



PATIENT

Jezzy Branle

SPECIES

Canine

BREED

Boston Terrier

SEX

Spayed Female

AGE

15 Years

WEIGHT

18.3 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Danielle Lanz

HOSPITAL NAME

New Holland VH

REFERRING VET

Dr. Danielle Lanz

INVOICE

43409

DATE

12/13/22

PRESENTING CLINICAL SIGNS

15yo FS Boston terrier presenting for 10lb weight loss over the past year and a 1lb weight loss over the past 2 weeks. P has Cushings disease controlled with trilostane. History of enucleation and severe arthritis x 4 limbs. Mildly decreased appetite. PE shows mm wasting on dorsum and hindlimbs, thickening of both elbows and stifle joints. No vomiting or diarrhea noted.

Abnormal PE/Chem/CBC/UA Results: CBC/Chem: ALT 155, ALP 758 GGT 20, Eosinophils 0 Platelets 490. ACTH stim pre 6.0 post 4.1 (normal) T4 evaluated 0.4 on 11/26 and 1.4 on 12/6 3 view chest and abdominal radiographs WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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.

The right kidney is normal in size (5.53 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 or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

The left kidney is normal in size (5.48 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 or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

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. The right adrenal gland measures 0.80 cm at the cranial pole and 0.80 cm at the caudal pole. The left adrenal gland measures 1.0 cm at the cranial pole and 1.1 cm at the caudal pole.

Spleen

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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.



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Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is empty with no evidence of obstruction or foreign material.

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

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.

Free Abdomen

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

There is no apparent lymphadenopathy noted in these images.

PRIMARY FINDINGS

- **Heterogenous Liver** – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- **Bilateral adrenomegaly** – consistent with the reported history of hyperadrenocorticism and Trilostane therapy.
- **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.

SECONDARY FINDINGS

- Non-obstructive nephrolithiasis bilaterally in the kidneys
- **Hyperechoic splenic nodules** – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- **Mild 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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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

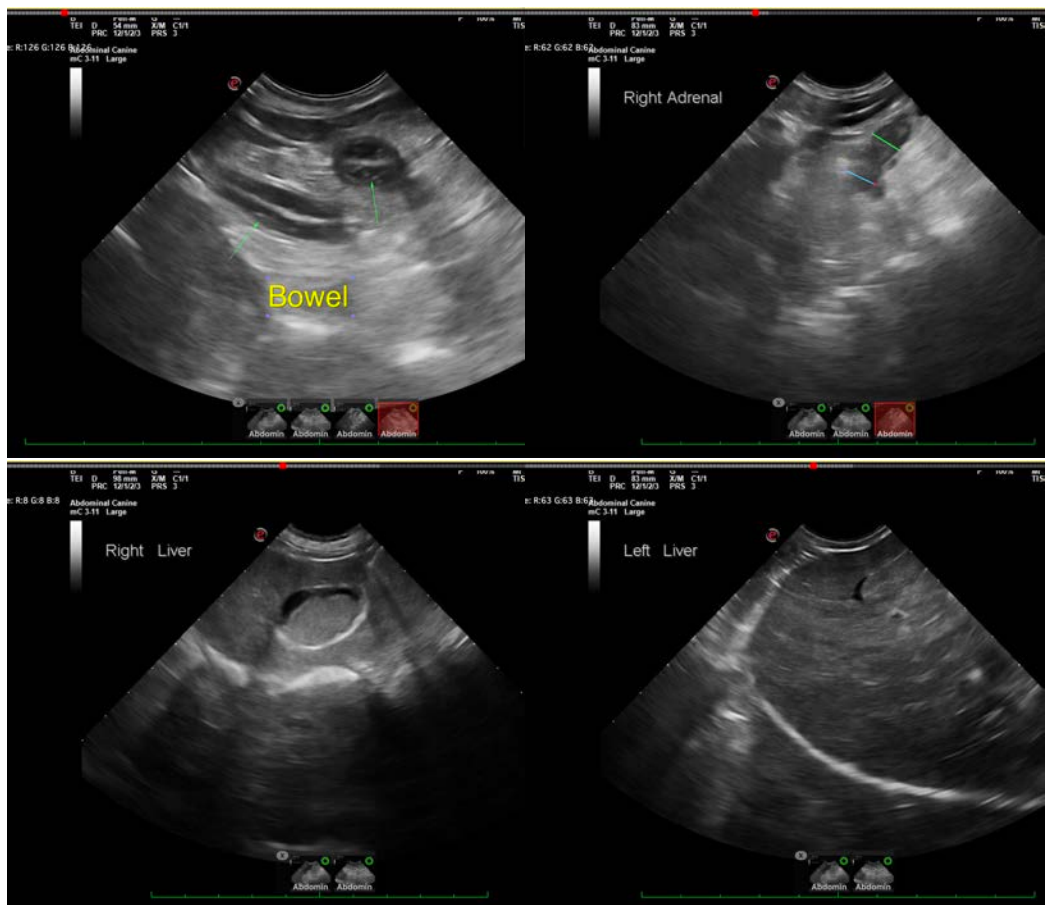
The pathology described above is largely consistent with the previous diagnosis of hyperadrenocorticism. However, given the pronounced weight loss, while the liver trends in appearance towards benign, a fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate.

Additionally, given the mucosal speckling and weight loss, 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.

In the meantime, if the weight loss is at all attributed to decreased appetite, temporary discontinuation of the Trilostane is recommended with restarting Trilostane potentially at a lower dose, when and if clinical signs of hyperadrenocorticism return.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended.

If not recently evaluated, 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 ratio is recommended.





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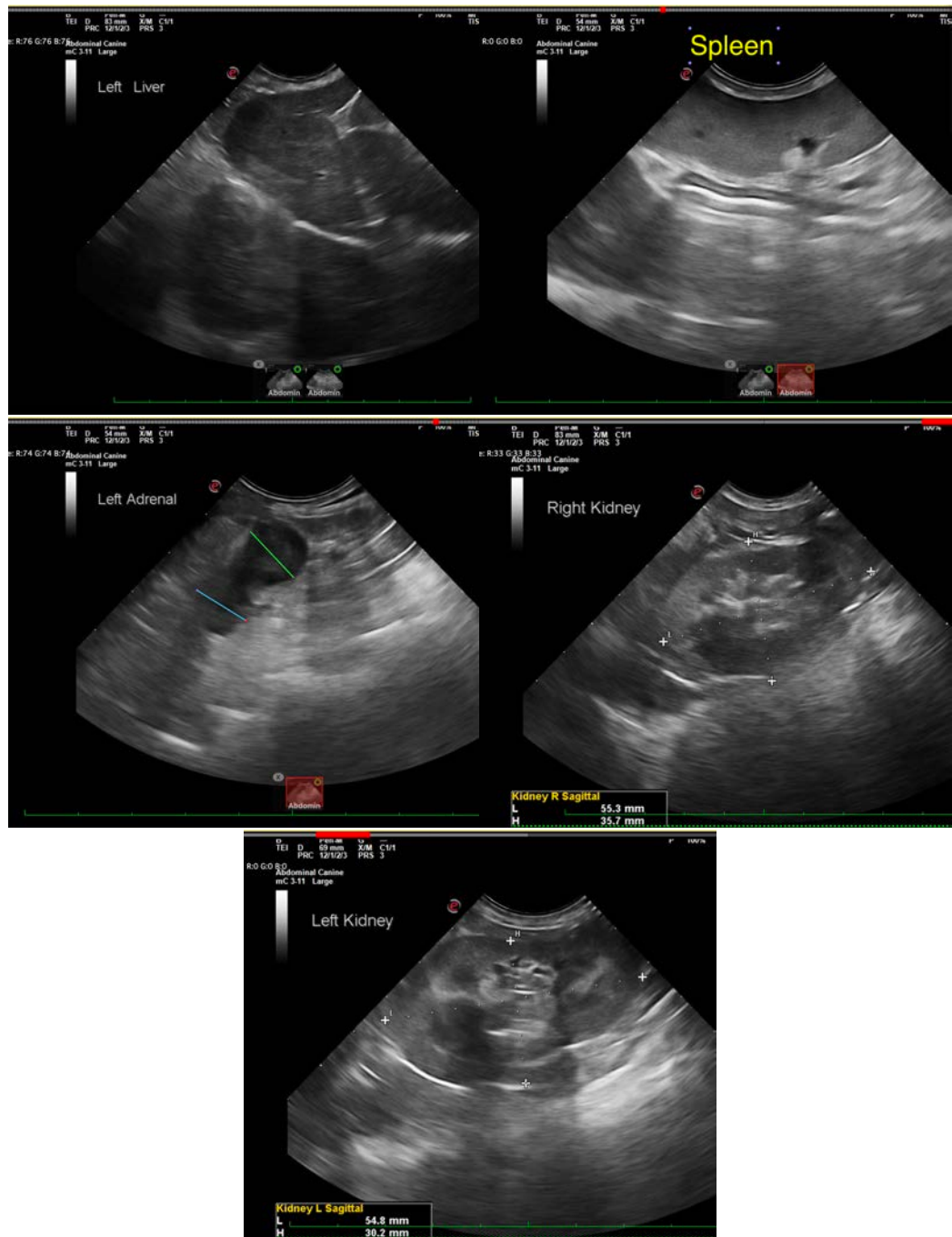
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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