



PATIENT	PRESENTING CLINICAL SIGNS
Chloe Spitz	inappropriate urination; suspect cushings disease (wnted US results prior to LDDST). Abnormal PE/Chem/CBC/UA Results: ALKP 250; UA: USPG 1.009
SPECIES	ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
Canine	Urinary System
BREED	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.
Maltese	The right kidney is normal in size (4.7 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.
SEX	The left kidney is normal in size (3.06 cm), shape and echogenicity. It has smooth peripheral margination. An incidental cortical cyst was noted. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.
Spayed Female	
AGE	Adrenal Glands
12.5 Years	The right adrenal gland is normal in size (1.23 cm long x 0.67 cm at the cranial pole and 0.50 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.
WEIGHT	The left adrenal gland is normal in size (1.6 cm long x 0.55 cm at the cranial pole and 0.44 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.
5 Pounds	
INTERPRETED BY	Spleen
Beth Johnson, DVM DACVIM	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.
IMAGING PERFORMED BY	Liver
Diane McFadden	Liver is subjectively enlarged with rounded margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature appears normal.
HOSPITAL NAME	The gallbladder contains 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.
Tranquility VC	
REFERRING VET	Gastrointestinal
Dr. Blackman	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.
INVOICE	
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DATE	The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions
2/1/22	



PATIENT

Chloe Spitz

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.

SPECIES

Canine

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.

BREED

Maltese

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

SEX

Spayed Female

ULTRASONOGRAPHIC FINDINGS

AGE

12.5 Years

- Early 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.

WEIGHT

5 Pounds

- Heterogenous liver – Differentials for hepatic changes include both benign steroid (vacuolar) hepatopathy or extramedullary hematopoiesis as well as infiltrative round cell or metastatic neoplasia.
- Incidental renal cortical cyst in the left kidney

INTERPRETED BY

Beth Johnson, DVM
DACVIM

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If history is consistent with hyperadrenocorticism, including polyuria, polydipsia, polyphagia, panting, potbelly, etc., a low-dose Dexamethasone suppression test would be indicated to diagnose hyperadrenocorticism. If hyperadrenocorticism is diagnosed, it is pituitary dependent based on these images. If hyperadrenocorticism is diagnosed, a urine culture is recommended, as is a blood pressure.

IMAGING PERFORMED BY

Diane McFadden

If the low-dose Dexamethasone suppression test is not consistent with Cushing's, then an empirical trail of Ursodiol and broad-spectrum antibiotics (while monitoring ALP) could be tried in case the ALP is increased due to the reported gallbladder sludge. A fine needle aspirate of the liver could also be considered if patient's coagulation status is appropriate. However, the most likely differential is a steroid or vacuolar hepatopathy based on this patient's history and suspicion for hyperadrenocorticism.

HOSPITAL NAME

Tranquility VC

REFERRING VET

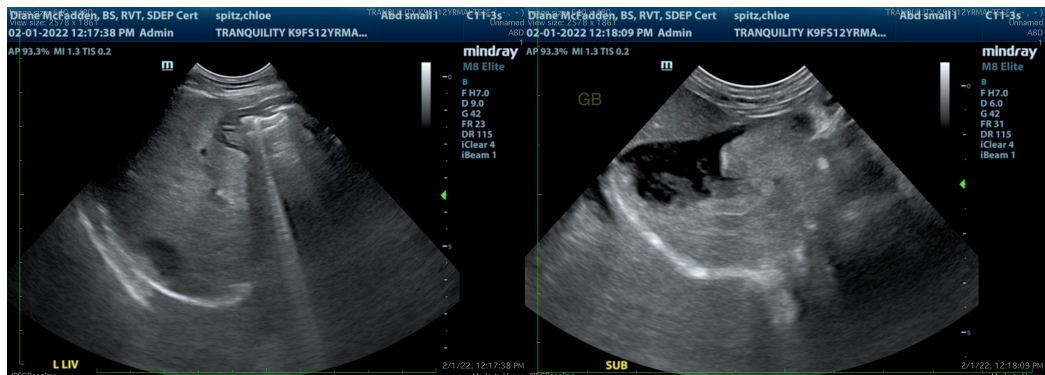
Dr. Blackman

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SPECIES

Canine

BREED

Maltese

SEX

Spayed Female

AGE

12.5 Years

WEIGHT

5 Pounds

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Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Diane McFadden

HOSPITAL NAME

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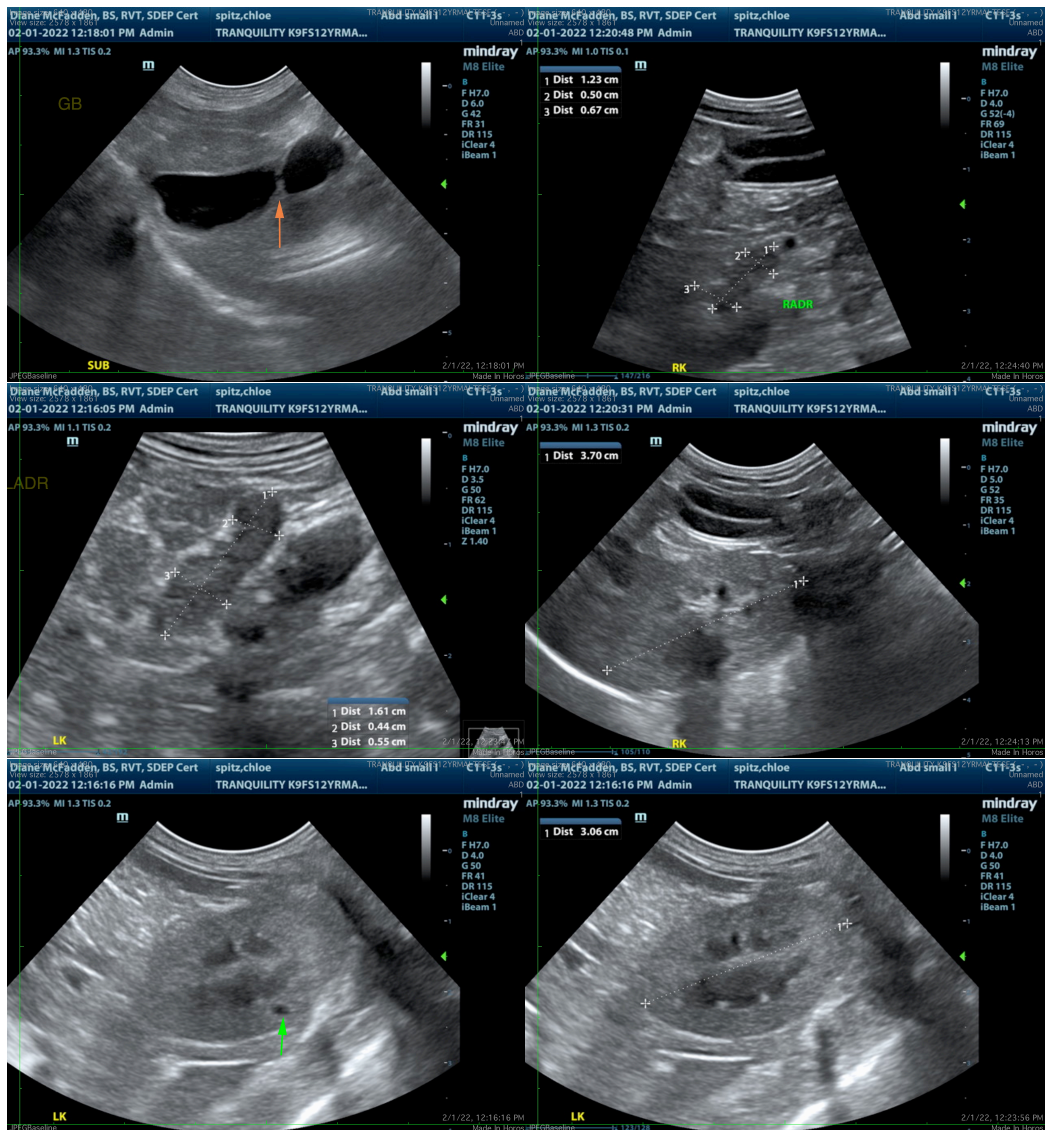
Dr. Blackman

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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