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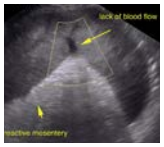
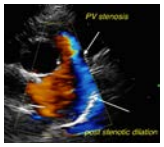
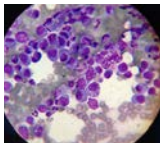
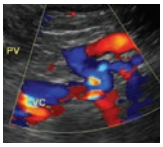

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1-800-838-4268 info@sonopath.com

PATIENT

Elektra Sosnak

SPECIES

Canine

BREED

Beagle

SEX

Spayed Female

AGE

10 Years

WEIGHT

20.3 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Jessica Bailes

HOSPITAL NAME

All Creatures Great & Small

REFERRING VET

Dr. Jessica Bailes

INVOICE

45739

DATE

3/7/23

PRESENTING CLINICAL SIGNS

Hx of intermittent lethargy, poor appetite, vomiting and soft stool. Much improved w/ EN or I/D diet as well as intermittent cerenia and gabapentin use. Is currently experiencing an episode of lethargy, poor appetite, soft stool. Hx of Pu/PD - LDDST performed - diagnostic for HAC but unable to DfDx between PDH or ADHAC. Trilostane started @ 10mg PO BID once GIT symptoms resolved; ACTH stim WNL so far even when patient experiencing GIT symptoms. Also hx of severe proteinuria - currenty on telmisarten 10mg/day and proteinuria improved (UPC was 10.2; now 1.2); was also on enalapril but had to D/C as elevated renal values noted when on enalapril. Also hx of liver mass - previous aspirates suspicious for hepatoma - thoracic rads taken and were clear.

Abnormal PE/Chem/CBC/UA Results: Pendulous abdomen, otherwise NSF on PE. Recheck ACTH stim, recheck BW/urinalysis pending today.

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. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface. A tiny, non-obstructive mineral density within the urethra is noted.

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. The right kidney measures 5.37 cm. The left kidney measures 5.14 cm.

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. Visible surrounding vasculature appears normal. The right adrenal gland measures 2.53 cm long x 0.78 cm at the cranial pole and 1.09 cm at the caudal pole. The left adrenal gland measures 2.21 cm long x 0.51 cm at the cranial pole and 0.73 cm at the caudal pole.

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

Diffusely, the liver is subjectively enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Focally, in the mid caudal liver, there is a 5.0 cm in diameter, mildly heterogeneous, iso- to hypoechoic mass with a small cystic/cavitated center. Visible vasculature and biliary tree appear normal without distension or congestion.

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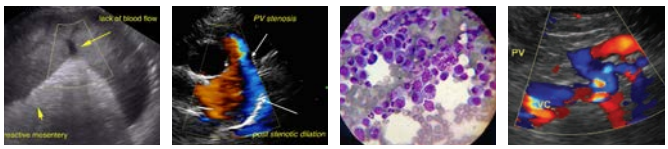

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Gallbladder is moderately distended with anechoic bile as well as mild suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine 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.

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

- **Bilateral adrenomegaly –** consistent with this patient's previous diagnosis of hyperadrenocorticism and current treatment with Trilostane.
- **Diffusely heterogenous liver with a liver mass –** 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. The liver mass has reportedly been cytologically diagnosed as a benign hepatoma. The mass is relatively static in size and appearance to the previous ultrasound.

SECONDARY FINDINGS

- Age related kidneys
- Urinary bladder debris with a tiny non-obstructive urethrolith suspected.
- **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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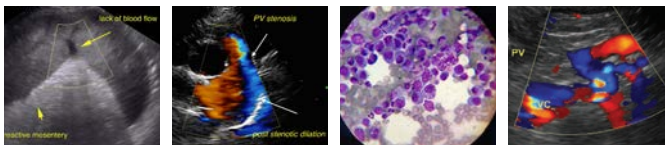

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of this study is relatively static to the previous exam. Given the urinary bladder debris, if a urinalysis and culture have not been recently obtained as part of Cushing's management, then a 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 ration is recommended.

Additionally, if not recently evaluated, a blood pressure is recommended.

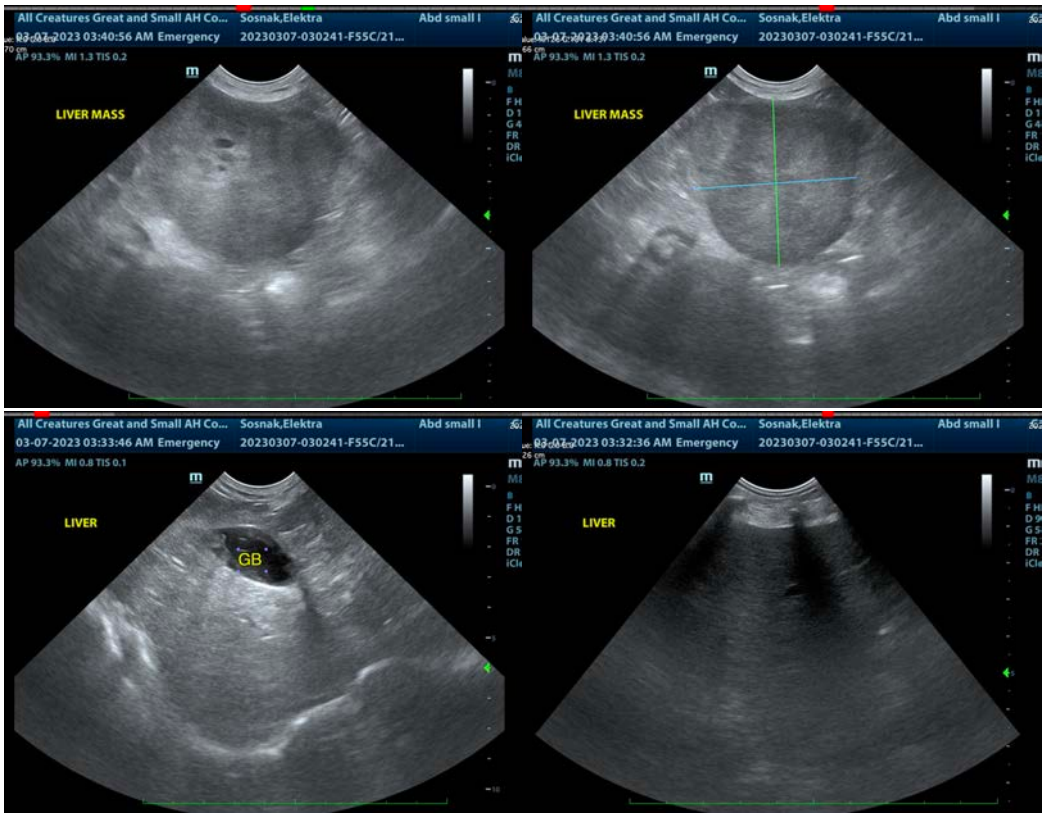
Given this patient's recurrent diarrhea despite management of the hyperadrenocorticism, follow up of the liver mass, etc., further evaluation of the gastrointestinal tract specifically is recommended, beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

Additionally, a fecal exam is recommended if not recently evaluated.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several attempts may be required.

Ultimately, if clinical signs persist, and a diagnosis is not reached, further evaluation of the GI tract via upper and lower endoscopy for visualization and biopsies may be warranted.



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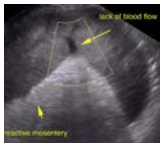
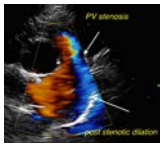
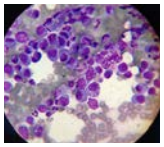
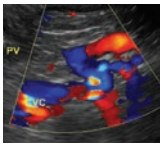

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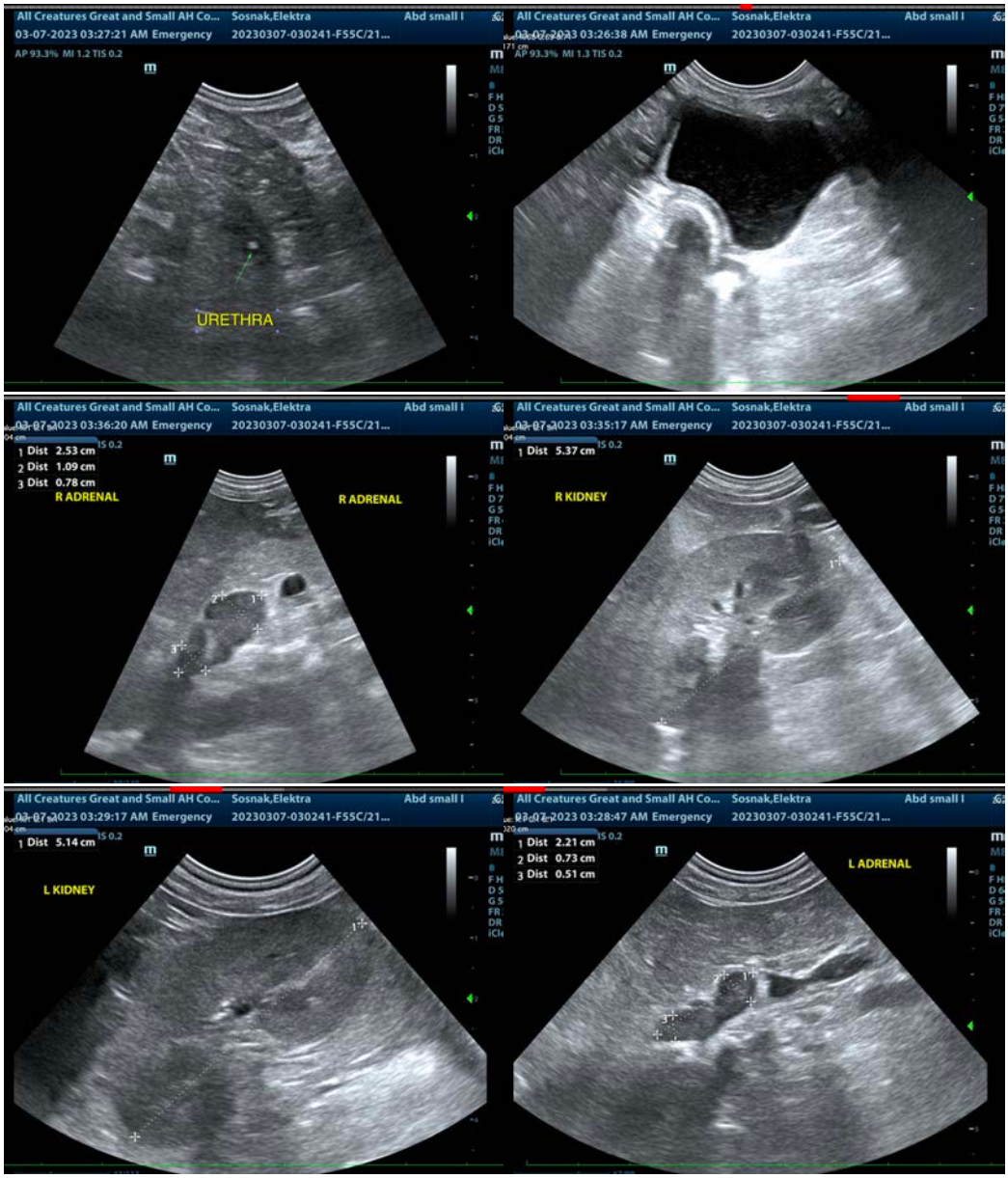

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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