

**PATIENT**

Maddie Feliks

SPECIES

Canine

BREED

Coton De Tulear

SEX

Spayed Female

AGE

15 Years

WEIGHT

13 Pounds

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING PERFORMED BY**

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VETWixom Family Pet
Practice**INVOICE**

42659

DATE

11/9/22

PRESENTING CLINICAL SIGNS

Current Medications: Trilostane 10mg PO BID; Ursodiol 100mg SID Patient History: Cushing's disease and hepatopathy, previous gall bladder issues, doing well at home, this is her annual scan.

Abnormal PE/Chem/CBC/UA Results: Haziness to lenses OU, menace, blink and PLR's are normal; mild to moderate tartar, slab fracture 208, mild diffuse gingivitis; grade 3/6 left sided heart murmur; caudal abdomen has small soft sq movable masses, about 1 cm diameter each Blood work: ALP 418 (3-131 IU/L) Tbil 0.5 (0.1-0.3 mg/dL) PSL 273 (24-140 IU/L) Platelets 576 (170-400 10³/uL) Recent ACTH stim: resting cortisol 13 (1-6 ug/dL) ; post cortisol 14.1 (1-6 ug/dL) Please see attached labs and previous aus report

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.42 cm thick). An echogenic density that appears to be attached to the bladder wall is noted, consistent with a benign polyp.

Infiltrative neoplasia cannot be ruled but is considered exceedingly less likely. Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

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 mineral or infarcts observed. A 0.8 cm cortical cyst is noted in the left kidney. Mild pyelectasia noted at 0.28 cm in the left kidney, measured in the transverse view. The left kidney measures 4.29 cm. The right kidney measured 4.7 cm. Mild pyelectasia noted in the right kidney at 0.21 cm, measured in the transverse view.

Adrenal Glands

The right adrenal gland is normal in size (0.62 cm at the cranial pole and 0.87 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is enlarged (3.2 cm long x 1.2 cm at the cranial pole and 2.0 cm at the caudal pole) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted without evident capsular escape or vascular invasion.

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

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.

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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.

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with 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. In a couple sagittal videos, the stomach wall looks diffusely thick with intact layering up to a heterogeneous, primarily hyperechoic, irregular thickened mucosa. Given the lack of consistency between views, this may be normal ingesta and fluid, potentially mild gastritis and prominent rugal folds.

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The visible small intestines are normal in wall thickness and layering. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min).

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

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Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

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DACVIM

There is no apparent lymphadenopathy noted in these images.

PRIMARY FINDINGS**IMAGING PERFORMED BY**

Amy Mayhew, LVT

- **Bilateral adrenomegaly** – Likely suggestive of adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism, potentially exacerbated by Trilostane therapy, as adrenal glands can become larger on Trilostane therapy. However, this patient's left adrenal gland is disproportionately larger, and larger than the previous reported sizes, so a left adrenal mass (i.e., adenoma or less likely adenocarcinoma or even pheochromocytoma) on top of pituitary dependent disease, although less common, cannot be definitively ruled out.
- **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.
- **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.
- **Mucosal speckling** – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- At least mildly thick hyperechoic gastric mucosa is suspected, which may indicate some mild gastritis. However, given normal appearance in the majority of the views and lack of

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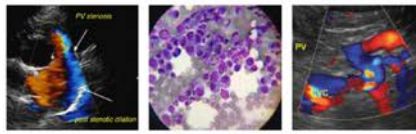
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svsimagingmi@gmail.com



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gastrointestinal signs reported, normal patient variant, prominent rugal folds, and some ingesta may be creating the impression of a diffusely thick stomach in some views. This finding should be interpreted in combination with supporting clinical signs and monitored for progression versus resolution.

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SECONDARY FINDINGS

- **Chronic Cystitis with a suspected benign polyp** - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely given the location and diffuse nature of the changes.
- Age related kidney changes with bilateral pyelectasia and cortical cysts

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient is reportedly doing well. This was a routine annual exam. Changes to the treatment course may not be indicated. However, given the reported ultrasound pathology described above, if not recently evaluation, Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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Additionally, if gastrointestinal signs are at all present (vomiting, diarrhea, weight loss, etc.), 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, and potentially, especially if the gastric thickening can be repeated and/or persists, a fine needle aspirate of the stomach could be considered if patient's coagulation status is appropriate. However, again, this is a non-definitively repeatable finding amongst views, and may be completely normal patient variant.

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If clinical signs of hyperadrenocorticism are still present, as was alluded to, it may be (based on the cortisol levels provided) that the patient simply needs a higher dose of Trilostane, or, especially if there is a concurrent adrenal dependent portion to this patient's hyperadrenocorticism, the patient may benefit from a transition from Trilostane to Lysodren/Mitotane.

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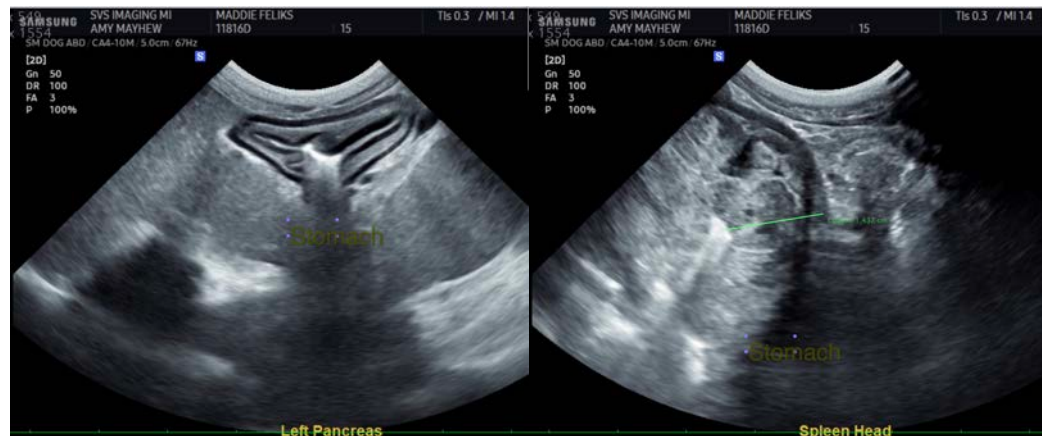
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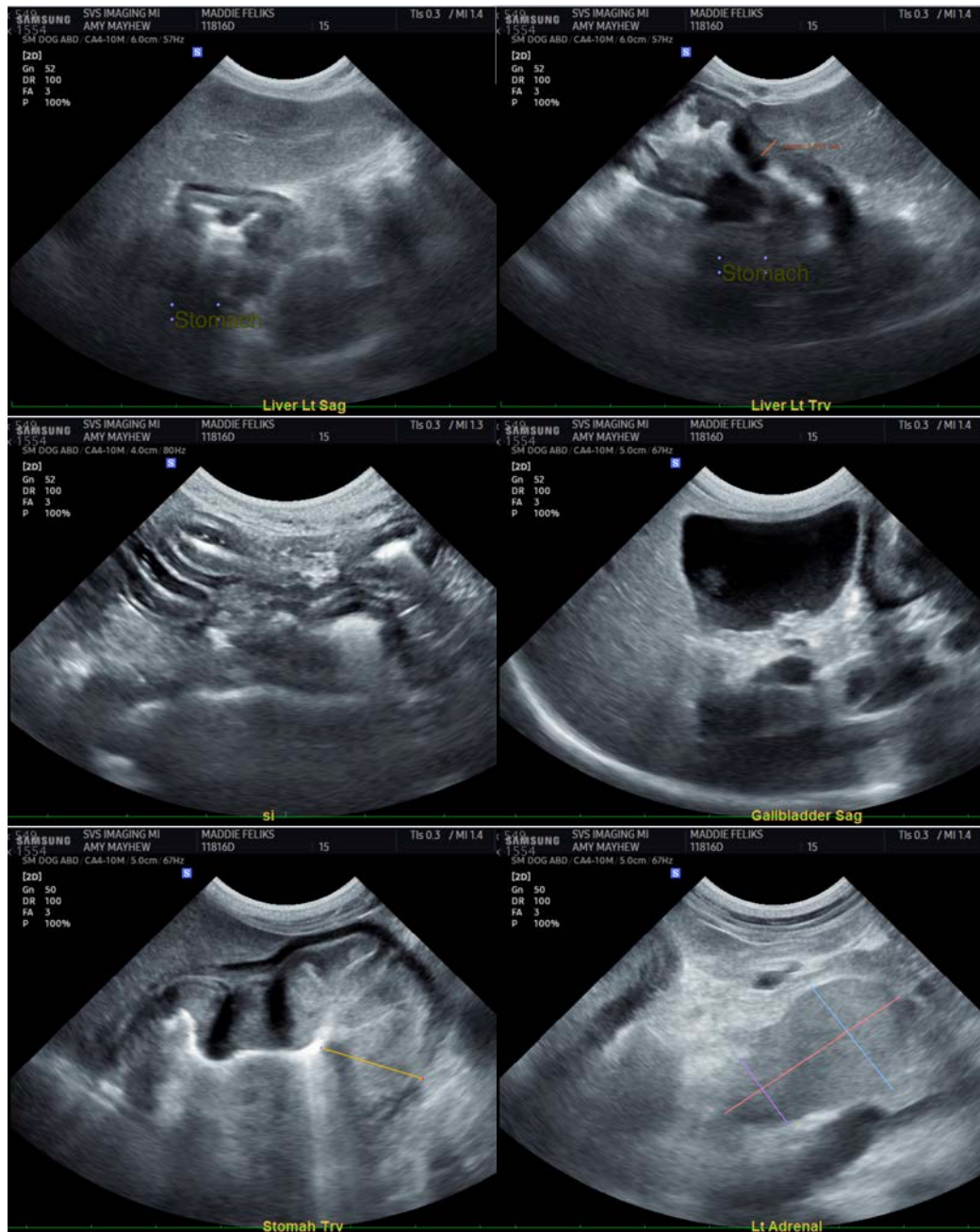
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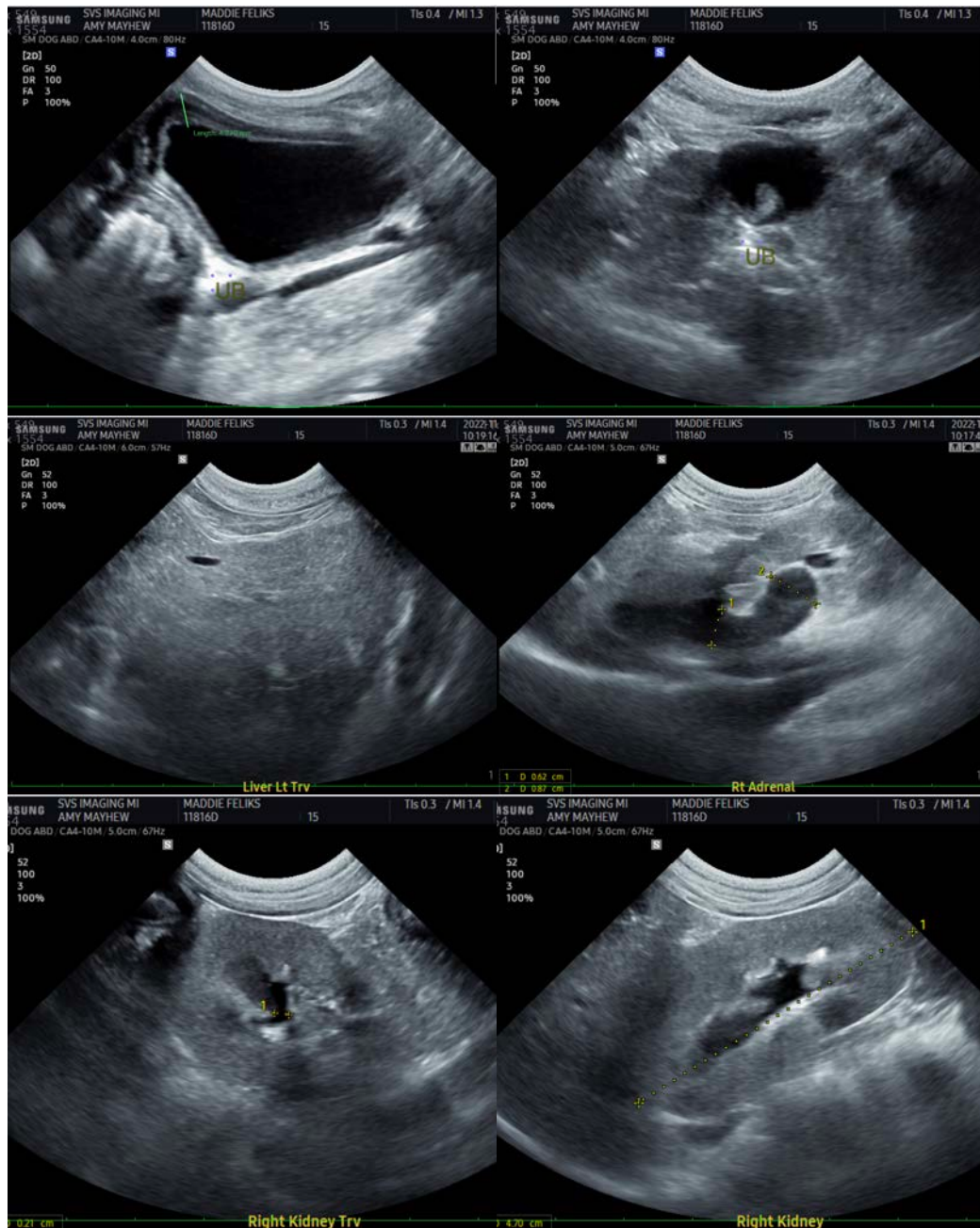
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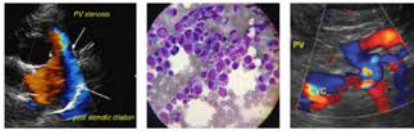
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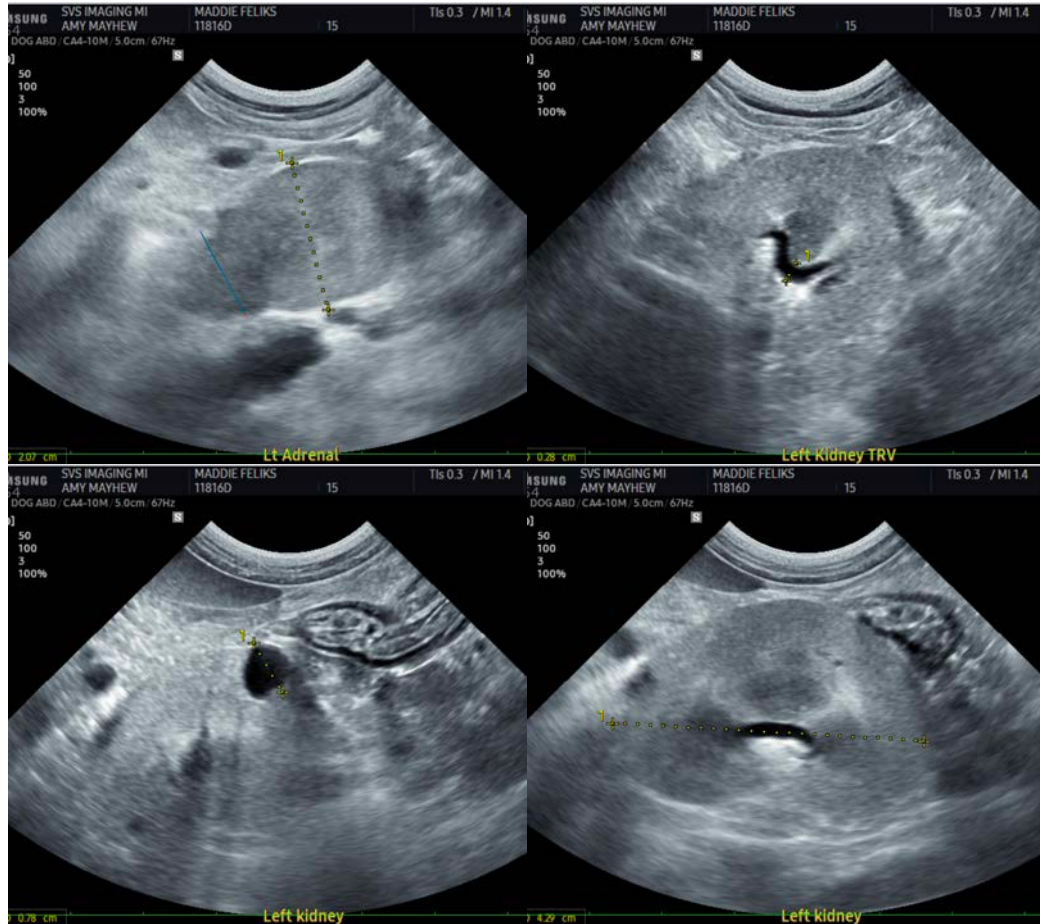
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com