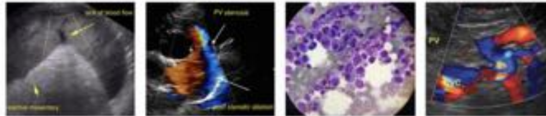


PATIENT

Maggie Carter

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

10.15.2008

WEIGHT

9.86 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

Park West Vet Assoc

REFERRING VET

Dr. Decker

INVOICE

11230

DATE

7.18.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Presenting for panting/pacing
Grade II/VI LAS murmur. Pot-bellied. LH MPL
Abnormal lab-work values. ALP 719. BUN 33. USG 1.015
Current Medications: Denamarin, Ursodiol, Pepcid, Benadryl, Gabapentin

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not 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 (3.58 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The **right kidney** is normal in size (3.56 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. One to two small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is mildly enlarged (0.43 cm at cranial pole) (0.66 cm at caudal pole) (1.61 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 normal size (0.62 cm at cranial pole) (0.59 cm at caudal pole) (1.62 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

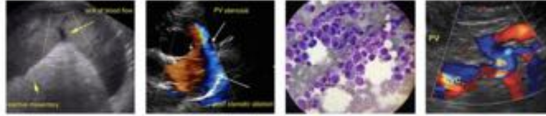
The **spleen** is normal in size (0.92 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few ill-defined, hyperechoic nodules/areas are observed throughout the organ. Splenic vasculature is normal.

Liver

The **liver** is subjectively enlarged with swollen peripheral contours The parenchyma is isoechoic to hyperechoic relative to the spleen, with several, small, ill-defined hypoechoic nodules/areas, the largest measuring 1.21 cm in length (right side). Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The **gall bladder** lumen is moderately distended. The wall is thin and smooth. A small amount of mostly gravity dependent, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal



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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. There is no evidence of an obstructive pattern.

Pancreas
The right limb of the **pancreas** is prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is hyperechoic relative to surrounding omental fat and slightly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated

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

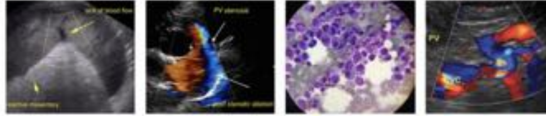
- The bilateral adrenomegaly, in conjunction with the patient's clinical history, could be consistent with pituitary-dependent hyperadrenocorticism.
- The hepatic parenchymal changes are nonspecific and may be secondary to vacuolar hepatopathy, regenerative nodular hyperplasia or less likely, infiltrative neoplasia. Inflammatory disease is considered unlikely in light of the normal ALT.
- Gall bladder debris – incidental/non-mucocele
- Bilateral, chronic, age-related renal changes with dystrophic mineralization and right nonobstructive nephrolithiasis

Secondary Findings

- The pancreatic changes are most consistent with age-related remodeling/fibrosis. Chronic pancreatitis is possible, particularly if the patient exhibits pain on cranial abdominal palpation and intermittent GI symptoms.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Further testing for Cushing's Disease (i.e., low-dose dexamethasone suppression test or ACTH stimulation test) is recommended. If Cushing's disease is confirmed, consider initiation of medical therapy (i.e., trilostane or mitotane). Also consider a baseline blood pressure measurement and serial monitoring of the patient's urine for the development of proteinuria.
- Given the mildly elevated BUN, transitioning to a prescription renal diet can be considered.



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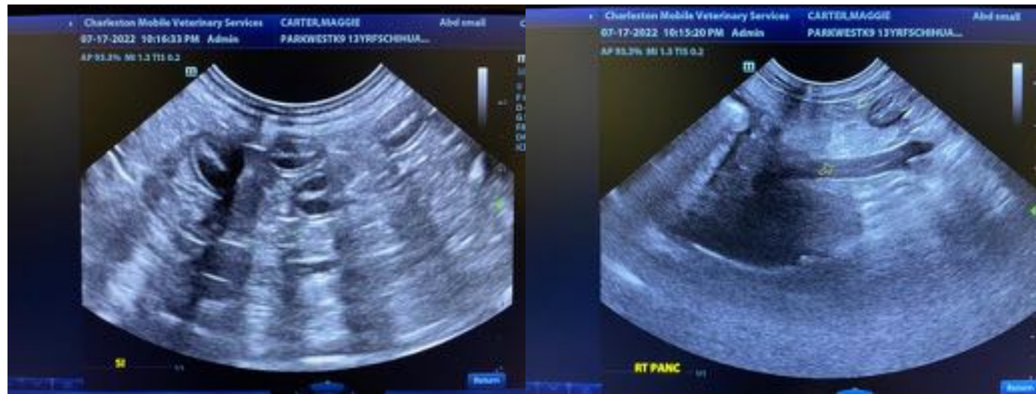
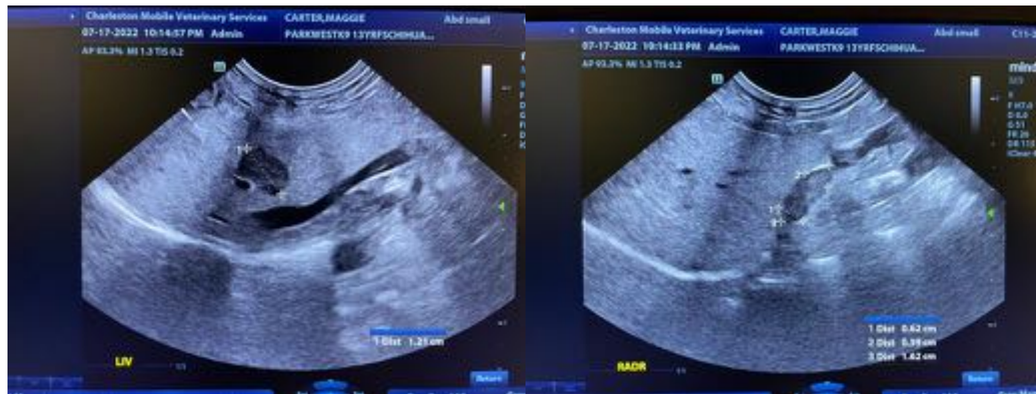
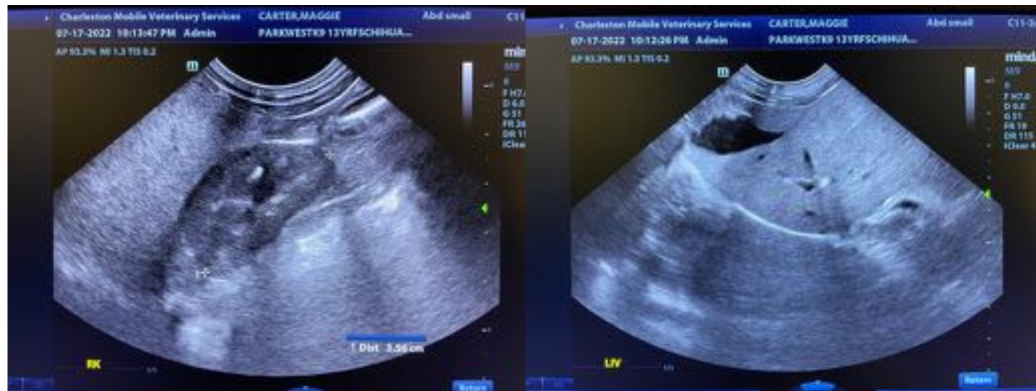
- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If values continue to increase, a repeat abdomen ultrasound +/- a more advanced hepatic work-up (i.e., tissue sampling) may be warranted.

- A repeat abdominal ultrasound can be considered in 1-2 months to assess for progression of the hyperechoic liver nodules/areas.







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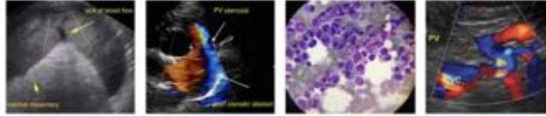

Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

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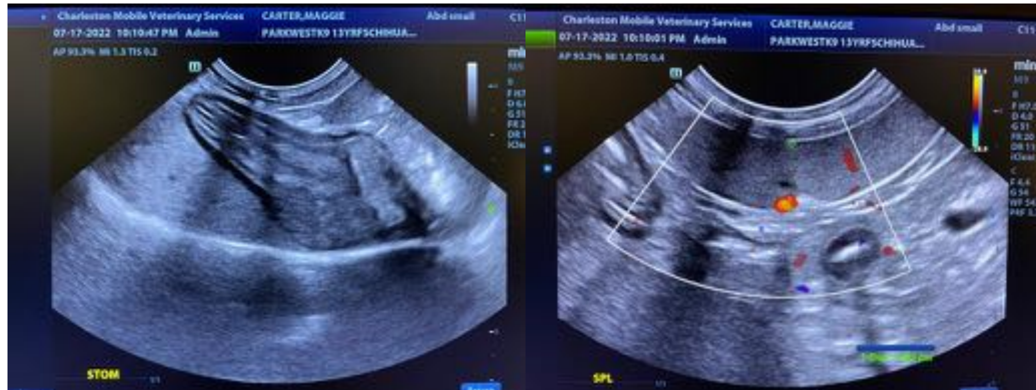

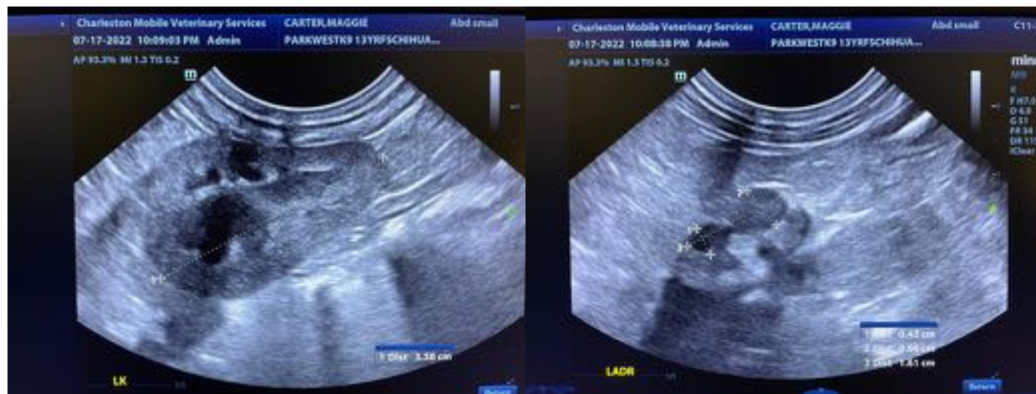

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com