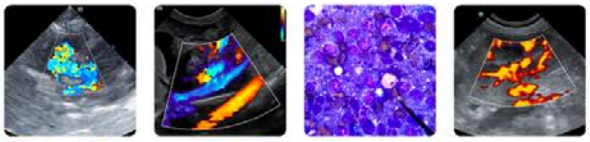


PATIENT

Jax Terrio

SPECIES

Canine

BREED

Boston Terrier

SEX

Neutered Male

AGE

9 Years 11 Months

WEIGHT

20.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Megan Cassels-Conway,DVM

HOSPITAL NAME

Central Broward Animal Hospital

REFERRING VET

Janeen Lezcano, DVM

INVOICE

71583

DATE

11/5/25

PRESENTING CLINICAL SIGNS

P presented for biannual wellness exam and follow up for HAC. O reports no v/c/s. Symptoms of HAC appear fairly controlled (ie OU/PD/PPD). O reports p appears to be "aging quickly", muscle loss and hair loss. P had giardiasis causing several incidents of marked severe enterocolitis. The Giardia appears to be resolved but p still has intermittent enteritis. P currently on i/d LF and canned Biome. On PE p does have generalized thinning of fur, muscle loss and pendulous abd. P is currently on Vetoryl 10mg po BID. P presented w symptoms compatible w HAC in 7/2024 AUS and LDDS test performed but unable to confirm. O eleceted to monitor and b/in for ACT stim test if symptoms recurred.

Abnormal PE/Chem/CBC/UA Results: 10/25: Chem: ALP: 165 PSL: 2711H; T4: 2.8 UA: SG: 1.047, 3+ prot, pyuria, bacteria, ACTH stim test, 5hrs post Vet: pre cortisol: 3.1, post cortisol: 5.5 fecal PCR: NEG 3/25: miniChem: creat: 0.7, Cortisol, pre-trilostane: 4.0 2/25: miniChem: ALP: 152H K: 5.3 ACTH stim test, 5hr post tril: pre: 4.8 post: 8.0 1/25: CBC: monocytosis Chem: ALT: 154H ALP: 243H GTP: 44H Phos: 6.1H creat: 0.6 T4: 2.0 UA: SG: 1.023, 3+ prot, quiet sediment ACTH stim test: pre: 4.1 1hr post: 30.2H 7/24: LDDS test: pre: 1.4, 4hr post: 0.8, 8hr post: 0.8 AUS: • Vacuolar hepatopathy liver pattern • Bilateral adrenal hypertrophy • Age-related kidney changes • Small bladder stone or accumulation of sand 7/24: Chem: creat; 0.7 ALT: 160H ALP: 172H GTP: 33H PSL: 206H T4: 1.6 UA: SG: 1.010, 2+ prot, UCS: NEG

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended with anechoic urine. The Bladder wall appears mildly thickened and irregular, measuring at 0.40 cm. In the dependent portion of the urinary bladder there are several small, hyperechoic foci most consistent with small stones visualized in the trigone area, extending into the pre-prostatic and prostatic urethra. These typically measure approximately 0.1 cm.

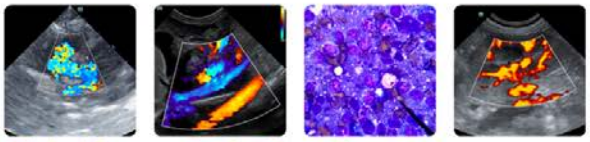
The prostate is normal in size (0.86 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (4.79 cm) with pinpoint mineralizations. Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (4.83 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. 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 large and hypoechoic, measuring 0.83 cm at the cranial pole and 0.97 cm a 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.



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The right adrenal gland is large and hypoechoic, measuring 0.79 cm at the cranial pole and 0.93 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 with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. 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 contains mild ingesta. 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 0.43 cm. Jejunum wall measures 0.33 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 right limb of the pancreas is prominent and mottled compared to the surrounding isoechoic 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

- Mildly thickened/irregular urinary bladder wall with pinpoint mineralizations extending into the pre-prostatic urethra – Recommend urinalysis +/- culture.

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- Bilateral adrenomegaly – Findings are most consistent with the current diagnosis of pituitary dependent hyperadrenocorticism.
- Hyperechoic hepatomegaly – Findings are most consistent with vacuolar hepatopathy. Other hepatopathies are possible.

SECONDARY FINDINGS

- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with chronic pancreatic remodeling.
- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

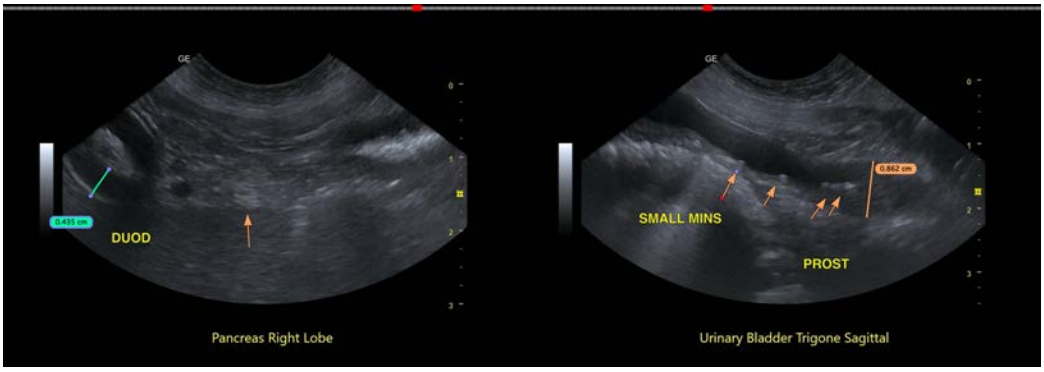
Many of the changes observed on today's scan are relatively similar to those previously described. The adrenals are large, and the liver is large and hyperechoic. These typically do not normalize with treatment.

There are persistent pinpoint mineralizations visualized in the trigone region and in the pre-prostatic urethra. Continued monitoring is warranted, as there could be some risk for these passing more distally into the urethra and causing more significant symptoms/partial obstruction, etc.

An obvious cause for the muscle loss, etc. is not clearly observed. You could consider increasing the dose of Trilostane for more tightened control of cortisol levels, but then there is always the potential risk of cortisol levels dropping to low, causing acute illness.

No significant changes were visualized associated with the GI tract. If underlying gastrointestinal disease is strongly suspected, you could consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate. If significant changes are present, further evaluation for an enteropathy could be considered.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).



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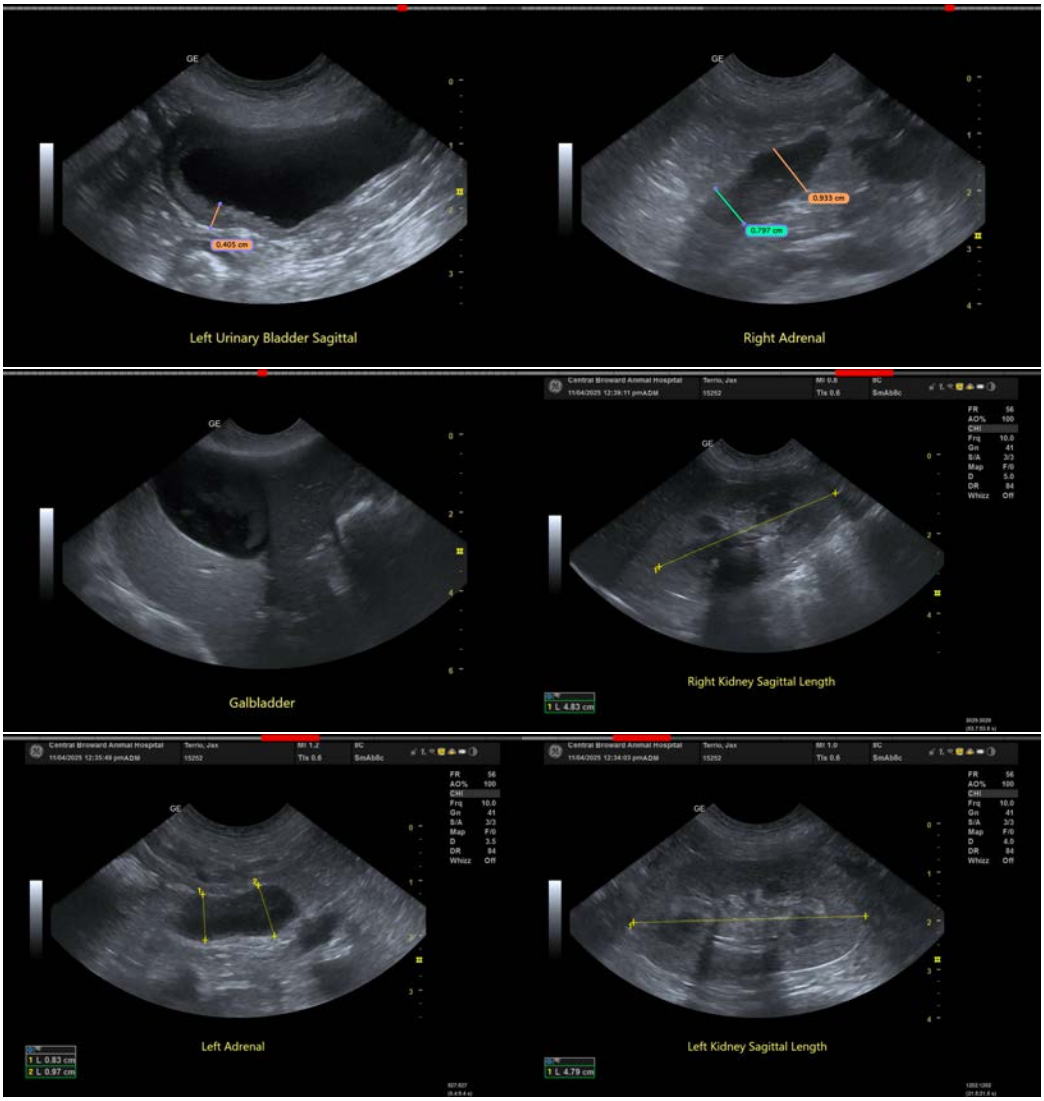

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com