.2mg po bid. On melatonin. Nocturia has improved somewhat since starting this supplement.

Radiographic Findings: N/A

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 left kidney is normal in size (4.62 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 hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.33 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 hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (0.99 cm at cranial pole) (1.07 cm at caudal pole) with swollen peripheral contours. The parenchyma is mildly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is enlarged (2.20 cm at cranial pole) (1.18 cm at caudal pole) with swollen/slightly irregular peripheral contours. The parenchyma is mildly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

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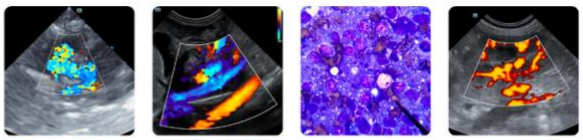

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Spleen
The spleen is normal in size (1.14 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver
The liver is subjectively 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 portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small- to moderate amount of aggregated, echogenic, partially dependent- to suspended sludge in a partially stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 ileocecocolic 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
There is no obvious evidence of free fluid.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral adrenomegaly consistent with the previous diagnosis of pituitary-dependent hyperadrenocorticism.
- The gallbladder changes are suggestive of a developing mucocele.
- 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.

Secondary Findings

- Bilateral nonspecific age-related renal changes

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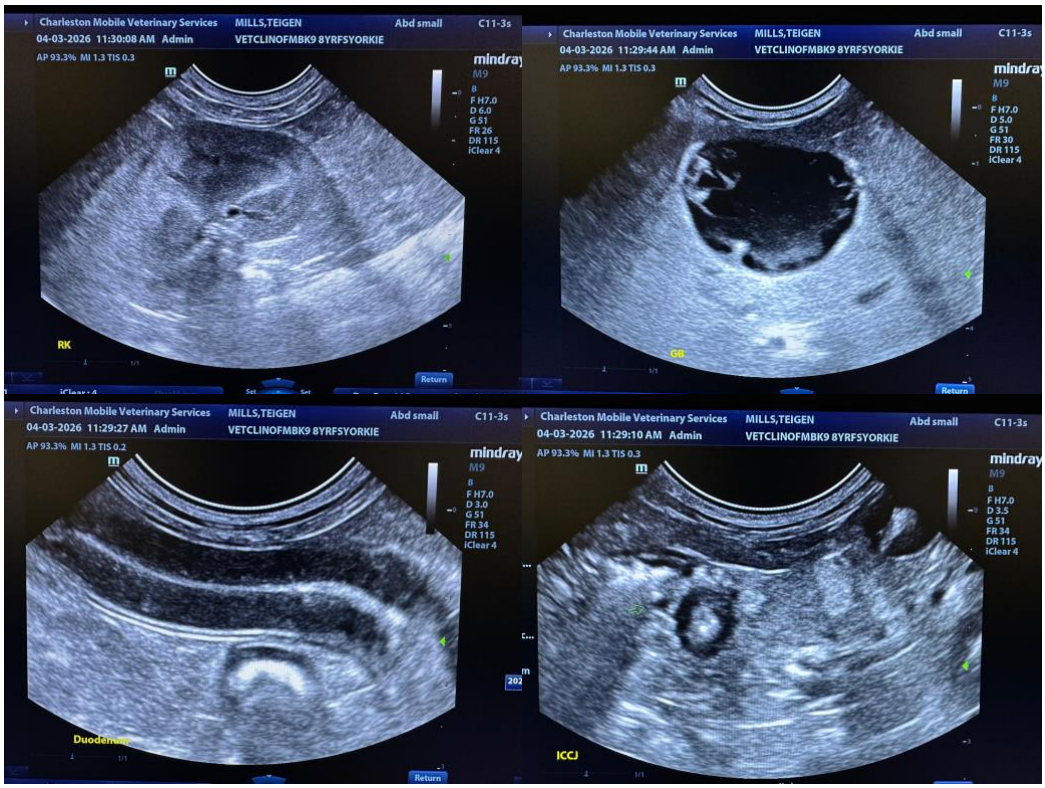
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider repeating an ACTH stimulation test +/- full adrenal panel 10-14 days after the most recent trilostane dose adjustment.
- Submission of a urine sample for urinalysis and culture and sensitivity is also recommended to assess for occult infection.
- Consider obtaining a baseline blood pressure measurement to evaluate for systemic hypertension.
- Continuation of melatonin is recommended as long as it appears to be beneficial to the patient.
- Continuation of Ursodiol therapy is also recommended, with serial sonographic monitoring (i.e., every 6-8 weeks) of the gallbladder to assess for progression to a fully-formed mucocele.



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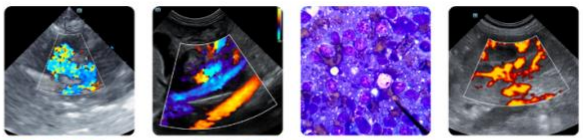

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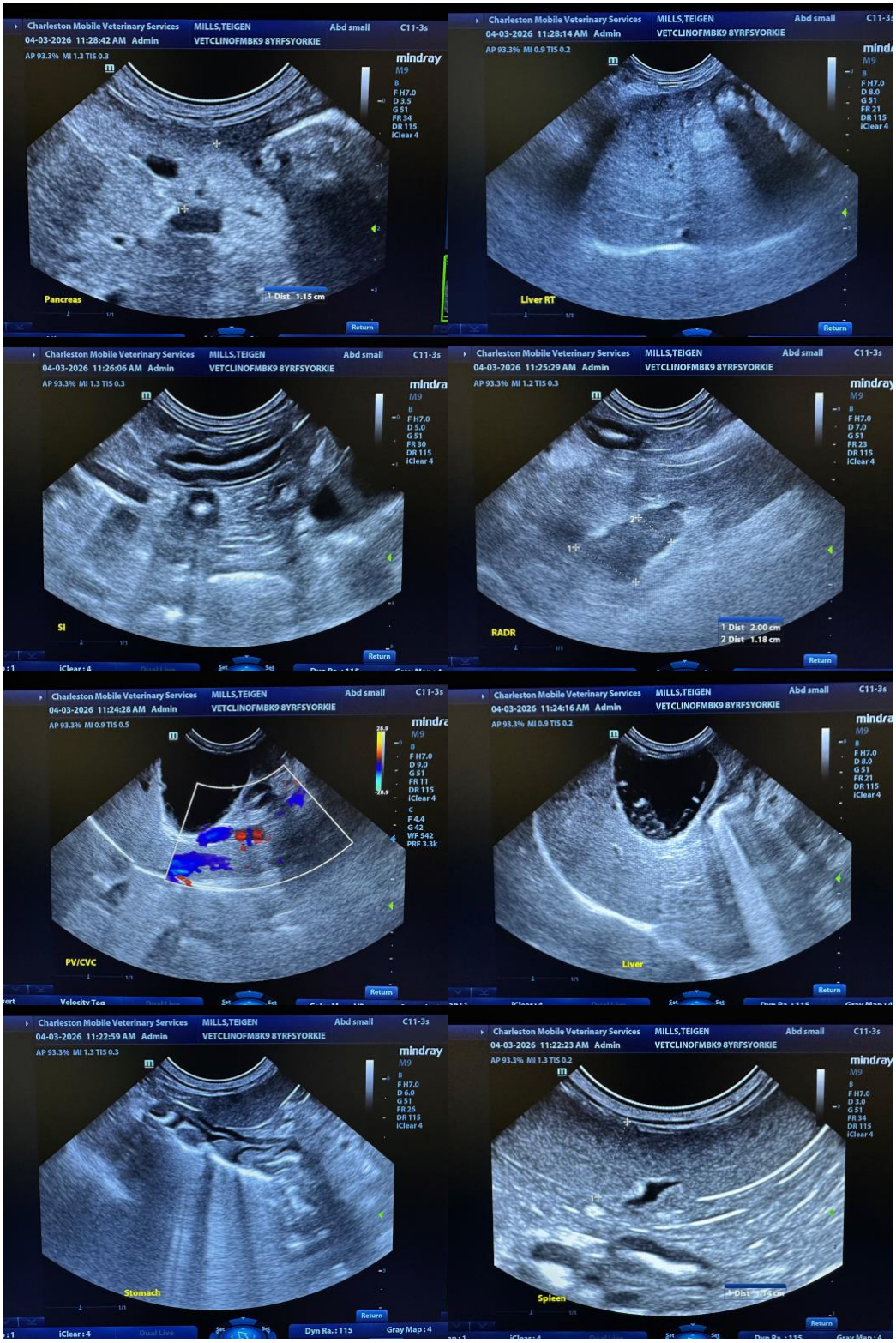

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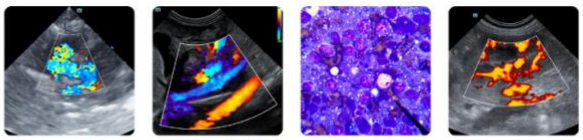

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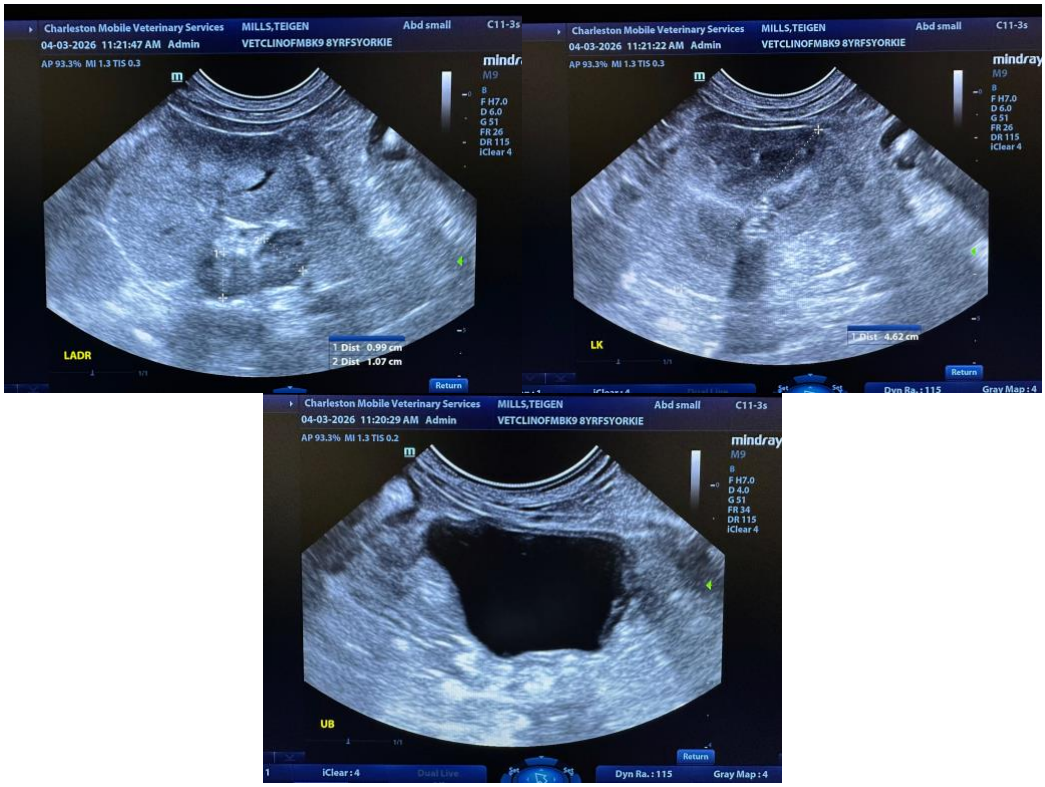

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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