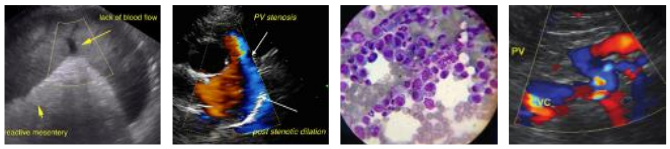
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Leo Statz

SPECIES
Canine

BREED
Bulldog

SEX
Neutered Male

AGE
11 Years

WEIGHT
83 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Brian Klug

HOSPITAL NAME
Sondel Family VC

REFERRING VET
Kara Wallisch

INVOICE
23102

DATE
6/26/23

PRESENTING CLINICAL SIGNS

History: Presented on 6/9/23 for panting a lot and not able to lose weight. Not PUPD. Sometimes coughing- suspect related to narrowed trachea vs BOAS. Performed additional testing and suspect early Cushings, possibly pituitary. On Thurs 6/22/23, P had a grand mal seizure. Scheduled for US today. P had a grand mal seizure while on US table, lasting appx 20-30 seconds. Other concurrent diagnoses: KCS OS, dental disease, narrowed trachea/tracheal collapse/brachycephalic airway syndrome

Abnormal PE/Chem/CBC/UA Results: BCS: obese 9/9, hair loss over both flank regions with hyperpigmentation of skin, otherwise quiet. Stertor & stridor when breathing. Large amount of sticky ocular discharge from uncontrolled KCS on L eye. ALP 492 Chol 366 Rest of Chem wnl CBC wnl T4 wnl Chest rads unremarkable, very narrow trachea LDDST: (results attached)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately 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 area of the prostate is examined without evident prostatic pathology.

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. Small cortical cysts are noted bilaterally. The left kidney measures 6.29 cm. The right kidney measures 5.98 cm.

Adrenal Glands

Left adrenal gland is mildly plump in size (0.77 cm at cranial pole and 0.82 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

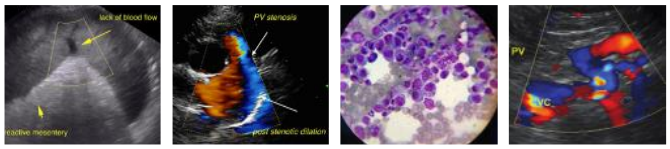
Right adrenal gland is mildly plump in size (0.73 cm at cranial pole and 0.78cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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. Splenic vasculature appears normal.

Liver

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.



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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 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 empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas 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 evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Mild age-related kidney changes with incidental small bilateral cortical cysts
- Mildly symmetrically plump adrenal glands- could be suggestive of early or emerging pituitary dependent hyperadrenocorticism, however, normal patient variant is just as possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patients reported panting, alopecia, etc., pituitary dependent hyperadrenocorticism could be emerging, however, the results of the low dose dexamethasone suppression test, while low dose dexamethasone suppression tests are not 100% sensitive, don't fully support pituitary dependent hyperadrenocorticism. Additionally, even patients with pituitary macroadenomas, often do not present with seizures. Therefore, in my opinion, a different cause of the seizures is more likely. Having said that, further evaluation of possible underlying causes of vascular events, that could have led to seizures, is recommended, beginning with looking for evidence of proteinuria via urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended. A blood pressure is also recommended, if not recently evaluated.

Pending results, further evaluation for possible pituitary macroadenoma, as well as other intracranial causes of the possible seizures, could be considered with advanced imaging, such as a CT scan, or even better, MRI of the brain.

In my opinion, addressing any proteinuria and/or hypertension present, as well as further working up the seizures should be pursued prior to considering medical management of possible early or emerging pituitary dependent hyperadrenocorticism, at least at this time.

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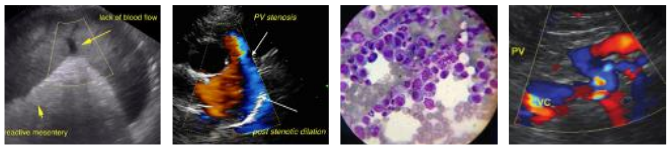

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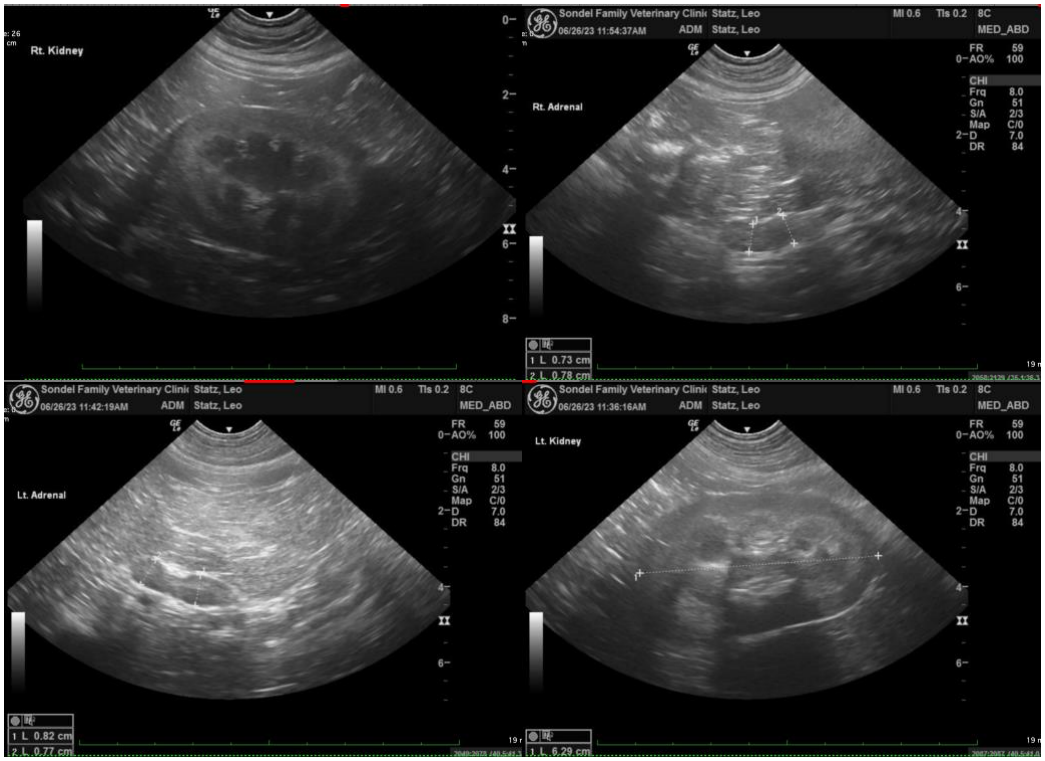

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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