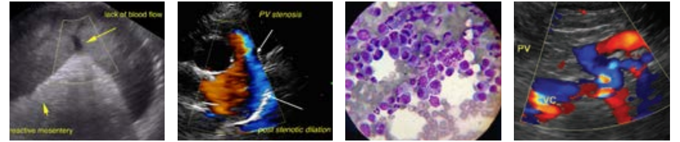

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1-800-838-4268 info@sonopath.com

PATIENT
Demi LaGreca

SPECIES
Canine

BREED
Setter X

SEX
Neutered Male

AGE
13 Years

WEIGHT
Not Provided

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Shari Reffi, CVT

HOSPITAL NAME
AH of Sussex County

REFERRING VET
Dr. Catania

INVOICE
44802

DATE
2/7/23

PRESENTING CLINICAL SIGNS

Chronic elevated liver values despite well controlled Cushings. Current meds: Vetoryl 30mg

Abnormal PE/Chem/CBC/UA Results: 12/26/2023-Alt 938, Alp 2046, Tbili 03, GGT 40, K 5.8, Ast 72, Cortisol 8.5 (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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal in size (6.11 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 (6.51 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. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measures 2.56 cm long x 0.97 cm at the cranial pole and 0.85 cm at the caudal pole. The right adrenal gland measures 2.77 cm long x 1.22 cm at the cranial pole and 0.77 cm at the caudal pole. Surrounding mesenteric fat is slightly enhanced/hyperechoic.

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.

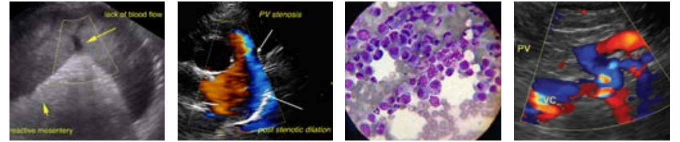
Liver

Liver is subjectively enlarged (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.

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 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.



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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 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 observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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

- **Bilateral adrenomegaly –** consistent with this patient's history of hyperadrenocorticism and Vetoryl therapy.

- **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.

- **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

- **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.

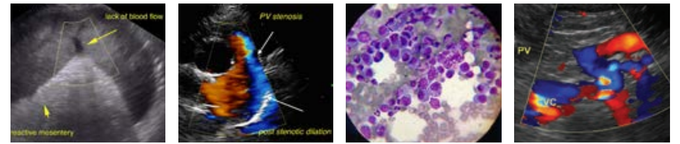
- **Pancreatic age-related remodeling –** Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's reported liver enzymes, a secondary hepatopathy may be present, and diagnostic considerations include testing for Leptospirosis as well as liver sampling in the form of a fine needle aspirate if patient's coagulation status is appropriate.

Additionally, given the mild bowel and pancreatic changes, a reactive hepatopathy could be present secondary to bowel or pancreatic disease, and considerations could include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

Finally, however, if this patient is receiving Vetoryl once daily, the patient could be remaining hypercortisolemic for the majority of the day. Many patients do better with a lower dose, but twice daily



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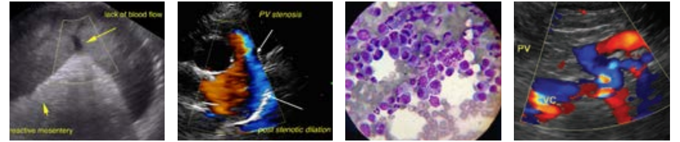
(i.e., 10-15 mg twice daily versus 30 mg once daily). If the Vetoryl is already being administered twice daily, disregard this suggestion.



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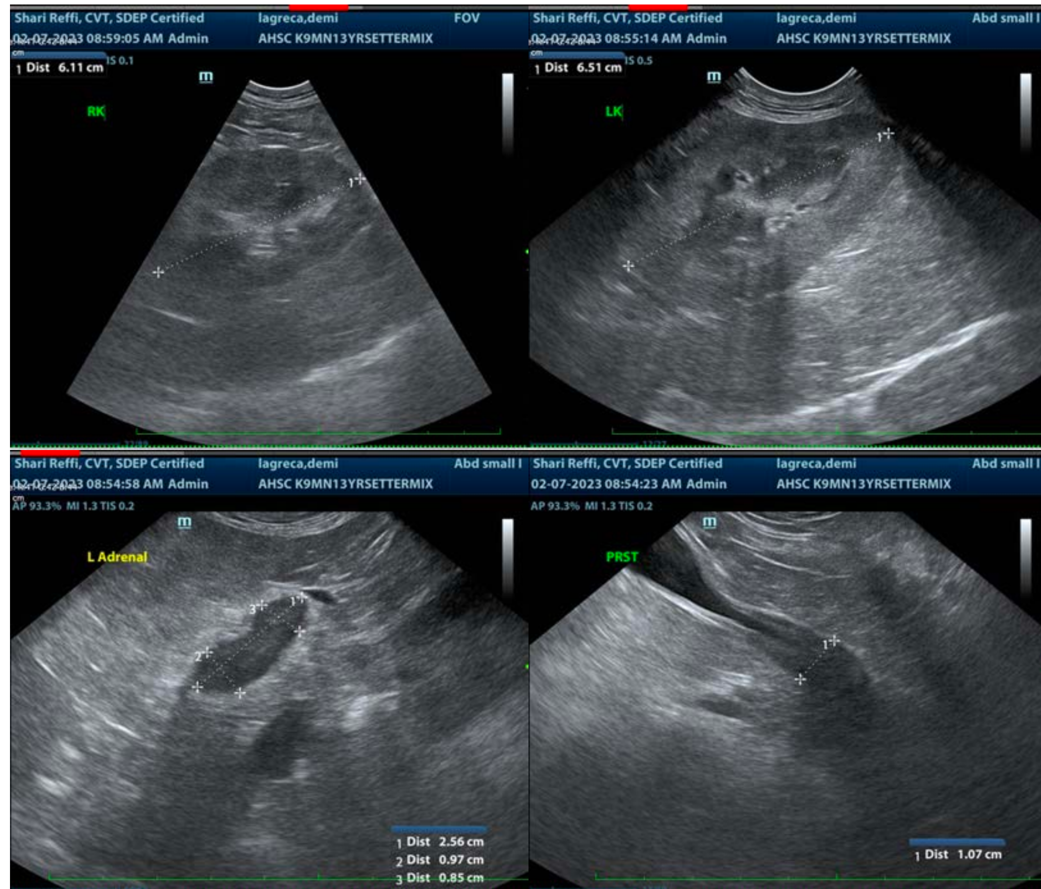

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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