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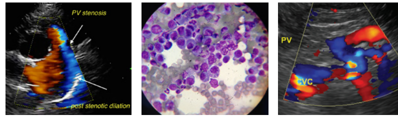

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

7/19/22

PATIENT

Chaz Moore

SPECIES

Canine

BREED

Cocker Spaniel

SEX

Neutered Male

AGE

7/27/09

WEIGHT

17.5 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Andi Parkinson RDMS

HOSPITAL NAME

Honeygo AH

REFERRING VET

Dr. Wright

INVOICE

39667

PRESENTING CLINICAL SIGNS

Cushing's, recent weight loss and muscle atrophy.

Current Medications: Vetoryl 30mg SID, Apoquel 8mg PRN, Vetprofen 25mg PRN (not often).
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 area of the prostate is examined without evident pathology.

The right kidney is normal in size (6.53 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 (6.84 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

The right adrenal gland is enlarged (4.71 cm x 2.66 cm) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted without evident capsular escape or vascular invasion.

The left adrenal gland is normal in size (2.35 cm long x 0.70 cm at the cranial pole and 0.74 cm at the caudal pole), shape and contour. 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 (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 visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. 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 area of the pancreas contains irregular hyperechoic pancreatic remodeling.

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

- **Right adrenal mass –** consistent with adenoma or possibly hyperplasia. Early pheochromocytoma cannot be ruled out. Interpret in combination with clinical signs of hyperadrenocorticism or other adrenal disease.

- **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.

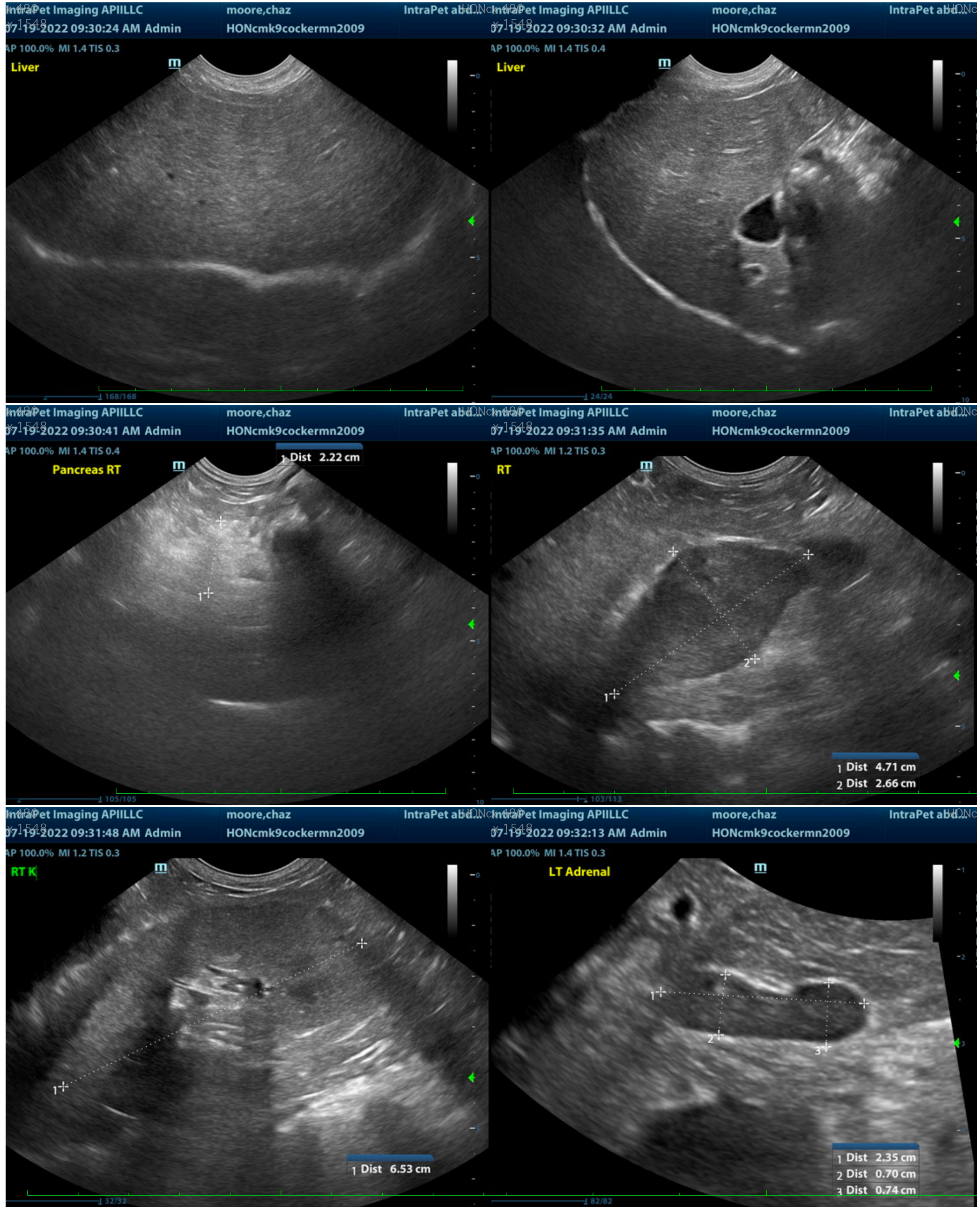
- **Hyperechoic pancreas –** This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Weight loss is not a typical presenting complaint for hyperadrenocorticism. Therefore, given the appearance of this patient's pancreas, etc., a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

- As stated above, likely unrelated to this patient's weight loss, the hyperadrenocorticism may be poorly regulated due to the presence of a right adrenal mass. Options to consider could include hormone testing in the form of a low-dose Dexamethasone suppression test to definitively diagnose adrenal dependent hyperadrenocorticism, at which time an adrenalectomy could be discussed, versus a transition from Vetoryl to Trilostane for more aggressive medical management of the adrenal mass.

- If these more aggressive options are not elected, and Vetoryl is continued, a lower twice daily does such as 10 mg twice daily or 20 mg twice daily versus the once daily dose may help minimize clinical signs, as some patients do much better with twice daily dosing when it comes to clinical sign management.



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Liver
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RT K
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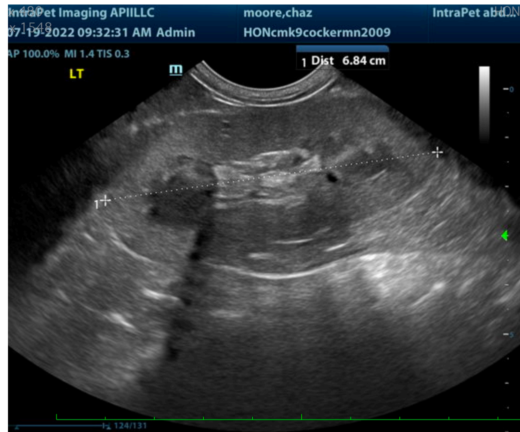
LT Adrenal
1 Dist 2.35 cm
2 Dist 0.70 cm
3 Dist 0.74 cm



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
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