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Clinical Sonography & Telecytology
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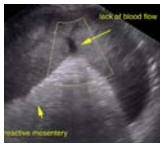
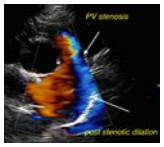
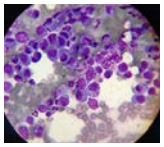
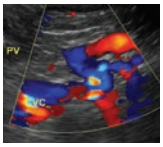





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Gemini Dusman

SPECIES

Canine

BREED

Border Collie X

SEX

Spayed Female

AGE

14

WEIGHT

24.9 kg

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Laura de Cordon

HOSPITAL NAME

Mason Dixon Animal Emergency Hospital

REFERRING VET

Valley Green Vet Hospital

INVOICE

45167

DATE

2/15/23

PRESENTING CLINICAL SIGNS

Lethargic for a few days Not eating much x2 days Retching last night but no V Drinking water No diarrhea History of Cushing's disease. Currently on Trilostane.

Abnormal PE/Chem/CBC/UA Results: Severe anemia mildly decreased platelets normal PT/PTT

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 (6.18 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 in size (5.32 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

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Some parenchymal heterogenicity is present without concerning capsular distortion, most notable in the caudal pole of the left adrenal gland. Visible surrounding vasculature appears normal. The left adrenal gland measured 1.5 cm at the cranial pole and 2.1 cm at the caudal pole. The right adrenal gland measures 1.4 cm at the caudal pole. The cranial pole of the right adrenal gland is not able to be well visualized in these images.

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

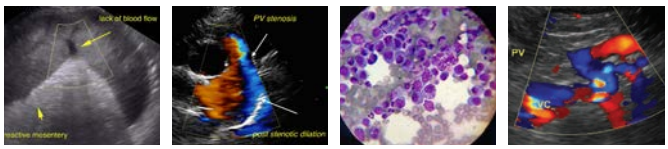
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal 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 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.

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 mildly distended with echogenic



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non-shadowing luminal contents and gas consistent with normal ingesta. There is 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

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.

ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenomegaly – Consistent with this patient's reported history of hyperadrenocorticism and Trilostane therapy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no ultrasonographically obvious cause for the patient's reported cytopenia or clinical signs.

While this patient is clinically ill, until a diagnose is made and therapy is initiated, Trilostane should be discontinued. Once the patient is clinically normal and again showing signs of hyperadrenocorticism, it could be restarted at that time.

In the meantime, an ACTH stimulation test is recommended to assess cortisol levels in case over suppression of cortisol is contributing to lethargy, decreased appetite, etc.

If that's the case, when and if Trilostane is ultimately restarted, it should be restarted at a lower dose and should be divided into twice daily dosing, as most animals do better with twice daily dosing versus once daily dosing.

Additionally, given the cytopenia, comprehensive infectious disease testing could be considered, as could further investigation of agglutination, etc. that may indicate an autoimmune component to the anemia and reportedly mild thrombocytopenia.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

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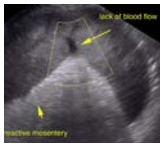
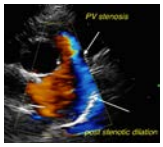
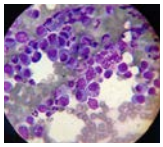
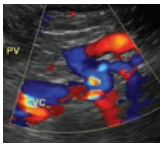

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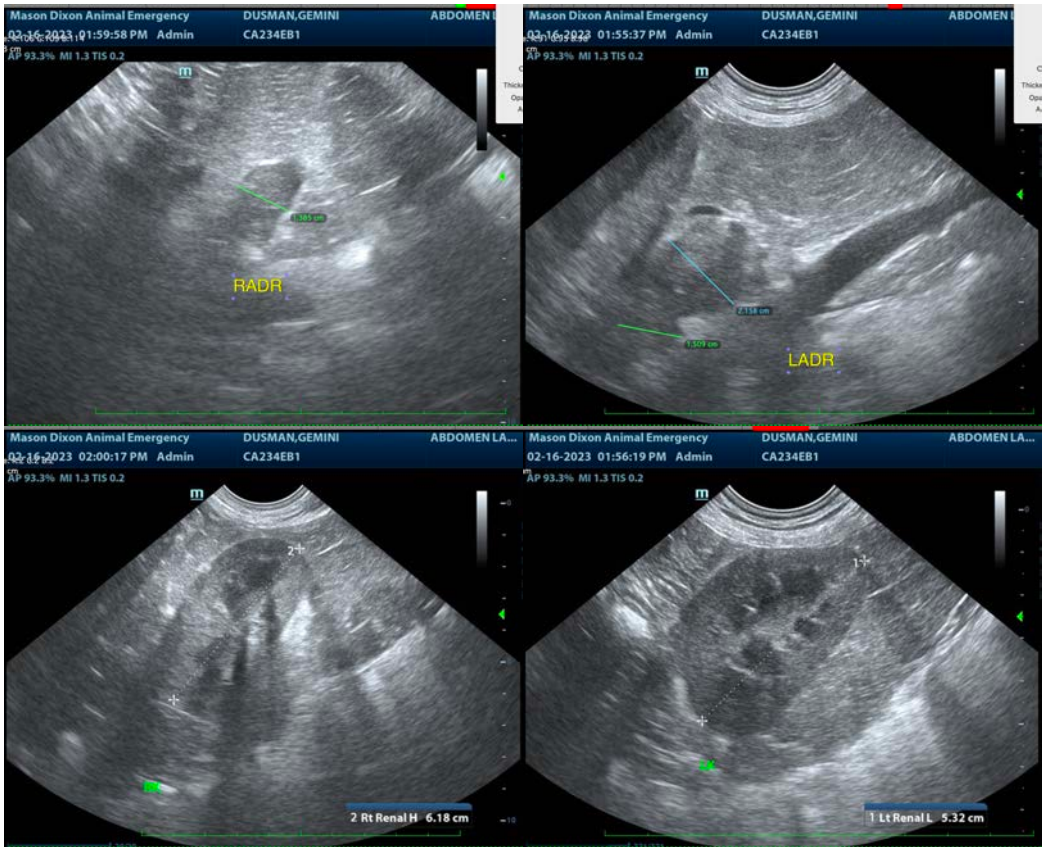

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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