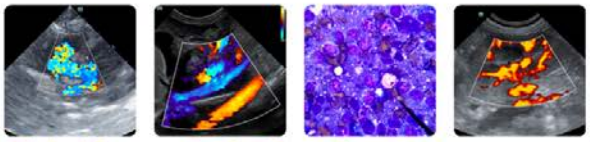


PATIENT

Sam Pacini

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Neutered Male

AGE

10 Years

WEIGHT

15 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Julia Bakker, DVM

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Kristen Henry, DVM

INVOICE

72254

DATE

12/2/25

PRESENTING CLINICAL SIGNS

Assessment/Differentials- Hyperadrenocorticism (Cushing's disease) - previously diagnosed, currently managed with trilostane; patient remains symptomatic with progressive signs- Progressive abdominal distension - rule outs: hepatomegaly (known from previous ultrasound), neoplasia (considering rapid progression), fecal impaction, gastrointestinal distension- Hyperlipidemia (hypertriglyceridemia and hypercholesterolemia) secondary to Cushing's disease- Hepatomegaly - confirmed on previous ultrasound- Bilateral ACL tears - chronic, managed conservatively- Decreased appetite - rule outs: progression of Cushing's disease, gastrointestinal disease, neoplasia, medication side effect Medications- Continue trilostane 13 mg PO q12h - Continue ursodiol 250 mg PO q24h - Continue Visbiome probiotic - Continue Denamarin as tolerated - Continue Royal Canin GI Low-Fat diet

Abnormal PE/Chem/CBC/UA Results: AUS from Jan 2025 attached for comparison

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots, as well as dependent mineral “sand” (crystals) debris. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or discrete definitive cystoliths 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.

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 measures 4.51 cm. Right kidney measures 4.47 cm.

Adrenal Glands

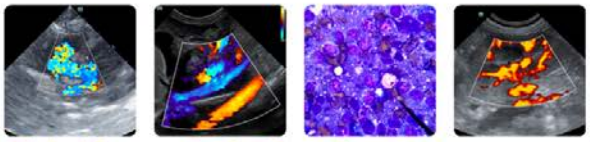
Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 1.4 cm at the cranial pole and 1.3 cm at the caudal pole. Right measures 1.2 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). No focal nodules or masses are observed. Multifocal mineral foci are noted. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules, hyperechoic nodules, and an occasional



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anechoic cystic density within the liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

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. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine 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 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

- The bilateral adrenomegaly is mildly progressive in appearance from the original ultrasound, but this is not uncommon in dogs with hyperadrenocorticism receiving medical management such as Trilostane.

- Moderately 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.

- Emerging mucocele – 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele. *The appearance of the gallbladder is subjectively mildly progressive compared to prior ultrasound.

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- 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.

- Spleen mineralization – This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism.

SECONDARY FINDINGS

- Age related kidney changes.

- Large amount of echogenic urinary bladder mineral/sand debris. Small cystoliths within the piles of debris can't be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient's reported clinical history of poorly controlled/symptomatic hyperadrenocorticism combined with decreased appetite indicate potentially two different problems, as hyperadrenocorticism typically does not result in reduced appetite unless cortisol levels have been dropped too low and/or patient is not tolerating medication. Therefore, if not recently evaluated, an ACTH stimulation test could be considered.

In the meantime, using compounded Trilostane should be pursued cautiously with close attention to concentrations and potentially a transition to brand name product, at least temporarily to see if that controls clinical signs anymore effectively. Ultimately, a change in dose and/or alternative medication, however, may be indicated.

Given patient's reduced appetite, however, concurrent bowel disease or potentially the emerging gallbladder mucocele are both differentials and may warrant further intervention. Further diagnostics in the meantime could include:

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.

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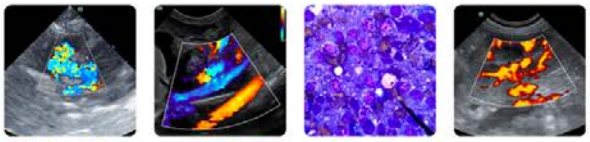

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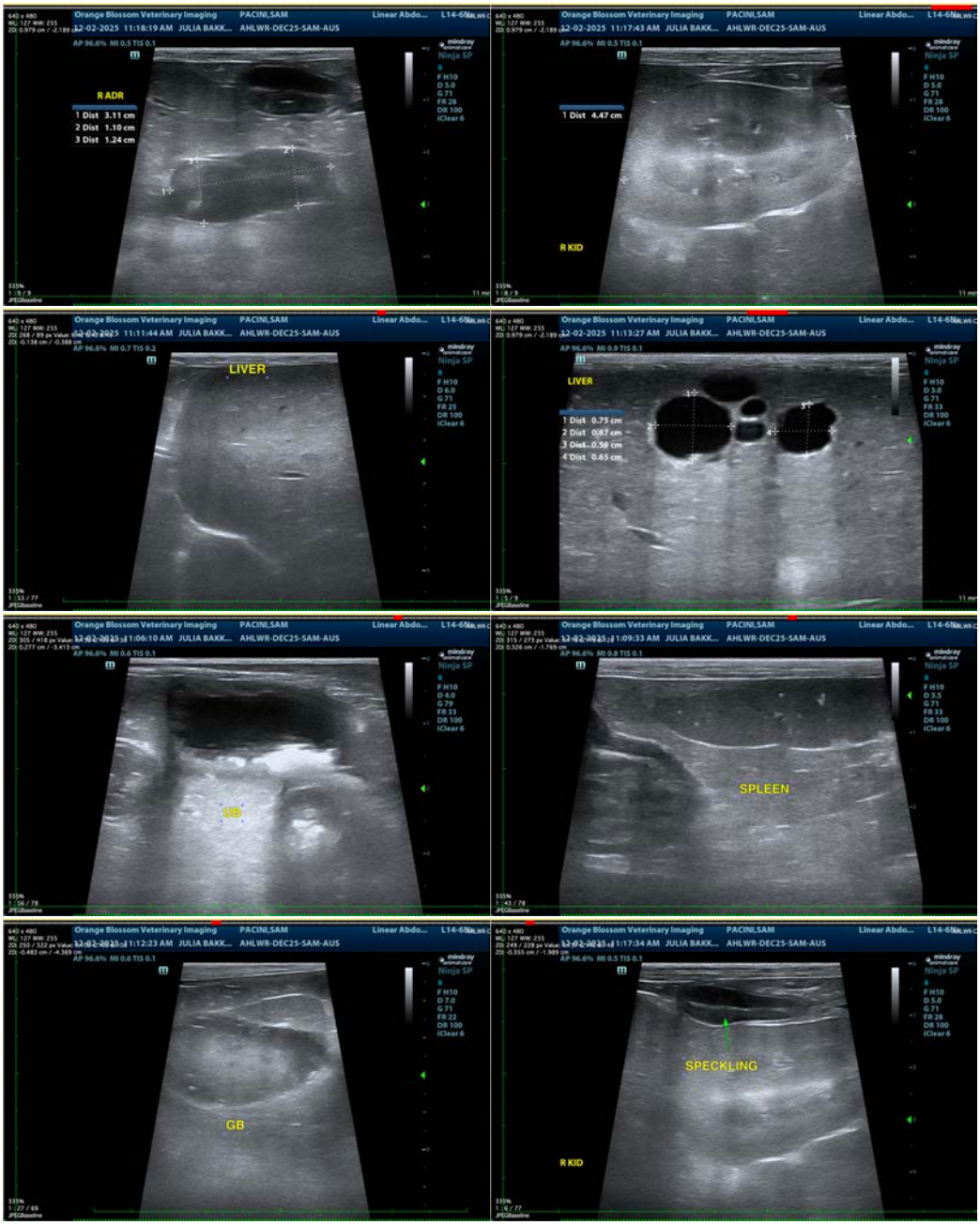

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 info@sonopath.com