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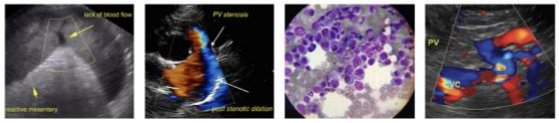

Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

**PATIENT**

Kimmy Edwards

**SPECIES**

Canine

**BREED**

Pug Mix

**SEX**

Spayed

**AGE**

3/24/2008

**WEIGHT**

23 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

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

**HOSPITAL NAME**

Flowertown AH

**REFERRING VET**

Dr. Kline

**INVOICE**

11016

**DATE**

6/3/22

## PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Overweight. OU nuclear sclerosis. Hyperadrenocorticism
Abnormal lab-work values: Elevated ALP (800s)
Current Medications: Vetoryl 10mg SID

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is mildly to moderately distended with anechoic urine. The wall in the region of apex is mildly thickened (up to 0.45cm) with a slightly irregular mucosal surface. The wall tapers to a normal thickness as it extends toward the urinary bladder neck. 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 size (5.06 cm in length); normal shape and architecture with 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 (4.47 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.

### *Adrenal Glands*

The left adrenal gland is enlarged (0.62 cm at cranial pole) (0.84 cm at caudal pole) (2.19 cm in length); with a slightly irregular 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 mildly enlarged (1.39 cm at cranial pole) (0.90 cm at caudal pole) (2.38 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 (1.03 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Several, varying sized hyperechoic nodules are observed throughout the organ, the largest measuring 0.83 cm in diameter. Extra-splenic tissue is observed just medial to the caudal aspect of the spleen. At least one hyperechoic nodule is observed within the extra-splenic tissue. Splenic vasculature is normal.

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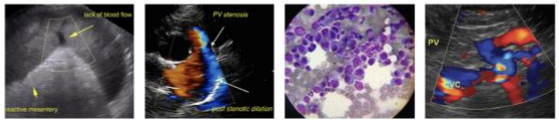

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### *Liver*

The liver is subjectively prominent in size with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogenous in appearance with a few, small parenchymal cysts visualized. Hepatic vasculature and intrahepatic 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 suspended sludge, in a partially stellate pattern 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 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.

### *Free Abdomen*

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

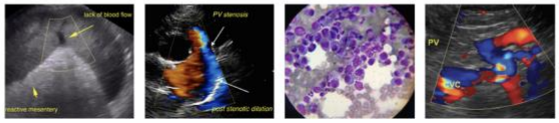
### *Other*

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

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- The gall bladder changes are suggestive of an emerging mucocele.
- Suspected benign, diffuse hepatopathy. Top differentials include regenerative nodular hyperplasia and vacuolar hepatopathy.





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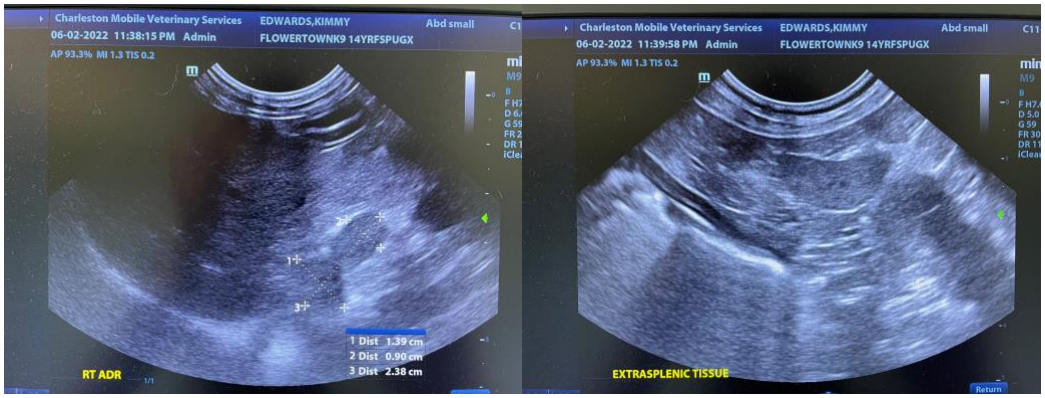
- Bilateral adrenomegaly, consistent with the previous diagnosis of pituitary-dependent hyperadrenocorticism.

### Secondary Findings

- Minor, age-related renal changes
- Age-related pancreatic remodeling
- Urinary bladder wall changes are suggestive of cystitis. However, correlation with the patient's urinalysis findings is recommended.
- Extra-splenic tissue – incidental.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider initiation of Ursodiol therapy for the suspected emerging mucocele. Alternatively, a repeat ultrasound can be considered in 4-6 weeks, preferably 2 hours post-small meal. If sonographic changes are similar to today's scan, Ursodiol can be initiated at that time. Regardless of when Ursodiol is initiated, serial sonographic monitoring (i.e., every 4-6 weeks) is recommended to assess for progression.
- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If values continue to increase, a repeat abdomen ultrasound +/- a more advanced hepatic work-up (i.e., tissue sampling) may be warranted.



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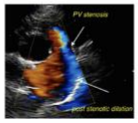
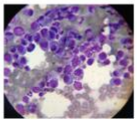
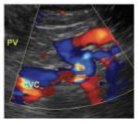

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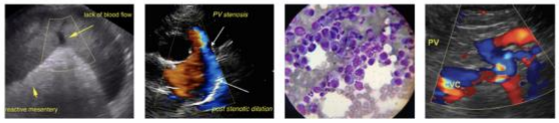

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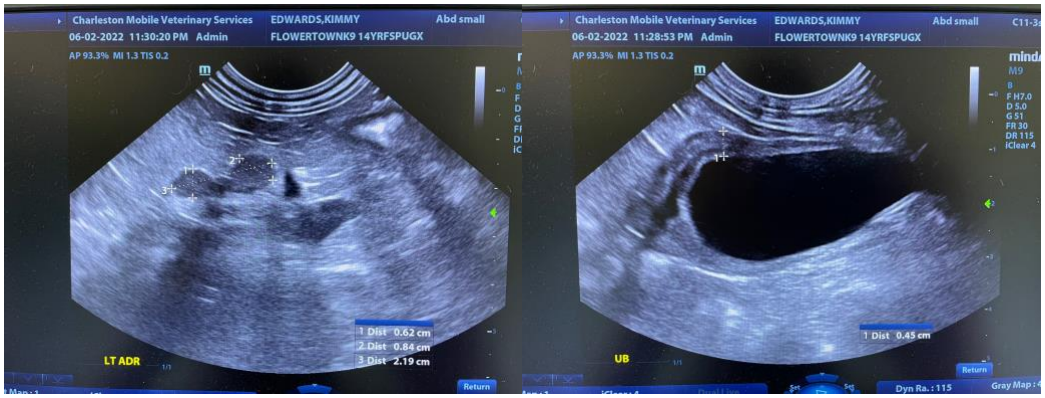


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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 DACVIM (Small Animal Internal Medicine)
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