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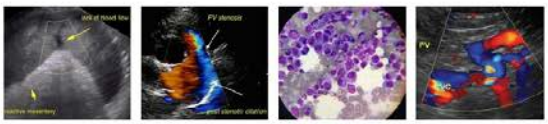


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Samson Ingram

SPECIES

Canine

BREED

Wirehair Pointing Griffon

SEX

Intact Male

AGE

10 Years

WEIGHT

74 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Desert Hills AH

REFERRING VET

Dr. Jen Vittori

INVOICE

42945

DATE

11/22/22

PRESENTING CLINICAL SIGNS

Sedation dex/torb Patient has been well controlled on Vetoryl for Cushing's disease for past 3 years. P has gradually lost approximately 30 pounds over last 3 years after starting tx for Cushing's, however 11 pound weight loss has occurred over last 8 months since P last seen. P became mildly inappetant approximately 2 weeks ago. Senior panel LW performed, ACTH stimulation test showed levels within range indicating good control of Cushing's disease, however LW also showed IRIS stage II renal disease. O's declined rx diet, strongly interested in homecooking, thus gave O options for nutritional consultation. However, O's report P became very acutely lethargic and stopped drinking water on Thursday night last week. Took P to BluePearl Reno (Emergency clinic) where he was dx'd as Addisonian. P started on Percorten injection Saturday 11/19 and also started initially on Predisone. P currently on Dexamethasone PO, changed over from Prednisone so as to avoid interference with next ACTH stimulation test when this needs to be done. Will tentatively plan on repeat general LW and ACTH stim test in 6 weeks from now according to recs from DVM at BluePearl. Scheduled tech appt for 11/30 for recheck lytes and explained treatment/control of electrolyte levels with Percorten injections. 11/30 will be 10 day mark after starting Percorten, and will tentatively plan on recheck again at day 25. Explained that Percorten will usually be given q 25-30 days based on individual levels of electrolytes. Continue Dexamethasone PO as instructed, advised no changes. Discussed physiologic dose of this rx, and should not interfere with renal function although will monitor closely with stage II renal disease. I have never had a Cushings patient convert to Addisonian, and feel it may be unusual to have this happen after being so well controlled with Vetoryl for over 3 years.

Abnormal PE/Chem/CBC/UA Results: CHest Rads: NSF

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

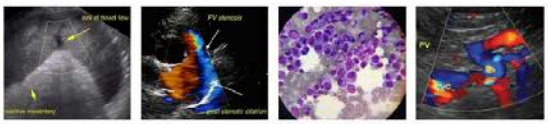
Urinary System

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 prostate is large, hyperechoic and mildly heterogeneous, measuring 2.95 cm. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (6.8 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. The cortex appears somewhat mottled with pinpoint hyperechoic foci (likely mineralizations). There are also numerous small cortical cysts and mild pyelectasia at 0.25 cm. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (7.34 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. The cortex appears somewhat mottled with pinpoint hyperechoic foci (likely mineralizations). There



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are also numerous small cortical cysts. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is borderline large in size measuring 0.93 cm at the cranial pole, 0.81 cm at the caudal pole, and 3.75 cm in length. 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 large in size measuring 1.22 cm at the cranial pole, 1.0 cm at the caudal pole and 3.9 cm in length. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is slightly abnormal in appearance in that there is some mottling and ill-defined hyperechoic tissue in the cranial pole. This area roughly measures 1.83 cm x 0.98 cm and does not disrupt the normal shape of the adrenal gland. There is no evidence of vascular invasion visualized.

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. There is a very large mixed echogenic mass effect visualized in the left medial aspect of the liver. This mass has somewhat ill-defined hyperechoic margins, but a more discrete center with hypoechoic areas likely representing necrosis. This mass lesions measures 6.61 cm x 8.63 cm.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. 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 layers 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. Duodenum wall measures 0.52 cm. Jejunum wall measures 0.37 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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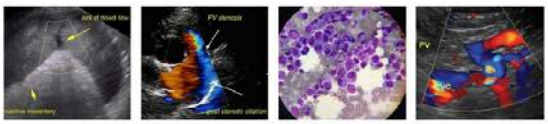

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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized 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. A mesenteric lymph node is visualized measuring 0.57 cm. The omentum is of normal uniform echogenicity.

Other

A brief view of the heart was submitted. No significant pericardial effusion was seen.

The left and right testicles are visualized and appear within normal limits.

ULTRASONOGRAPHIC FINDINGS

- Large, heterogeneous prostate – Findings are most consistent with benign prostatic hypertrophy +/- prostatitis.
- Bilateral adrenomegaly with an ill-defined hyperechoic region in the cranial pole of the right adrenal gland – 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. The hyperechoic focus in the right adrenal gland is of uncertain nature. Recommend continued monitoring with ultrasound for progression of this lesion.
- Decreased corticomedullary distinction in both kidneys with somewhat mottled cortex with cysts and pinpoint hyperechoic foci – Findings are most consistent with chronic progressive renal disease.
- Large, mixed echogenic liver mass – This mass effect is somewhat ill-defined, but the center is more encapsulated and there is a hypoechoic region that is concerning for possible necrosis/abscessation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large mixed echogenic hepatic mass present. The hypoechoic center is concerning for possible necrosis. Recommend a contrast CT scan and evaluation for surgical removal. If this is a primary hepatic mass (adenoma or carcinoma), the prognosis can be good if surgical removal is possible.

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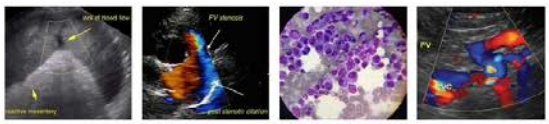

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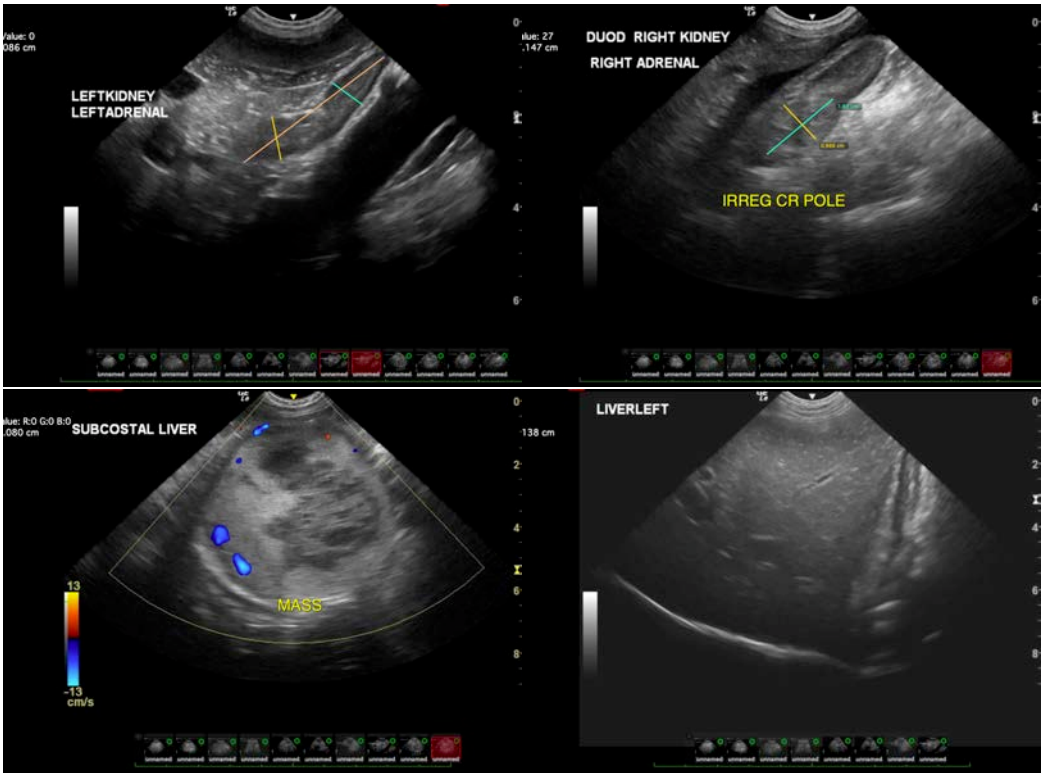
Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

Both adrenals are large, as would be expected with Cushing's disease. It is not uncommon for the medication dosing to change over the course of a patient's treatment. I suspect this dog developed an additional illness, which causes stress and a relative adrenal insufficiency. Recommend close monitoring of this patient for the possibility of requiring significantly less steroids at some times and more during times of stress, keeping in mind that a physiologic dose is very low, and there is a strong possibility of reverting back to a cushingoid state (but not always).

The right adrenal appears somewhat irregular. Recommend continued monitoring with ultrasound in case this is a neoplastic lesion and monitor for change/progression. Additionally, if a contrast CT scan is done of the liver, the adrenal glands should be further evaluated.

Both kidneys appear abnormal and have significant parenchymal changes (cysts, mottling, pinpoint mineralizations, etc.). Recommend a blood pressure, urinalysis and culture as a baseline, and continued therapy and monitoring of likely underlying renal disease.

The prostate is large and heterogeneous. This is relatively normal for an intact male dog. Recommend the aforementioned urinalysis and culture also to screen for possible prostatitis.



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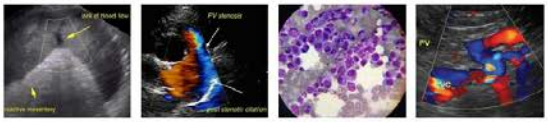

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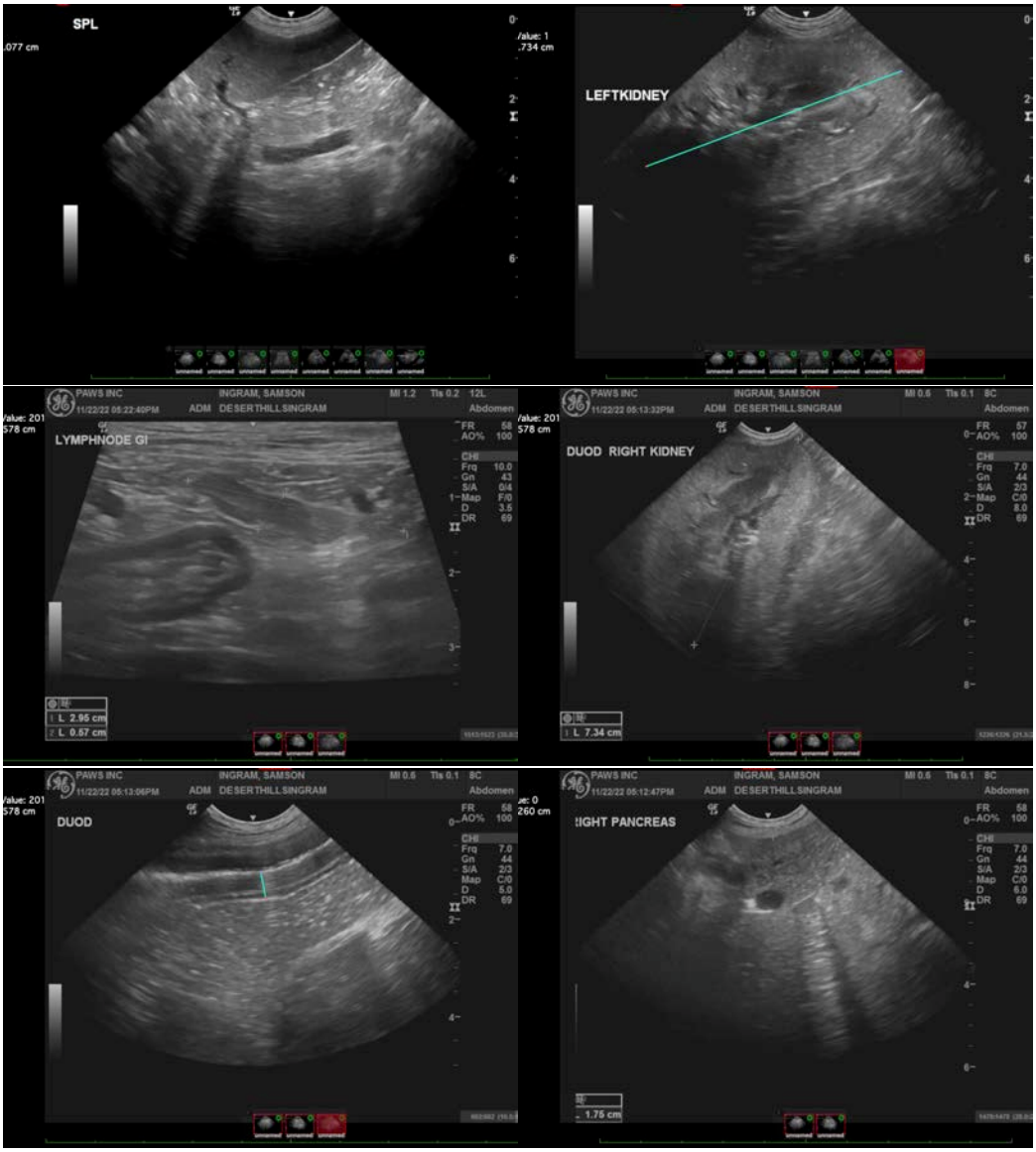

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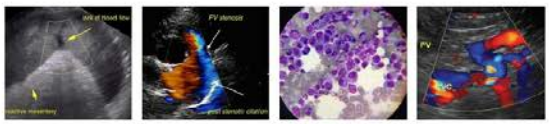

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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kathleen.sennello@sonopath.com