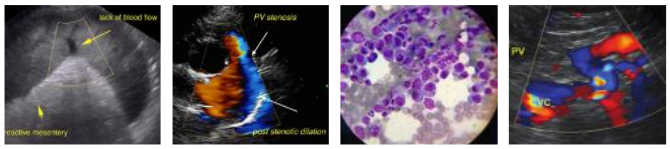
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Coco Lovelace

SPECIES

Canine

BREED

Beagle

SEX

Neutered Male

AGE

13 Years

WEIGHT

18.4 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Moser

INVOICE

17022

DATE

8/24/22

PRESENTING CLINICAL SIGNS

History: Presented at our hospital for AUS. Started with symptoms of cushings, took to rdvm, dx cushinoid based off LDDS (USG was 1.004 and Alkp was >1000 and GGT elevated) started treatment and started feeling better for about 5 days. Then lethargic again, NE, refuses treats. Took back to rdvm, did bloodwork, liver values were elevated, rec AUS. Previous Health Concerns: no Current Medications: Cereina inj today at rdvm, Vetoryl Appetite/When did they eat last: small amt this am

Abnormal PE/Chem/CBC/UA Results: Rdvm bloodwork: MCV 57.1; MCH 20.2; RDW 24.1; Retic Hemo 21.4; PDW 8.6; Chl 105; ALP >2000; GGT 26; Chol 338

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.

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

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 left kidney measures 5.97 cm. The right kidney measures 6.51 cm.

Adrenal Glands

Left adrenal gland is normal in size (2.5 cm long x 0.59 cm at cranial pole and 0.92 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.59 cm at cranial pole and 0.74 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

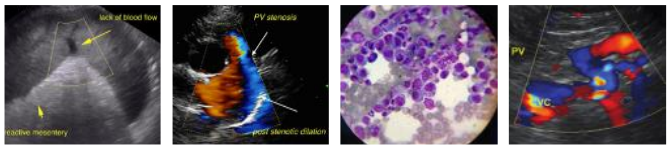
Spleen contains several mixed partially cavitated nodules/masses; one is a 2.0 cm nodule near the cranial pole head of the spleen, that results in capsular bulge, and the other is a 3.0 cm x 3.5 cm mass, that disrupts the capsule near the caudal or tail end of the spleen.

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



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The visible stomach wall is normal in thickness and layering. The lumen of the stomach 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. 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

Primary Findings

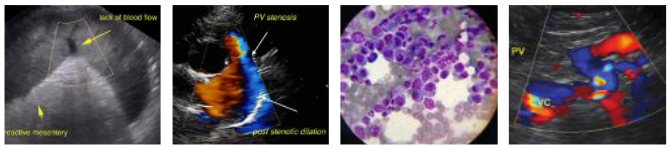
- Two hypo- to anechoic cystic splenic nodules/masses. This could represent benign lesions, such as cysts, hematomas, nodular hyperplasia or extramedullary hematopoiesis. However, infiltrative neoplasia can mimic benign lesions and cannot be ruled out.
- Hyperechoic hepatomegaly – This appearance is 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.

Secondary Findings

- Age-related kidney changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's splenic changes, recommendations include three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated, followed by either a fine needle aspirate of the splenic nodules, if patients coagulation status is appropriate, or given the risk of hemorrhage, etc. with any cavitated splenic lesions, even benign ones, an exploratory laparotomy for a planned splenectomy could be pursued alternatively. This finding, however, may not be the cause of the patients acute clinical decline, as some patients can't tolerate Vetoryl at the doses needed to control



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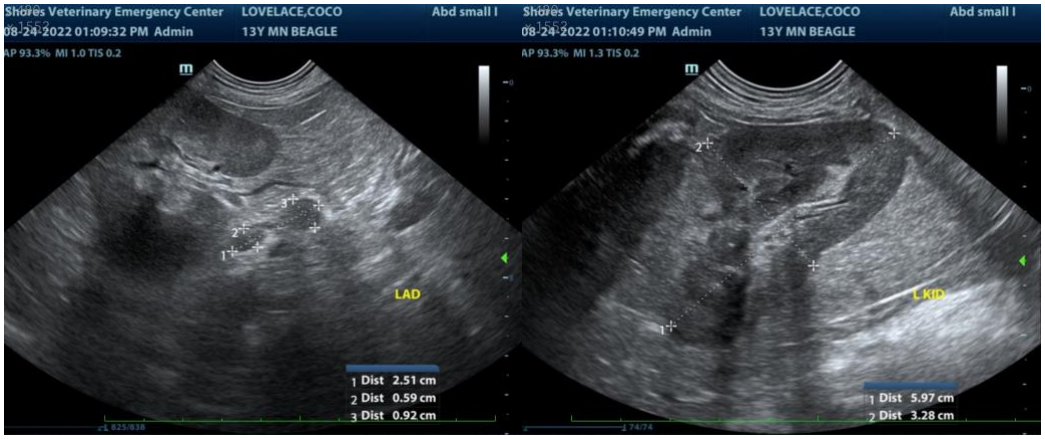
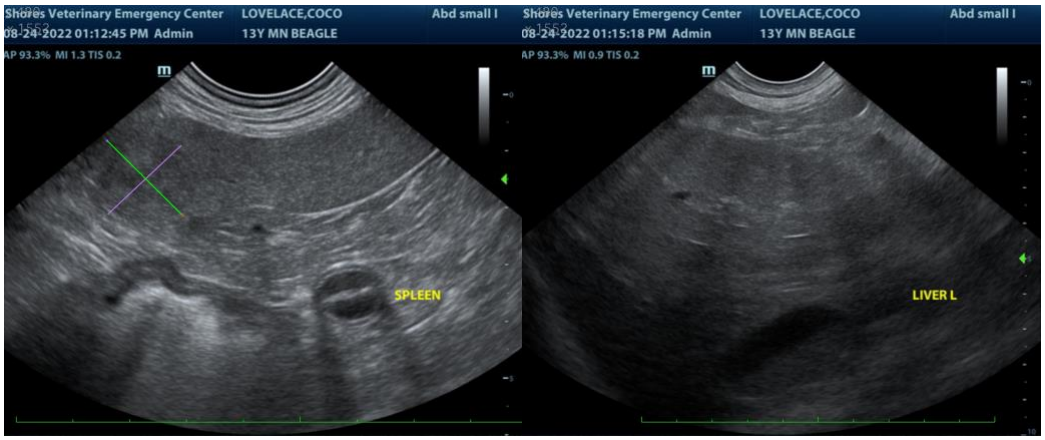
the hyperadrenocorticism. Therefore, recommendations include discontinuation of the Vetoryl until after the splenic lesions are addressed and until clinical signs of hyperadrenocorticism return, at which time it can be restarted at a lower dose. Ideally, a low 2x per day versus a high 1x per day dose.

In the meantime, an ACTH stimulation test can be obtained to help determine whether or not cortisol levels are appropriate at this current dose.





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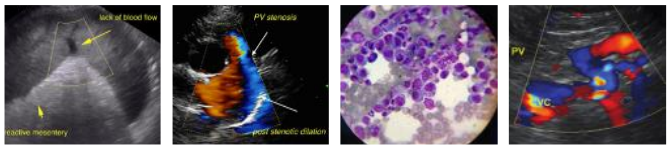

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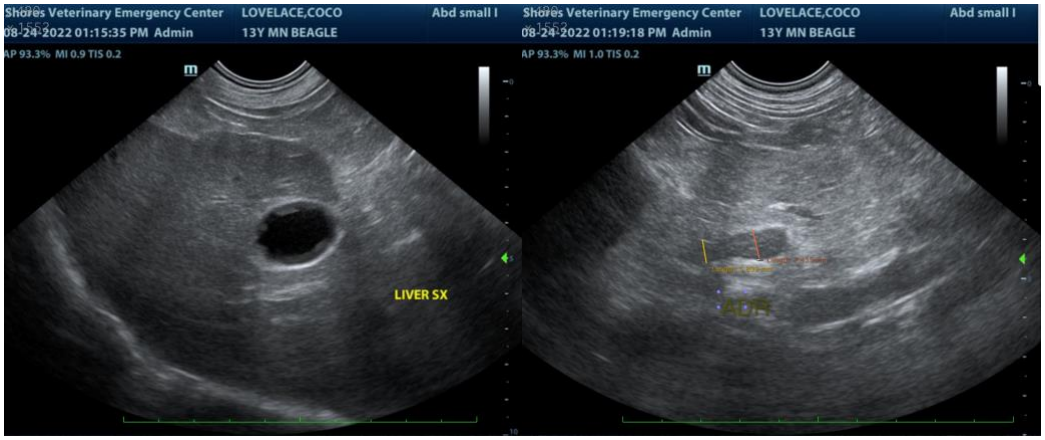

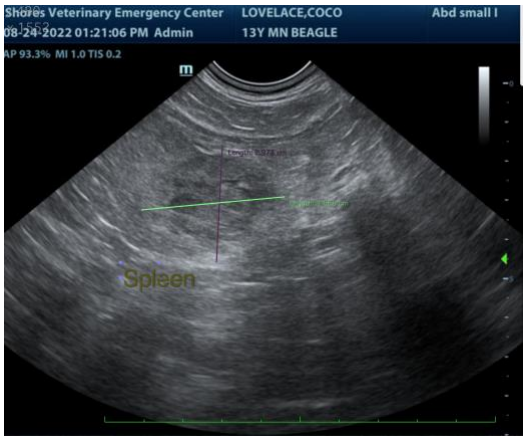

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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