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Clinical Sonography & Telecytology
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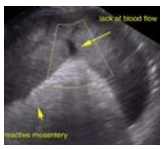
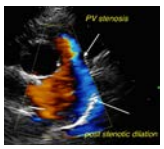
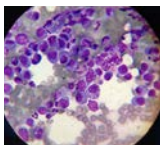
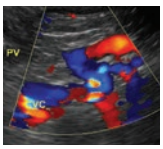

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1-800-838-4268 info@sonopath.com

PATIENT
Mugsy Smith

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
Neutered Male

AGE
11 Years

WEIGHT
13.8 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Bethany Coe

HOSPITAL NAME
Riverside AC

REFERRING VET
Dr. Bethany Coe

INVOICE
38570

DATE
6/9/22

PRESENTING CLINICAL SIGNS

Severe PU/PD and weight loss noted 1/2022. Slight inappetence, but no v/d. Diagnosed with hyperadrenocorticism via LDDST end of January. Pt started on low-dose BID Trilostane 2/1/2022. No improvement clinical signs, per owner. ACTH Stim showed inadequate control. Trilostane dosing increased gradually, first on 2/23/22, then again on 3/16/22. On 3/28/22, ACTH stim repeated (still borderline on efficacy) but patient still PU/PD and still losing weight. No change Trilostane dosing. On 5/16/22, patient not eating well, bloody diarrhea. CBC/Chem WNL. Recommended to stop Vetoryl. Patient started on 1.5mg Prednisone EOD, given SQ LRS/Cerenia in-hospital. At recheck 4 days later, still not eating well, NOT Pu/Pd (on Prednisone), no diarrhea. Diarrhea recurred 6/1/22, continued inappetence and profound weight/muscle loss. Ultrasound recommended. Owner considering euthanasia.
Abnormal PE/Chem/CBC/UA Results: Elevated ALKP/GGT, USG 1.006 in 1/2022. LDDST supportive of Cushing's in 1/2022. Chemistry normal in 5/2022 (on Vetoryl). Repeated ACTH stim testing never achieved "adequate" control of Cushing's, though did improve.

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

The right kidney is normal in size (5.76 cm) 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 echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (5.7 cm) 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 echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The left adrenal gland is swollen/plump in size (2.65 cm long x 1.0 cm at the cranial pole and 1.0 cm at the caudal pole). Normal shape and contour are maintained. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

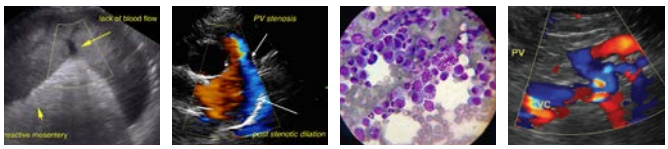
The right adrenal gland is swollen/plump in size (2.09 cm long x 1.0 cm at the cranial pole and 0.83 cm at the caudal pole). Normal shape and contour are maintained. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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

Liver is subjectively enlarged. Margins are smooth but round. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and



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increased echogenicity relative to the spleen. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

GB 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.

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 (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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 (< 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 peritoneal effusion. There is no apparent lymphadenopathy.

PRIMARY FINDINGS

- Bilateral adrenomegaly – consistent with adrenal hyperplasia secondary to pituitary depending hyperadrenocorticism vs normal variant.
- Hyperechoic hepatomegaly – most consistent with benign steroid (endocrine) hepatopathy or reactive or idiopathic hepatopathy. Infiltrative neoplasia such as round cell neoplasia is also possible, but considered less likely.
- 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.

SECONDARY FINDINGS

- Age related kidney change – This finding is expected/consistent with age-related mild degenerative disease and should be interpreted clinically in combination with laboratory changes.

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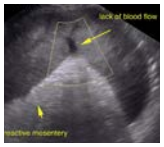
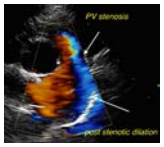
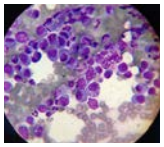
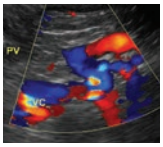

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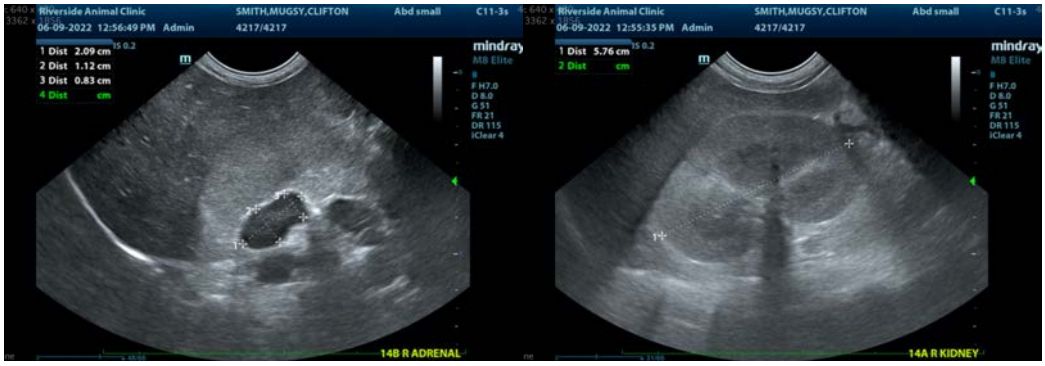
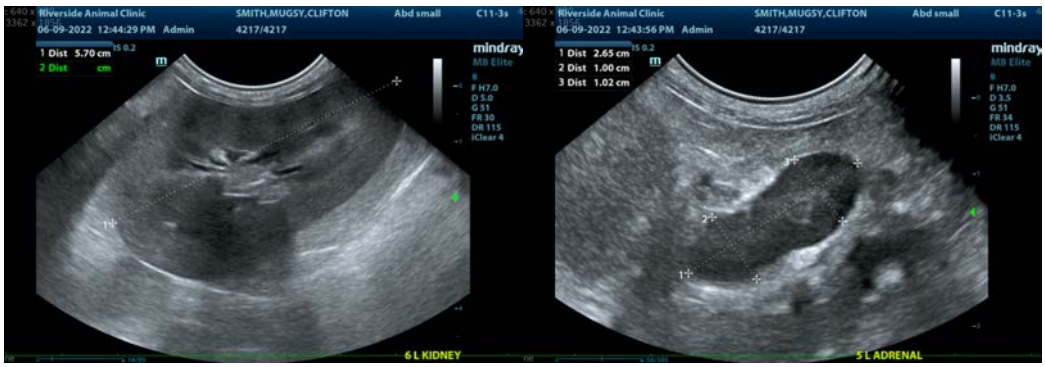
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the long-term decreased appetite combined with the most recent GI signs, a gastrointestinal malabsorption panel including TLI, PLI, folate and cobalamin to Texas A&M GI laboratory is recommended for further assessment of gastrointestinal and pancreatic function.

The adrenomegaly, liver changes, and gallbladder changes combined with the historical PU/PD are all certainly consistent with hyperadrenocorticism. However, it is atypical for hyperadrenocorticism to result in decreased appetite or weight loss.

Therefore, recommendations include continuing to assess and manage the decreased appetite and concurrent weight loss prior to restarting Vetoryl. Recommendations for this include assessment of dental health and/or orthopedic or cervical pain and/or other neurologic disease contributing to the decreased appetite. A blood pressure is recommended due to the hyperadrenocorticism, if not recently evaluated, as is a urinalysis with follow up urine culture, if indicated based on urinalysis results. Follow up UPC recommended if indicated based on urinalysis results, in case protein loss is also contributing to weight loss.





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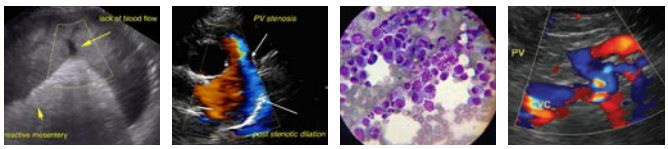

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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