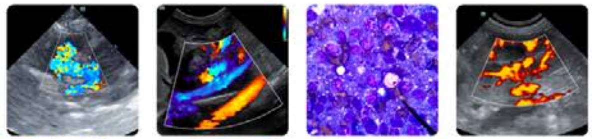


PATIENT

Katie Beard

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

15 Years

WEIGHT

19.6 kg

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Haley Harasimowicz

HOSPITAL NAME

Waterbury Veterinary Hospital

REFERRING VET

Dr. Emily Crawford

INVOICE

73443

DATE

3/5/26

PRESENTING CLINICAL SIGNS

Geriatric dog with multifocal OA and very stiff gait. Suspect atypical hyperadrenocorticism. PE 2/26 reveals pendulous abdomen, cranial organomegaly. US to rule out neoplasia and to evaluate adrenal glands. PPH: Dog had sudden weight gain in early 2024 and owner also noted pu/pd, panting, and abd distention. Dog had very mild ALT elevation at that time and normal ALP. Elevated urine cort:creat (home-caught), so proceeded with LDDST and ACTH Stim testing. Workup was not conclusive for Cushing's Dz: r/o early disease vs. atypical Cushing's Dz. ACTH wnl though post high normal (see lab section below). This workup was all done 2024. Recommended follow up LDDST in coming months but symptoms stabilized and dog has had annual baseline bw, no additional tests for Cushing's. Dog has clinically been stable, overall well except progressive mobility concerns.

Abnormal PE/Chem/CBC/UA Results: Recent labwork 2/26 reveals ALT 266, ALP 241, GGT 15. All else wnl. Prior results—spring 2024 LDDST done spring 2024: Pre. 2.0 4hr post. 1.2 8 hr post. 2.1 ACTH stim testing Pre 1.7 Post 17.7 Idexx interpretation key: 6-18 5-15 Normal Post-ACTH cortisol 18-22 15-19 Equivocal post-ACTH cortisol >22 >19 Post-ACTH cortisol consistent with hyperadrenocorticism

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen. No papillae seen.

The right kidney presents normal size (6.5 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

The left kidney presents normal size (5.6 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adrenal Glands

The right adrenal gland measures at the upper end of normal limits for size. Caudal pole measures 6.5 mm. Cranial pole measures 9.0 mm.

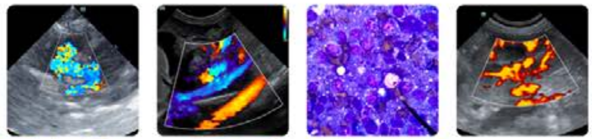
The left adrenal gland measures at the upper end of normal limits for size but is otherwise normal in appearance. Caudal pole measures 7.6 mm. Cranial pole measures 7.0 mm.

Spleen

The spleen is normal in size, shape, margination and echogenicity. There are hyperechoic lesions within the spleen that are most likely benign myelolipomas. A representative lesion measured 4.5 mm x 2.9 mm. In the body of the spleen there is a 2.4 cm x 3.0 cm capsule displacing lesion. The dorsal aspect of this lesion has multifocal hyperechoic foci present within it. The lesion is not cavitated.

Liver

The liver is mildly diffusely enlarged and diffusely hyperechoic with normal echotexture. Liver margins are rounded. Within the right liver cranial to the gallbladder there is a 6.6 mm in diameter round, hyperechoic lesion present.



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The gallbladder presents normal size with a moderate amount of aggregated echogenic debris adhered to the luminal margin of the gallbladder. Normal gallbladder wall. No evidence of bile duct distention or obstruction.

Gastrointestinal

The stomach wall is diffusely normal in thickness and layering, measuring 3.5 mm in width. The jejunum is diffusely normal and measures 4.3 mm in width with normal layering. Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Upper end of normal/slightly enlarged bilateral adrenal glands – Consistent with a diagnosis of possible pituitary dependent hyperadrenocorticism.
- Gallbladder debris – Possible bacterial cholangitis.
- Hyperechoic lesions within the spleen, most likely benign myelolipomas.
- Splenic mass described may represent malignant neoplasia such as hemangiosarcoma or may be a benign hemangioma.
- Enlarged, hyperechoic liver – most likely consistent with vacuolar hepatopathy caused by patient's suspected hyperadrenocorticism.
- Hyperechoic lesion cranial to the gallbladder within the liver – most likely a benign regenerative nodule.

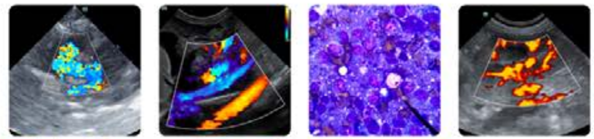
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the gallbladder debris, recommend aspirate of bile via ultrasound guidance with submission of the bile for aerobic and anaerobic bacterial culture and cytology to rule out bacterial cholangitis.

The low-dose Dexamethasone suppression test from Spring 2024 support hyperadrenocorticism. Recommend starting treatment with Trilostane at 1mg/kg by mouth every 12 hours and adjusting dose based on ACTH stimulation test results performed every 10-24 days after starting Trilostane.

Recommend a fine needle aspirate of the splenic mass. If cytology is inconclusive, there are two options. The first would be to monitor the mass via ultrasound over the next 2-3 months to determine if it is increasing in size or becoming more concerning in its appearance. If the mass is changing in appearance, then consider splenectomy and submission of spleen for histopathology. The other option would be to consider splenectomy at this time and submission for histopathology.

If possible, attempt a fine needle aspirate of the hyperechoic liver lesion cranial to the gallbladder to rule out a neoplastic cause.



SonoPath.com info@sonopath.com 1.800.838.4268

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No suspicion for renal disease seen on this exam.

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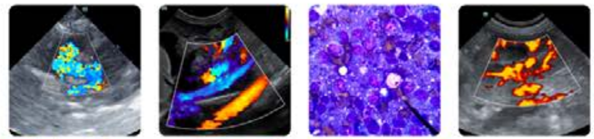

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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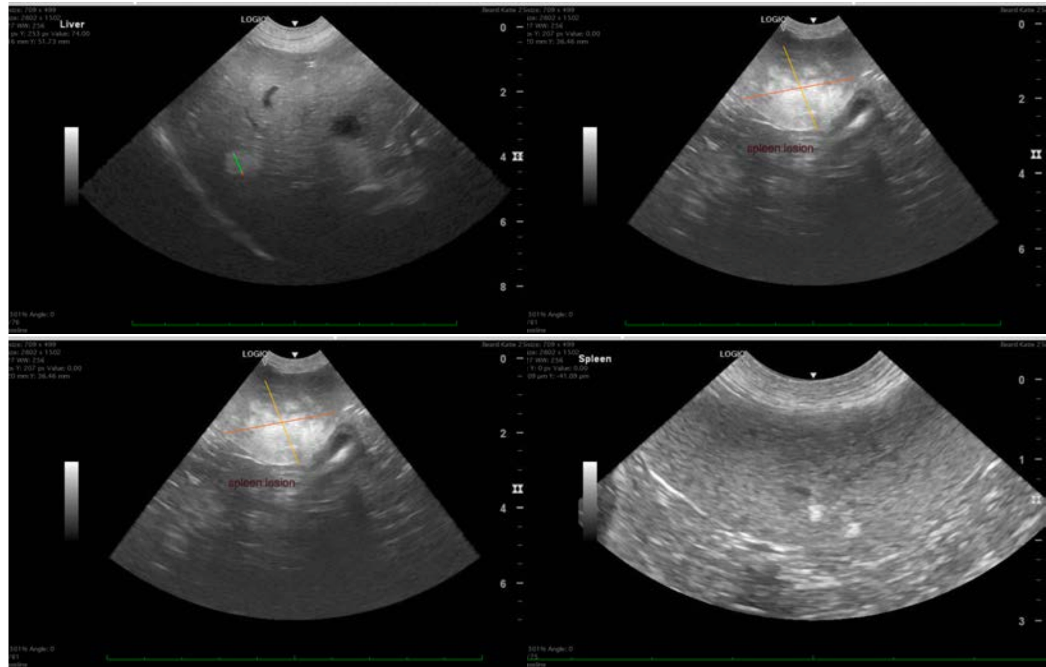

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com