IMAGING PERFORMED BY

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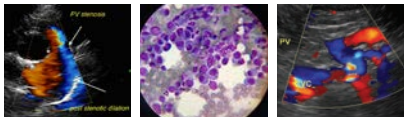

SonoPath
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DATE

10/13/21

PATIENT

Rey Parris

SPECIES

Canine

BREED

Border Collie

SEX

Spayed Female

AGE

2/12/14

WEIGHT

57.6 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Westminster VH

REFERRING VET

Dr. Hall

INVOICE

26254

PRESENTING CLINICAL SIGNS

History: Patient presented for routine exam on 8/2/21. At this appointment owner noted that patient had been savaging the yard and everything she can for the last month or so. Pet also seems to eat her food more quickly than she used to. PE: mostly unremarkable. Bloodwork was recommended to further work up the polyphagia, owner returned on 9/9/21 for this to be completed. Concern for Cushing's was noted, and pet was scheduled for a LDDST which confirmed Cushing's diagnosis but not if it was pituitary vs adrenal dependent. Abdominal US was recommended to decipher

Current Medications: No current medications.
Lab Results: 9/9/21: LAB RESULTS CBC - stress leukogram, otherwise WNL; CHEM - ALT 370 H, ALP 4062 H, GGT 67 H, Chol 716 H, CL 105 L, otherwise WNL; UA - USG 1.006 (LOW), no bacteria, no WBC; T4 1.7; Fecal OPG neg. 9/16/21: LDDST pre- 5.0ug/dL, 4hr post: 2.8ug/dL, 8hr post: 4.5 ug/dL. The result of the low dose dexamethasone suppression (LDDS) test in this dog may support a diagnosis of hyperadrenocorticism and does not differentiate pituitary-dependent from adrenal-dependent disease.
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Gabapentin 200mg PO upon arrival to the hospital.
Stat Report: not requested

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (7.02 cm) with pinpoint non-obstructive nephroliths. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.48 cm) with pinpoint non-obstructive nephroliths. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal to slightly enlarged in size measuring 0.86 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal/borderline enlarged in size measuring 0.94 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver
The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal
The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas
The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Mild bilateral adrenomegaly – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.

- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

- Focal shadowing material within the gastric lumen – Given the history of polyphagia, this could represent foreign material or could be consistent with a recent meal. Correlate with feeding history and abdominal radiographs if needed. There is no evidence of an obstruction.

SECONDARY FINDINGS

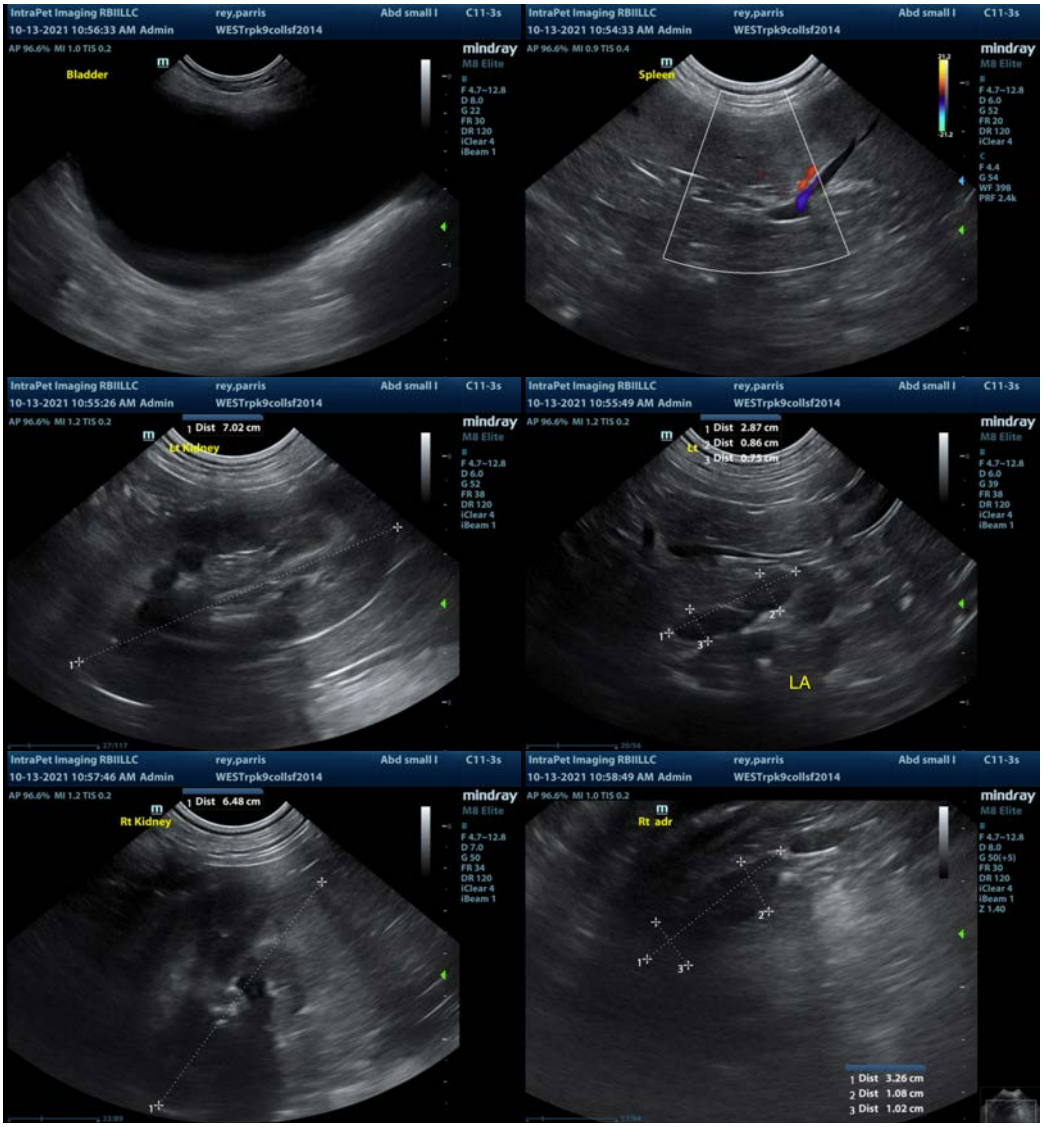
- Mild gallbladder sludge – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

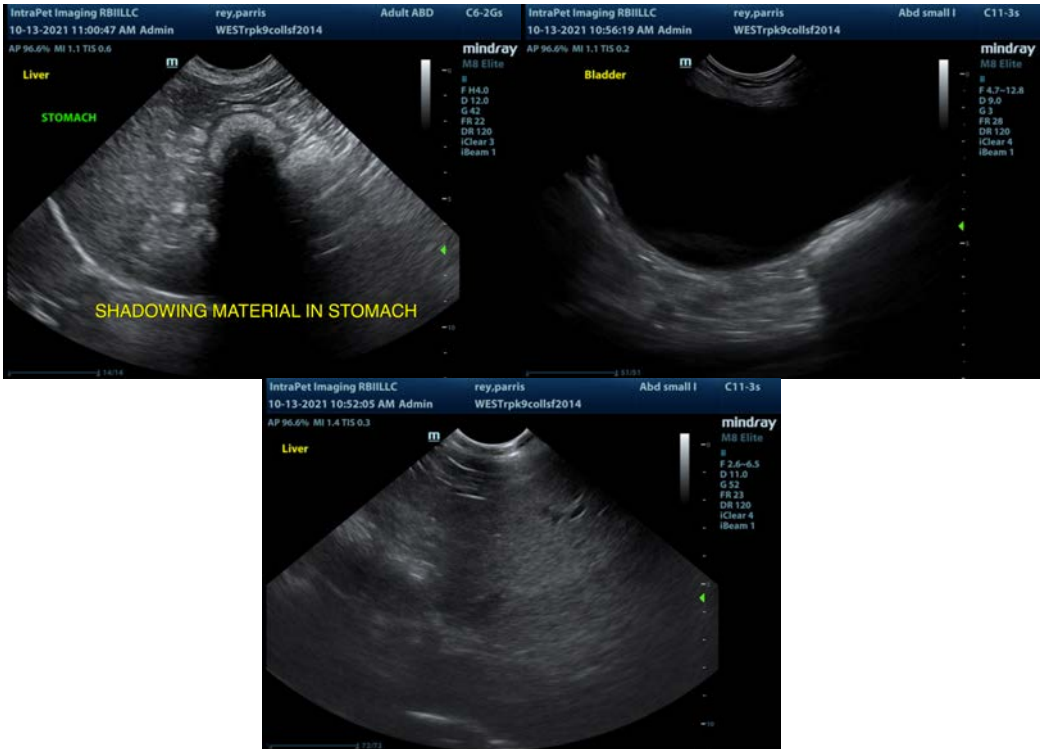
- Pinpoint non-obstructive nephroliths in both kidneys – The hyperechoic mineralized foci observed at the corticomedullary junction of the left/right kidney are consistent with small, non-obstructive nephroliths.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's ultrasonographic findings would be most consistent with a diagnosis of pituitary dependent hyperadrenocortism if this fits clinically. The changes observed in the liver likely represent a vacuolar or steroid hepatopathy.

There is some discreet shadowing material within the gastric lumen. if there is any vomiting or GI signs, consider abdominal radiographs to evaluate for foreign material.





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.

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