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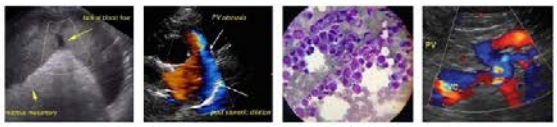


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Tessa Howarth

SPECIES

Canine

BREED

Cocker X

SEX

Spayed Female

AGE

11 Years

WEIGHT

10.2 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

BPH Ancaster

REFERRING VET

Dr. Davis

INVOICE

40153

DATE

8/4/22

PRESENTING CLINICAL SIGNS

Was diagnosed with cushings forgot one dose of her meds and everything went wrong not eating not drinking eyes are all red and swollen had infection on her back which mad way up to the neck blood coming out near back end How long has this change been present? about a month or so ago meds: trilostane 20mg

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 right kidney is normal in size (6.76 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 (5.65 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 2.58 cm long x 1.13 cm at the cranial pole and 0.89 cm at the caudal pole. The right adrenal gland measured 2.27 cm long x 1.37 cm at the cranial pole and 0.71 cm at the caudal pole.

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.

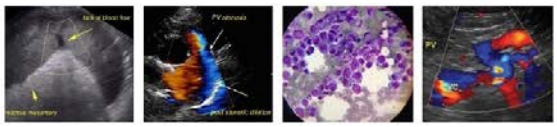
Liver

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.

Gallbladder is mildly overdistended with 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.



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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 free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- **Bilateral adrenomegaly** – consistent with the reported historical diagnosis of hyperadrenocorticism and 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.
- **Emerging 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

CBC/Chem panel, electrolytes and urinalysis are recommended if not recently evaluation. At this time, the ultrasound findings described above are consistent with the diagnosis of hyperadrenocorticism with no obvious visible cause for the patient's acute decline, unless this patient is clinical from the emerging mucocele. Decisions regarding gallbladder disease management should be made in combination with supporting laboratory changes and/or physical exam findings such as cranial abdominal pain, etc, which if present would warrant proceeding with a possible cholecystectomy.

Similarly, the liver changes are likely secondary to chronic hyperadrenocorticism. However, if liver enzyme changes suggest an inflammatory process, etc., a fine needle aspirate of the liver could be considered as well.

Otherwise, in this patient's history, it was noted that blood is coming from the patient's back end, and it is not clear if this from the described dermatologic problems or if this is hematochezia. If hematochezia is noted, a fecal exam is recommended followed by empirical deworming with a 5-day course of Panacur, Metronidazole or Tylosin, and potentially a probiotic.

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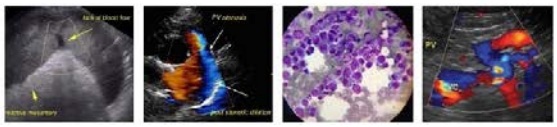

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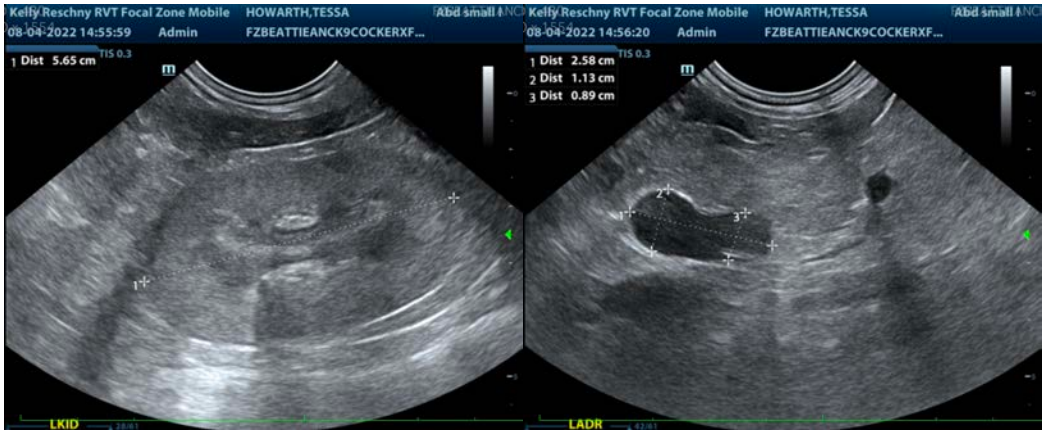

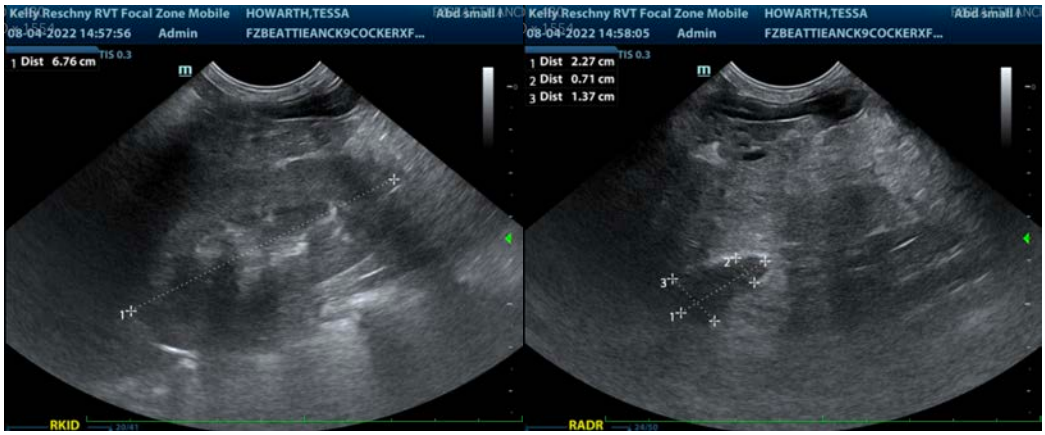

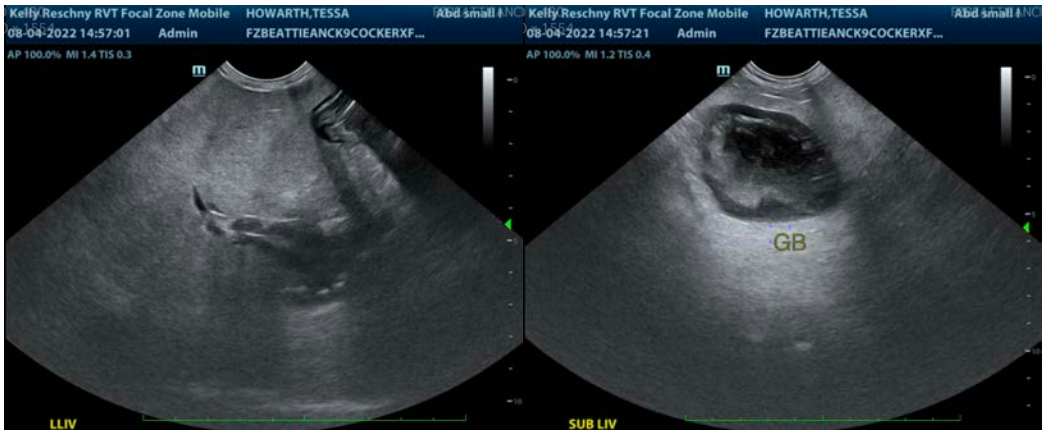

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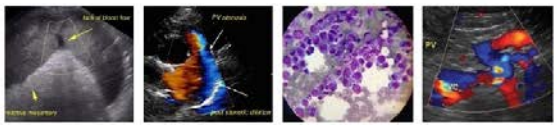

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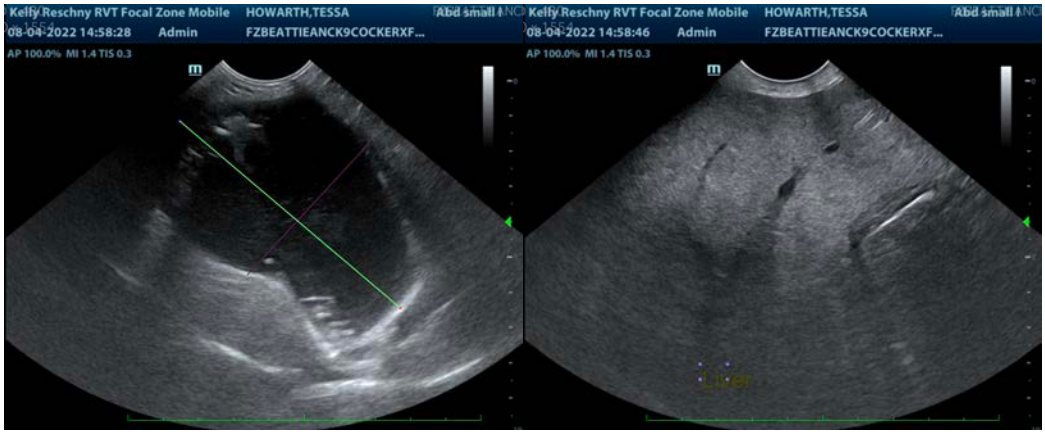

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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