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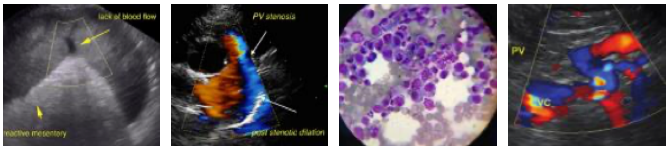

PATIENT
Kelby Masiglat

SPECIES
Canine

BREED
Maltipoo

SEX
Male, neutered

AGE
13 Yrs.

WEIGHT
6.6 kg.

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

IMAGING PERFORMED BY
Dr. Barthelemy

HOSPITAL NAME
Fen Vet

REFERRING VET
Dr. Hammond

INVOICE
15198

DATE
8/21/23

PRESENTING CLINICAL SIGNS

History: Diagnosed with hyperadrenocorticism June 2023. Initially did well on Vetoryl and then recently became very pu/pd. Diagnosed with diabetes mellitus and was started in insulin 2.5 IU BID but has continued to be hyporexic (not getting insulin consistently because of this), lethargic.
Abnormal PE/Chem/CBC/UA Results: Elevated ALP. Hyperglycaemia.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and 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 visible portion of the proximal urethra are normal.

The prostate is normal in size (0.72 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (4.46 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A hyperechoic medullary band is observed in the corticomedullary junction. 1-2 small cortical cysts are seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (5.11 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A hyperechoic medullary band is observed in the corticomedullary junction. 1-2 small cortical cysts are seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is enlarged with an irregular shape (0.96 cm at cranial pole) (0.58 cm at caudal pole). The parenchyma is mildly heterogeneous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is enlarged with an irregular shape (1.03 cm at cranial pole) (0.75 cm at caudal pole). The parenchyma is mildly heterogeneous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.59 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few irregular hyperechoic nodules are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and subtly heterogeneous with a few ill-defined hyperechoic nodules/areas. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is distended. The wall is mildly thickened (up to 0.20 cm), hyperechoic and irregular. A moderate amount of organized suspended sludge in a stellate pattern was observed within the lumen. The cystic and common bile ducts are normal/not seen.

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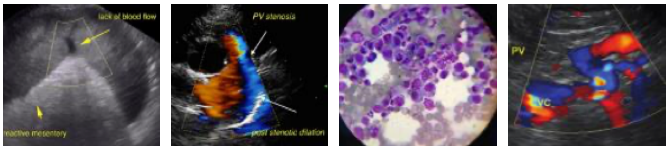

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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. 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 base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly 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

There is no obvious evidence of free fluid. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gallbladder changes are most consistent with a fully formed mucocele. The wall thickening is suggestive of cholecystitis.

Secondary Findings:

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely. Correlation with the patient's liver values is recommended.
- The bilateral renal changes are consistent with a diabetic nephropathy.
- The bilateral adrenomegaly is consistent with a previous diagnosis of pituitary-dependent hyperadrenocorticism.
- The hyperechoic lesions adjacent to the splenic vessels are most consistent with myelolipomas. Although a neoplastic process within the spleen cannot be excluded, it is considered unlikely in this patient.
- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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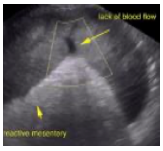
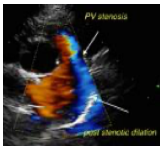
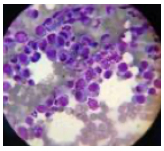
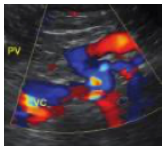

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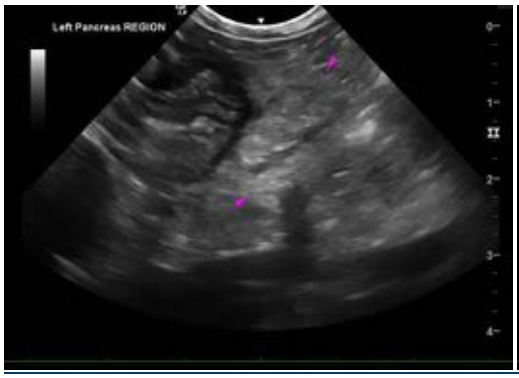
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A prophylactic cholecystectomy should be considered due to the potential risk of future gallbladder rupture with subsequent bile/septic peritonitis. If a cholecystectomy is not pursued at this time,
- A cPLI and urine culture and sensitivity are recommended to further evaluate for pancreatitis and occult urinary tract infection, respectively.
- Also consider three-view thoracic radiographs to assess for occult pathology in the chest.
- Ursodiol therapy should be initiated with close sonographic monitoring (i.e., every 3-4 weeks) to assess for worsening gallbladder pathology. Given the possibility of cholecystitis, consider empirical treatment with antibiotics. However, if the patient's hyporexia does not improve within 3-5 days of initiating antibiotic therapy, the medication should be discontinued.



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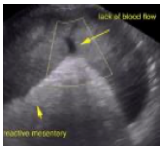
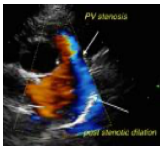
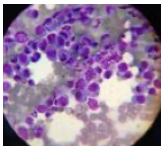
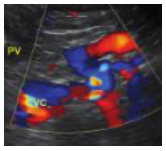

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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