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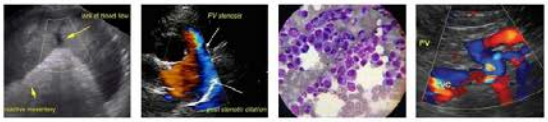

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Cooper Whitside

SPECIES

Canine

BREED

Coonhound

SEX

Neutered Male

AGE

9 Years

WEIGHT

80 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

REFERRING VET

Dr. Kristin Lee

INVOICE

40538

DATE

8/17/22

PRESENTING CLINICAL SIGNS

Chief Concern/Provisional Diagnosis: - Hyperadrenocorticism - Elevated liver enzymes - PU/PD - Skin and coat changes History/Physical Findings: Patient presents for PU/PD for the last year and has now become polyphagic and is exhibiting coprophagia with some weight loss. Upon physical exam, patient has mild periodontal disease, multiple subcutaneous masses, an alopecic scarred appearance patch on the right dorsal neck, and an alopecic patch on dorsal tail. BCS 5/9. Abnormal PE/Chem/CBC/UA Results: - Elevated ALT 126 (10-118 U/L) - Elevated ALKP 457 (20-150 U/L) - Systolic BP: 203mmHg - LDDST: Baseline - 1.5 ug/dL 4hr Post - 2.2 (0-1.1ug/dL) 8hr Post - 2.1 (0-1.1ug/dL) RADS of thoracic taken and pending rad report

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 normal in size 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 (7.91 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.18 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is borderline large in size measuring 1.1 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is somewhat abnormal in appearance in that there is a small hyperechoic focus in the caudal pole measuring 0.64 cm x 0.44 cm, which does not deform the margins of the adrenal gland. There is no significant vascular invasion observed.

The right adrenal gland is normal in size measuring 0.88 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. The spleen echotexture is heterogenous and mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is an ill-defined hyperechoic lesion measuring 1.24 cm x 0.87 cm and another lesion measuring 1.07 cm x 1.34 cm.

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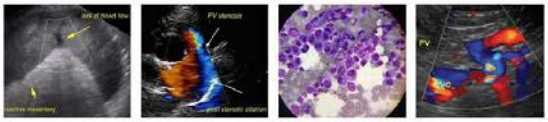

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Liver

The liver is subjectively normal in size, and hypoechoic 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 hyperechoic mixed echogenic nodule visualized measuring 2.0 cm x 3.64 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 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 measured 0.42 cm. Jejunum wall measured 0.43 cm. 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 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

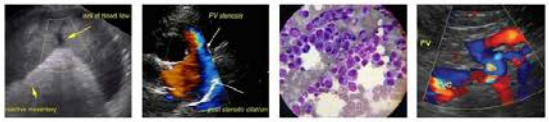
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. Mesenteric lymph nodes are visualized at 0.51 and 0.37 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Borderline 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.

- Hyperechoic focus in the caudal pole of the left adrenal gland – The significance of this is unclear. This could be an incidental finding or could represent an early benign or neoplastic lesion. Recommend continued monitoring.

- Mottled spleen with hyperechoic nodules – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis,



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infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

- Heterogeneous, hypoechoic liver with mixed echogenic nodule – 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. The ill-defined nodule could represent a benign or neoplastic process. Consider continued monitoring.

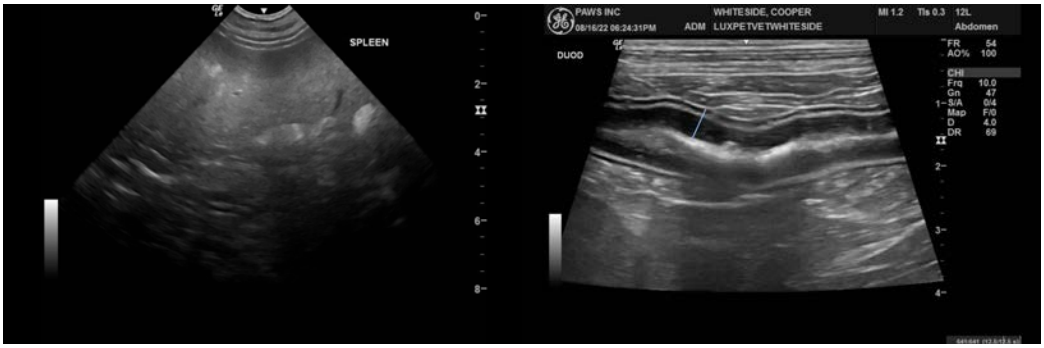
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both adrenal glands appear somewhat "plump" and there is a hyperechoic focus on the caudal pole of the left adrenal gland, which is of uncertain significance. Recommend close monitoring of the caudal pole of the left adrenal gland (recheck in approximately 8 weeks) to ensure that it is not changing rapidly.

The liver is heterogeneous and somewhat hypoechoic with an ill-defined mixed echogenic mass/nodule. Consider a baseline liver function test and fine needle aspirate of the liver, particularly the nodule if possible. The generalized heterogeneous liver could be secondary to a vacuolar hepatopathy. If Cushing's is strongly suspected and you would still like further confirmation, you could consider an ACTH stimulation test or an adrenal panel through University of Tennessee combined with an ACTH stimulation test.

The spleen appears somewhat mottled with some coalescing, mildly hyperechoic regions. If you're considered about an underlying neoplastic process, consider a fine needle aspirate.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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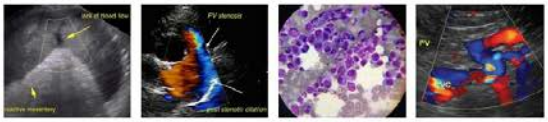

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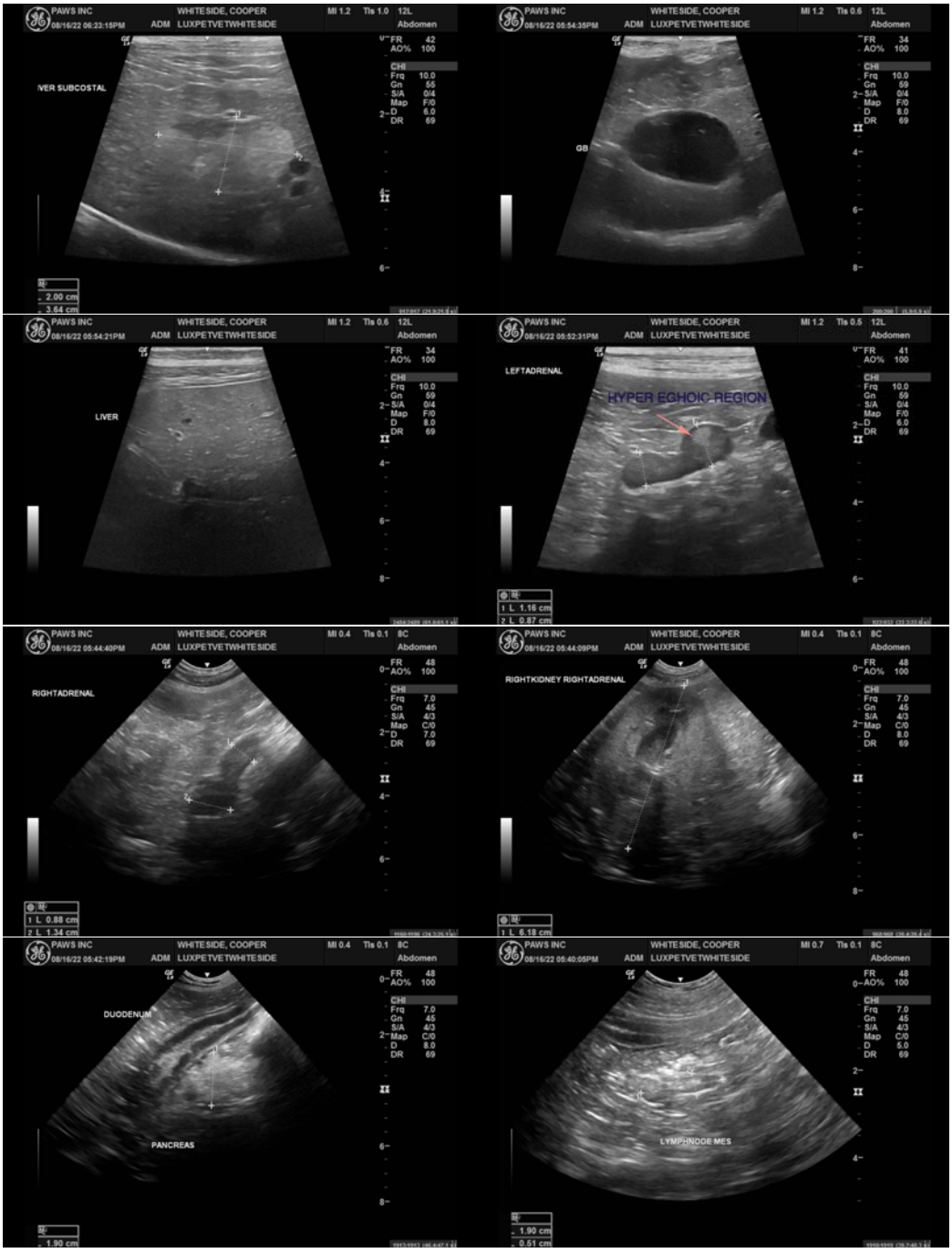

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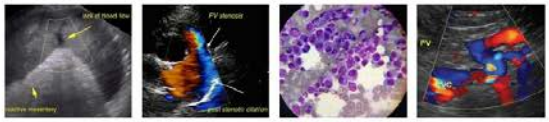

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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