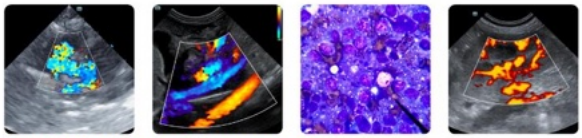


PATIENT

Kinki Wenschof

SPECIES

Canine

BREED

Dacshund

SEX

Female, spayed

AGE

6 Yrs. 5 months

WEIGHT

11.4 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

Pawleys

REFERRING VET

Dr. Welch

INVOICE

13352

DATE

12/17/25

PRESENTING CLINICAL SIGNS

Pt had an ultrasound with Charleston Mobile in January. At that time had enlarged adrenals and hepatic changes. Subsequently diagnosed with Cushing's disease and has been on Vetoryl relatively well controlled. Most recent post cortisol was in the 7s. Vetoryl increased from 15-18 mg once a day a few days ago. Became diabetic in October. Is currently on Vetsulin at 7 units twice a day. Initially had been well controlled but then developed DKA. That has currently resolved but diabetes still not well controlled although slightly improved on today's glucose curve. ALT is currently in the 300s, was in the 200s last month. ALP in the 1,000s.

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 proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (4.64 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Pinpoint hyperechoic foci are observed within the cortex. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.11 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Pinpoint hyperechoic foci are observed within the cortex. A 0.42 cm non-obstructive nephrolith is visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (0.84 cm at cranial pole) (0.92 cm at caudal pole) with swollen peripheral contours. The parenchyma is hypoechoic with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is enlarged (1.01 cm at cranial pole) (0.75 cm at caudal pole) with a normal shape. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

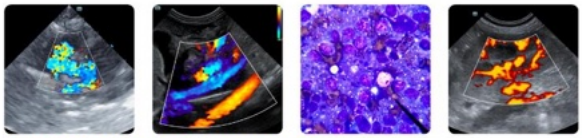
The spleen is normal in size (0.63 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Pinpoint hyperechoic foci are observed throughout the organ. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with smooth peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and 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, gravity-dependent sludge is observed within the lumen. The cystic and common bile ducts are normal. The duodenal papilla is normal in size (0.25 cm in width).

Gastrointestinal



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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 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 obvious evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is 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

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

Other

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

ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenomegaly consistent with the previous diagnosis of pituitary dependent hyperadrenocorticism.
- The diffuse hepatic changes are most consistent with vacuolar hepatopathy (i.e., endocrine, idiopathic) with a lower possibility of inflammatory disease, infiltrative neoplasia, or other hepatopathy.
- Gallbladder sludge, non-mucocele
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Minor bilateral age-related renal changes with dystrophic mineralization and right non-obstructive nephrolith.
- Splenic dystrophic mineralization. This is typically a benign incidental finding often associated with endocrinopathies.

*Overall, changes are similar to the previous sonogram.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's clinical history, consider the following:

1. Urine culture and sensitivity to assess for occult infection as a possible cause for poor diabetic regulation
2. Recheck glucose curve 7-10 days after adjusting insulin dose based on today's glucose curve.
3. Depending on the results of the above diagnostics, a change in insulin type may be warranted.

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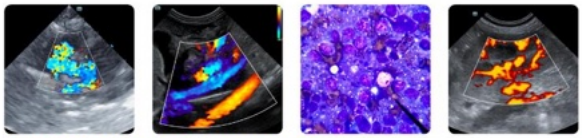

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Educational Teleconsultation Services™

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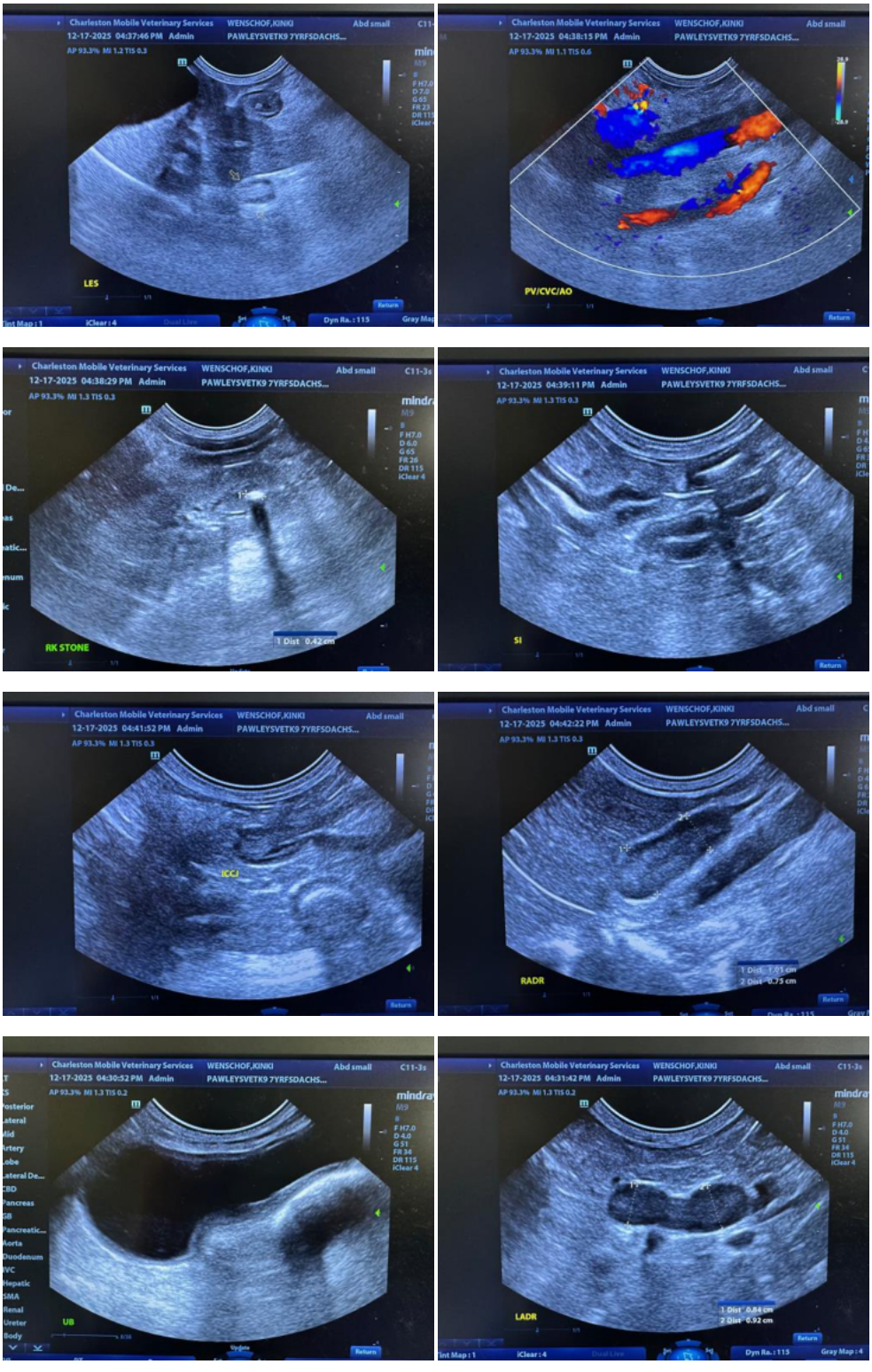

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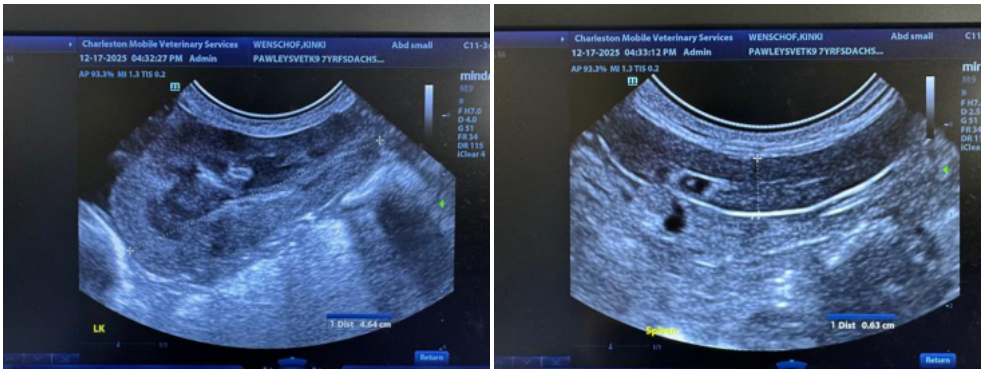

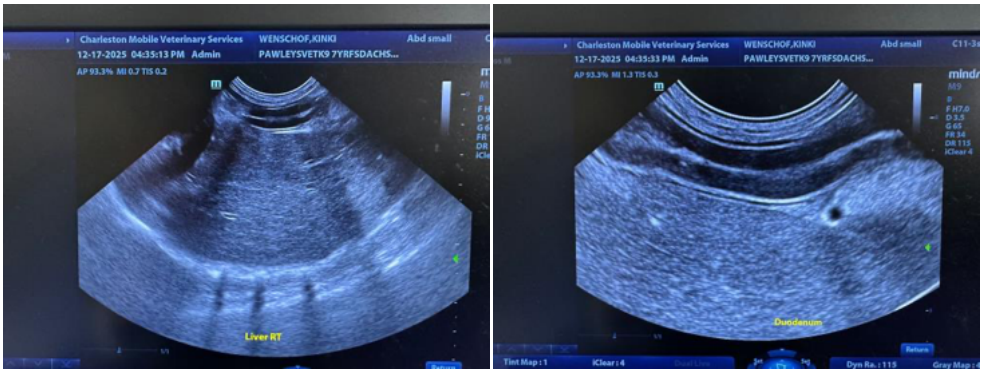

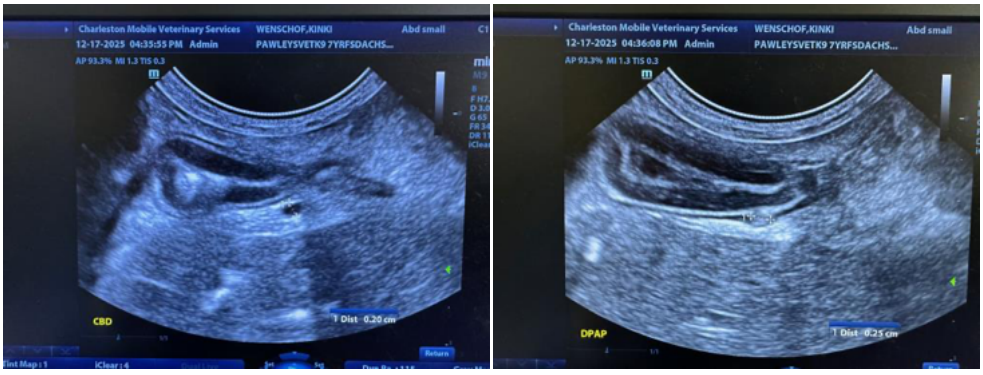

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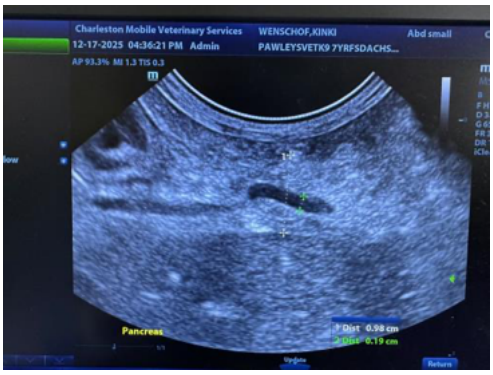

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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