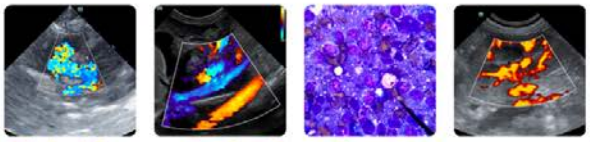

PATIENT

Murray Newcomb

SPECIES

Canine

BREED

Maltese x

SEX

Neutered Male

AGE

5 Years

WEIGHT

9.6 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Heatherlynn McFarlane, DVM

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PRESENTING CLINICAL SIGNS

AUS to further screen for HAC, elevated ALP and recurrent dermal lesions (collarettes, scaling). Presented to IM service for further evaluation of a recent hyperadrenocorticism diagnosis. Returned from FL end of May/June and shortly after had several recurrent dry, flake collarettes form. Due to recurrent skin issues and weight gain, a work-up for Cushing's was recommended leading to BW showing lymphocytosis (4.9K), thrombocytosis (508K), mild-moderate elevation of ALP (479), and hyperproteinemia due to hyperalbuminemia. ACTH stimulation and LDDST were performed and submitted to MSU. ACTH stimulation is not supportive of HAC but LDDST does have a pattern supportive of PD-HAC. However, the results are difficult to fully interpret due to possible concurrent use of medicated topical spray that has betamethasone as an ingredient. No report of PU/PD/PP.

Abnormal PE/Chem/CBC/UA Results: Oct 2025 Diagnostics: - CBC: WBC 15.8K, Neut 9.1K, Lymph 4.96K (H), Eos 0.98K, HCT 49.3%, PLT 508K (H) - Mini Chem: TP 7.6 (H), Alb 4.4 (H), Glob 3.2, Creat 0.9, BUN 15, ALT 28, ALP 479 (H) - T4: 2.4 - ACTH Stimulation: 1hr post: 455nmol/L [RI 220 - 550] (Conversion --> 16.5mcg/dL) - LDDTS: Cortisol Baseline: 301nmol/L (H) [RI 15-110] (Conversion --> 10.9mcg/dL) Cortisol 4hr post: 39nmol/L (H) [RI 0-30] (Conversion --> 1.4mcg/dL) Cortisol 8hr post: 130nmol/L (H) [RI 0-30] (Conversion --> 4.7mcg/dL) ** O was intermittently using medicated topical cream with betamethasone, may have received several

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is only mildly distended/empty. Therefore, the urinary bladder wall is unable to be fully assessed for pathology without further distention. Having said that, is one 0.50-0.60 cm in diameter cystolith suspected. No visible masses are observed The 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.

The right kidney is normal is size (4.11 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (4.07 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

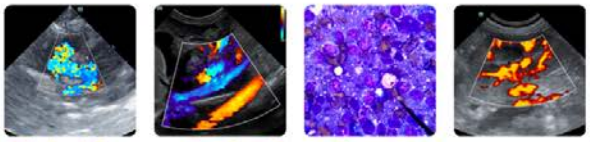
Adrenal Glands

The right adrenal gland is normal in size (1.0 cm at cranial pole and 0.56 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.47 cm at cranial pole and 0.60 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size (1.4 cm thick at the hilus) with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity



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relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with 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

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

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

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic hepatomegaly – This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.
- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Mildly to moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- At least one urinary bladder cystolith is visible.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

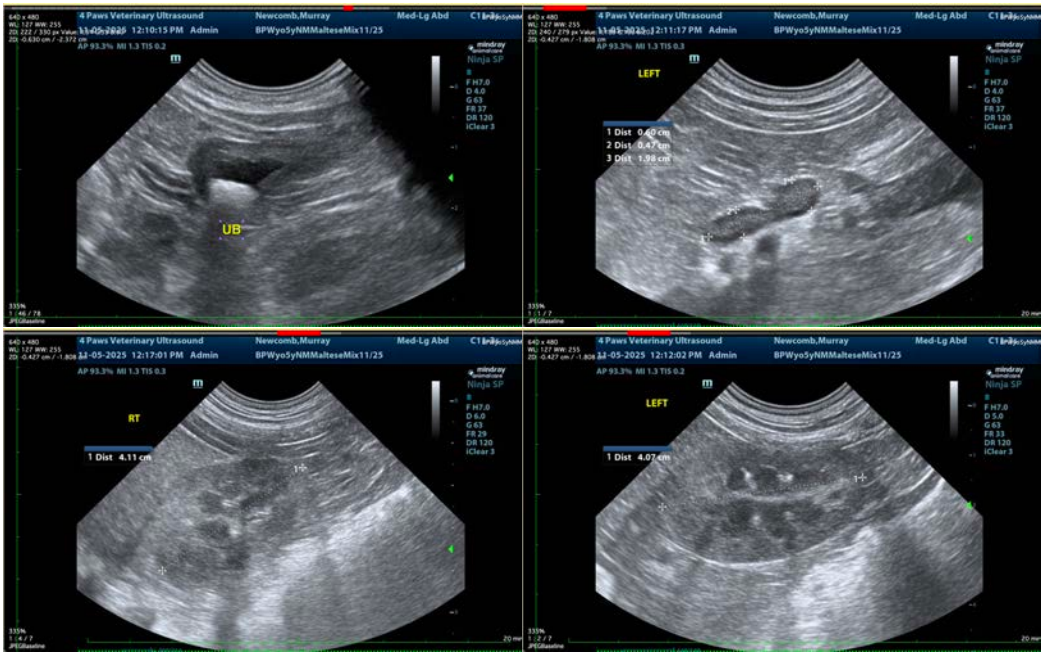
As is reportedly already pending, a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

Further evaluation of the lymphocytosis could be considered, beginning potentially with a pathology review.

Given the pancreatic changes, 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.

Hyperadrenocorticism can't be ruled out by largely normal appearing adrenal glands. Therefore, if clinical signs and/or ongoing testing, etc. are consistent, then an additional therapy may be warranted. However, given patient's history and the lack of reported clinical signs consistent with hyperadrenocorticism, a recheck low-dose Dexamethasone suppression test when patient has not received steroids and/or when and if patient becomes clinical for hyperadrenocorticism could be considered.

Other recommendations, both further diagnostic as well as therapeutic are largely dependent on results of above.



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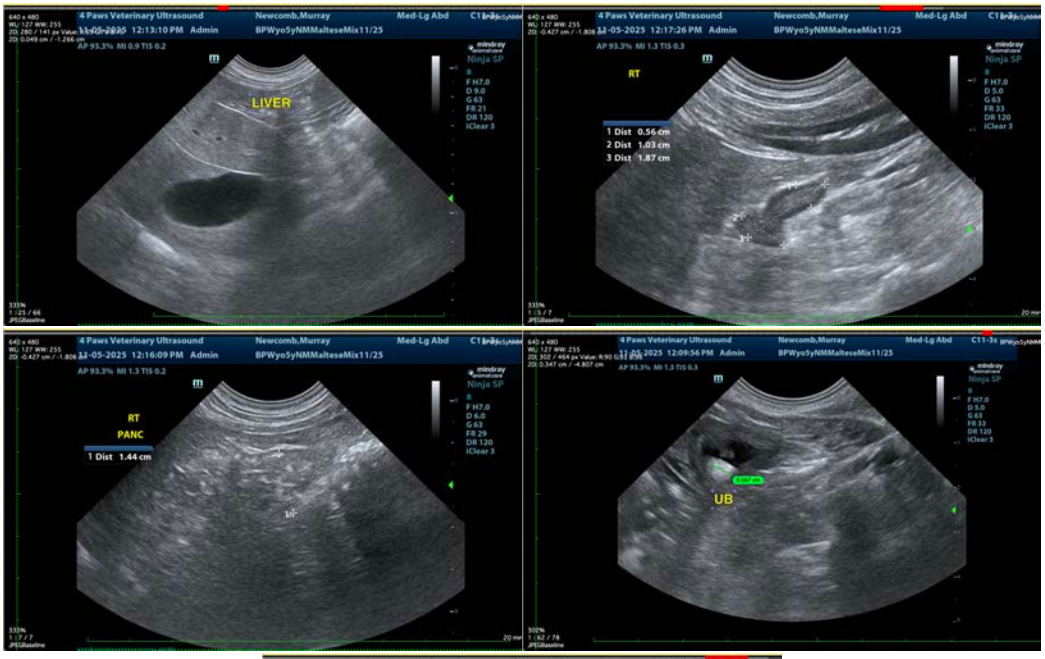

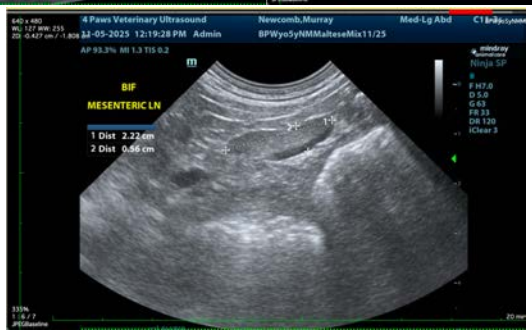

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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