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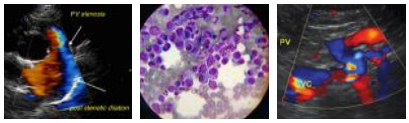

SonoPath
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DATE
8/2/22

PATIENT
Lady Baker

SPECIES
Canine

BREED
Pitbull

SEX
Spayed Female

AGE
7/26/13

WEIGHT
39 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

HOSPITAL NAME
Pleasantville AH of Fallston

REFERRING VET
Dr. Gounaris

INVOICE
16683

PRESENTING CLINICAL SIGNS

History: Diagnosed as hyperadrenal Cushing disease November 08,2021 and 60 mg once a day trilostane was started. Around March 7 2022 owner feels is doing poorly and losing weight and poor appetite, the ACTH stim test showed low cortisol levels, the trilostane was discontinued and restarted at a much lower dose. She was better but has waxed and waned not doing well since then despite low trilostane doses, has lost weight. Even when owner gives only 5 mg trilostane once a day feels she acts lethargic. The past two baseline cortisol levels done pre trilostane or when not on trilostane have been 6.4 on March 16 2022 and cortisol of 6.3 on May 19, 2022 and routine blood tests May 25 2022 showed
blood levels of Alk phos of 1169 and ALT of 191

Current Medications: Apoquel 8 mg daily for skin allergies when needed, not on trilostane currently.
Lab Results: Elevated alk phos around 1000, mildly elevated ALT around 190. Low dose dex suppression test November 2021 showed baseline 9.7, 4 hour 6.4, 8 hour 6.0
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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.

Left kidney is normal is size (7.3 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.

Right kidney is normal is size (7.21 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 measured 3.46 cm long x 1.05 cm at the cranial pole and 0.97 cm at the caudal pole. The right adrenal gland measured 3.46 cm long x 1.05 cm at the cranial pole and 0.91 cm at the caudal pole.

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 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.

Gallbladder is moderately distended with anechoic bile as well as 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 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, except for the duodenum, which 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 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 appreciable free fluid.

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

A prominent but non-pathologic uterine stump is visible.

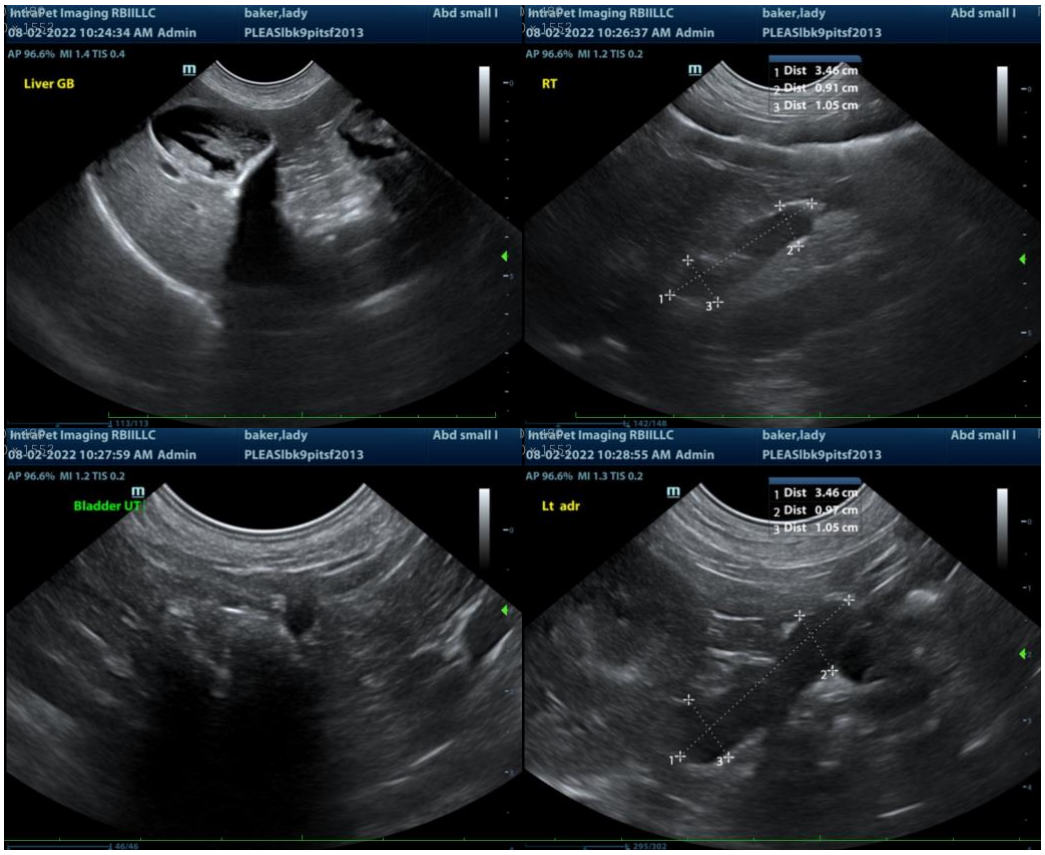
ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenomegaly. Consistent with the reported history of hyperadrenocorticism followed by trilostane 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.
- 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.
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient's ultrasound images are consistent with the historical diagnosis is hyperadrenocorticism, followed by trilostane therapy without an evident cause for the reported ADR/gastrointestinal signs present ultrasonographically. Given the timeline with trilostane therapy and clinical signs, recommendations include full discontinuation of the trilostane until clinical signs of hyperadrenocorticism, such as polyuria/polydipsia, panting, etc. return. At that time, trilostane can be restarted at an ultra-low dose with close monitoring for recurrence of clinical signs or this patient may not tolerate trilostane at the dose required to maintain clinical signs, in which case, alternative therapies including lysodren, could be considered. As a side note, most patients with hyperadrenocorticism do better with low, twice daily dosing with trilostane versus high, once daily dosing.

In the meantime, if not recently evaluated, a blood pressure is recommended, as well as 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.



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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