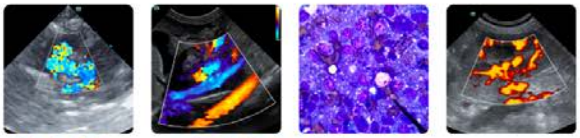

SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Finnegan Berg

SPECIES

Canine

BREED

Terrier x

SEX

Neutered Male

AGE

13 Years

WEIGHT

7.5 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Woodstock Veterinary Hospital

REFERRING VET

Dr. Wagler

INVOICE

71591

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PRESENTING CLINICAL SIGNS

Over a month of increased thirst and urination, and has had significant, ongoing weight loss of approximately 2 kg since June, despite an increased appetite. IDEXX internal medicine consultant was consulted regarding Finnegan's watery diarrhea, which developed after starting Vetoryl The specialist diarrhea could be a reaction to the Vetoryl itself, and or False positive Cushing's. Recommended to discontinue the Vetoryl medication Current Medications Royal Canin Low Fat Hypoallergenic Food. Gastro probiotic, and Gabapentin to address shaking and tremors (50mg BID), Vetoryl

Abnormal PE/Chem/CBC/UA Results: Cushing's disease was confirmed with ACTH Stim test week later. - Initial bloodwork Sept 16th showed elevated liver enzymes (8XALT and >10XALKP), low albumin - An ACTH stimulation test performed after starting 10mg BID Vetoryl demonstrated a good response to the medication, no toxicity on ACTH Stim repeat 2 wks into trial. - Hypertensive.His blood pressure was well-controlled while on Vetoryl, with readings of 120 and 140. - His BUN is low at 2.0, and he has low total protein. His chloride is also low at 98. - Platelets elevated at 420. - His kidney values are normal, and a urinalysis showed no protein, which makes a protein-losing kidney disease unlikely as the cause for his low protein. - USA of 1.006 Reason for scan? concern for liver disease, such as liver failure or neoplasia, PLE?

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 4.61 cm. Right kidney measured 4.35 cm.

Adrenal Glands

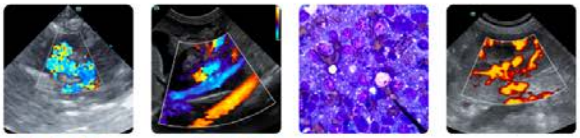
Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.72 cm at the cranial pole and 0.61 cm at the at the caudal pole. Right measures 0.59 cm at the cranial pole and 0.84 cm at the caudal pole.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and



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homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Mild/emerging inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

- Moderate gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

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- Otherwise, an obvious cause for the reported increased liver enzymes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia (considered unlikely), etc. cannot be definitively ruled out.

SECONDARY FINDINGS

- The bilateral adrenomegaly is consistent with patient's reported suspected history of hyperadrenocorticism.

- Age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

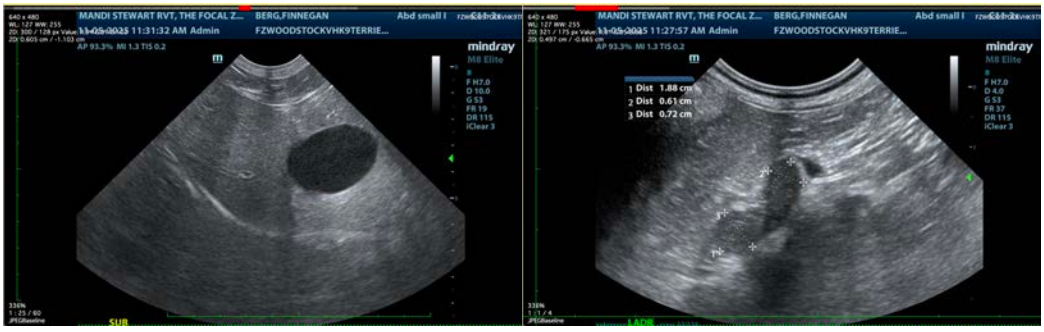
The bowel changes described above are very subtle/mild and could be in part normal patient variant. Similarly, there is not significant liver pathology to help further differentiate dysfunctional liver versus bowel disease contributing to patient's reported lab work changes. Given the concurrent diarrhea, further gastrointestinal workup is recommended, including routine fecal/giardia exam if not recently evaluated.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Full pre- and post-prandial bile acid testing could be considered if patient's total bilirubin is not increased. Ultimately, however, biopsies of both the liver and G tract may be necessary for definitive diagnosis and therefore to further guide medical management.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.



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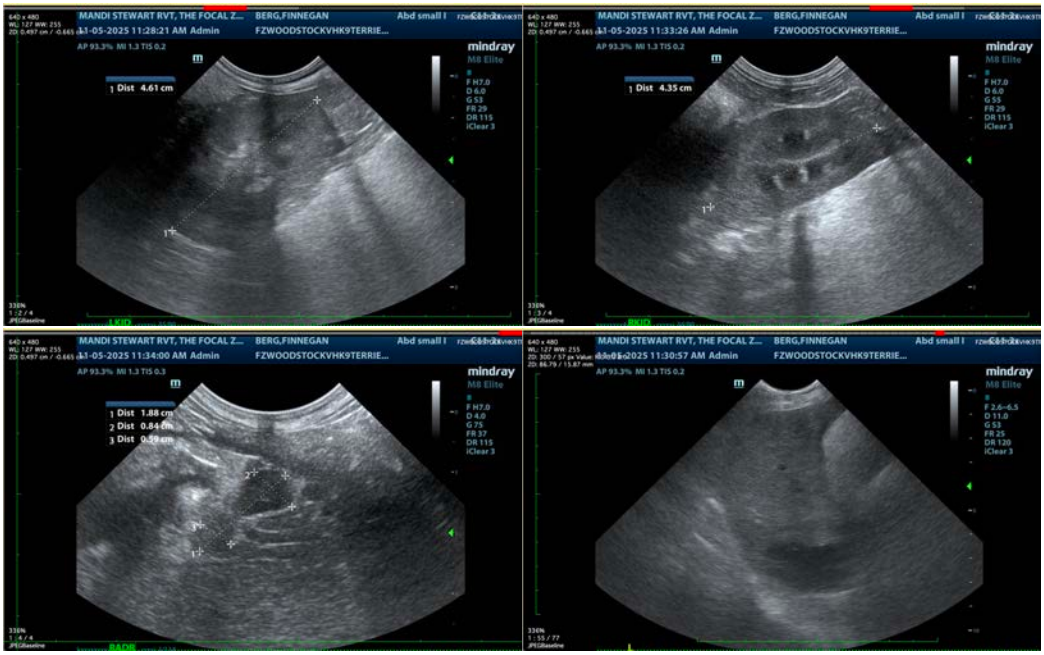

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com