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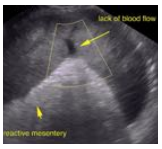
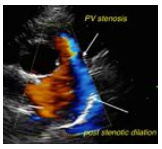
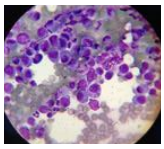
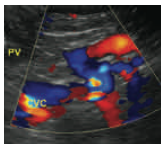

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Molly Alexander

SPECIES
Canine

BREED
Border Collie Mix

SEX
Spayed Female

AGE
12 years

WEIGHT
27.7 lbs

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

IMAGING PERFORMED BY
Dr. Harris

HOSPITAL NAME
TotalBond VH

REFERRING VET
Dr. Epstein

INVOICE
91370

DATE
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PRESENTING CLINICAL SIGNS

History: Progressive significant increases of ALP, new onset of PU/PD since modest bump in Phb dose; Prior LDDST Jan 2020 WNL; however recent UC:Cr and LDDST consistent w/ CCD but can not distinguish PD from AD. **Previous Hx refractory seizures, hypothyroidism, significant bile sludge and on polypharmacy: · ThyroTab 0.3 mg increasing to 1 2/3 0.5mg. Can refill w/ 0.5mg · zonisamide 100mg PO twice daily · Phenobarb 60 mg PO BID · Fenofibrate 54 mg 1/4 tab once daily · Levetiracetam, 250 mg tablets Give 1 tablet every 8 hours · Ursodiol, 250 mg 1/4 tablet orally every 12 hours. · Denosyl (225mg) once a day.

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 (5.62 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. Rare, small cortical cysts were noted. 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 (6.34 cm). Overall echogenicity is slightly hyperechoic with poor 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.

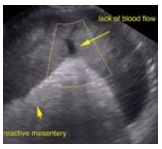
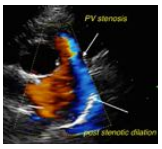
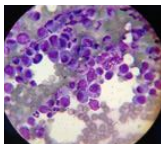
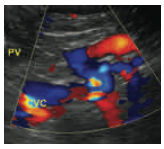
Adrenal Glands

The left adrenal gland is normal/subjectively large in size measuring 1.0 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/subjectively large in size measuring 1.06 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.

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Liver

The liver is subjectively large in size, and 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 gallbladder lumen is moderately distended. The wall of the gallbladder 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 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. The duodenum measured as normal (0.53 cm) and the jejunum measured as normal (0.35 cm, 0.39 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 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.

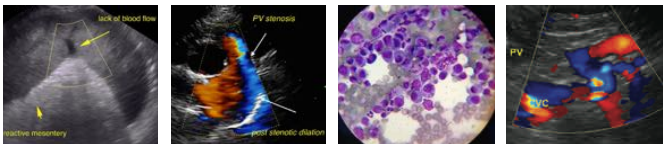
Free Abdomen

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.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Large, heterogenous 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.
- Mild gallbladder sludge. The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.
- Borderline bilateral adrenomegaly. The bilateral adrenomegaly could be consistent with



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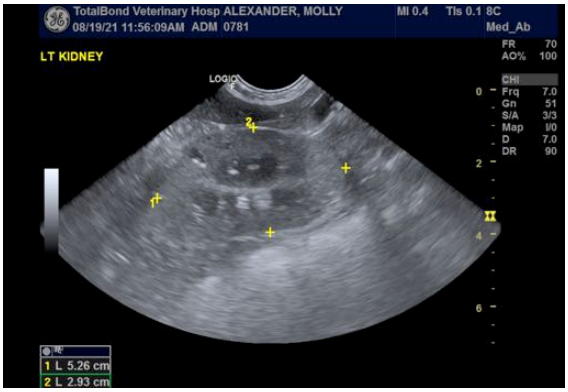
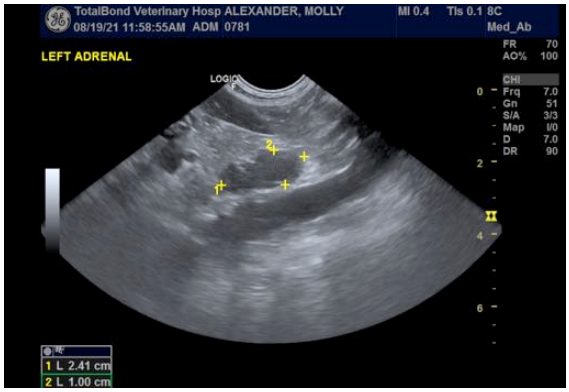
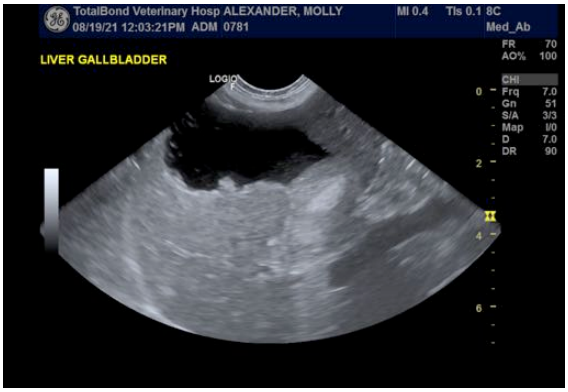
bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.

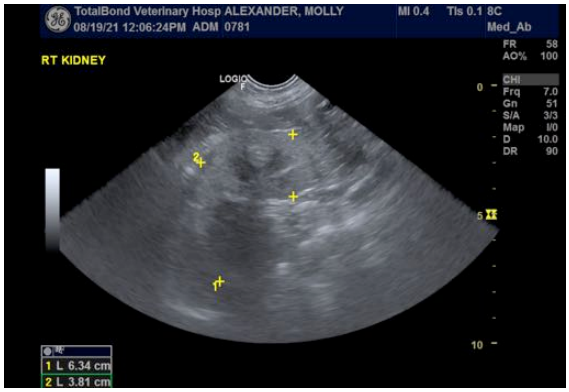
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

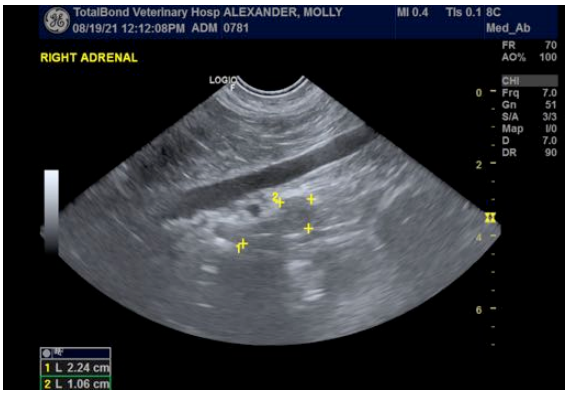
This patient could very well have Cushing's disease although it is always difficult when they are on Phenobarbital as it will increase the liver size and make them PU/PD and cause an ALP elevation as well. This appears to be a challenging epileptic. If at all reasonable to consider tapering off Phenobarbital that would be great (but this seems unlikely). I recommend liver function test, urinalysis and culture and if the change in PU/PD does not coincide with the change in Phenobarbital dose you can consider treatment for Cushing's disease. You can also consider an ACTH stimulation test so you have baseline levels before starting medication and this test is less affected by non-adrenal illness.

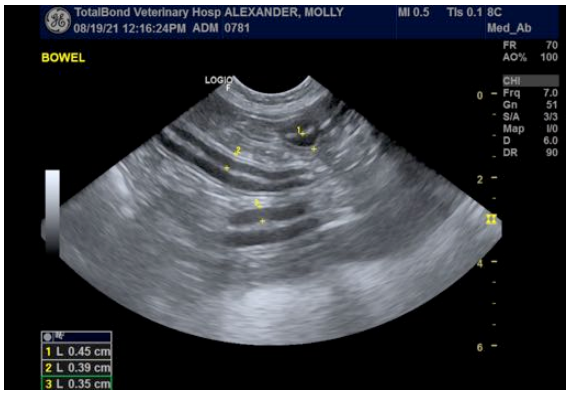












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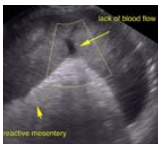
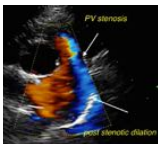
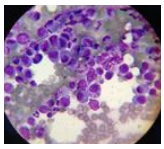
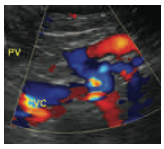

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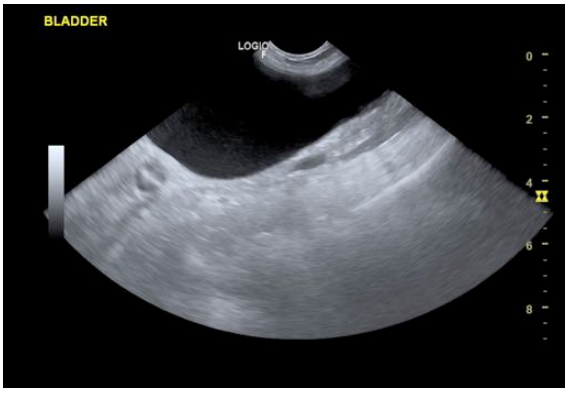

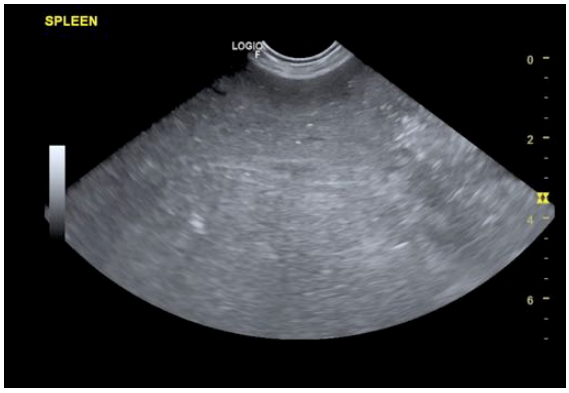

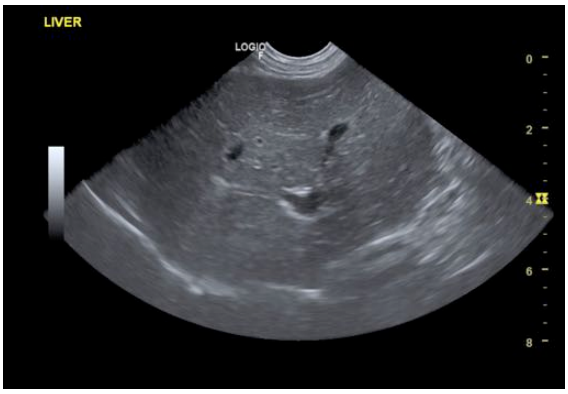

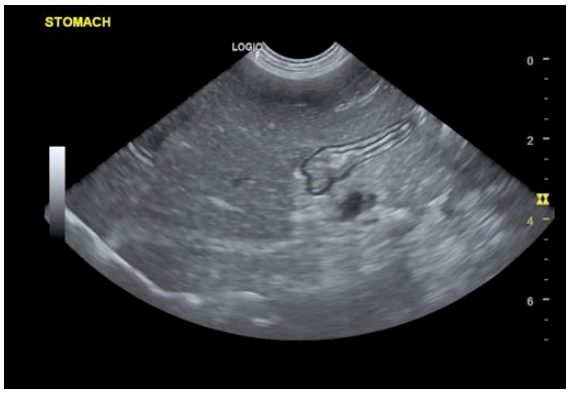

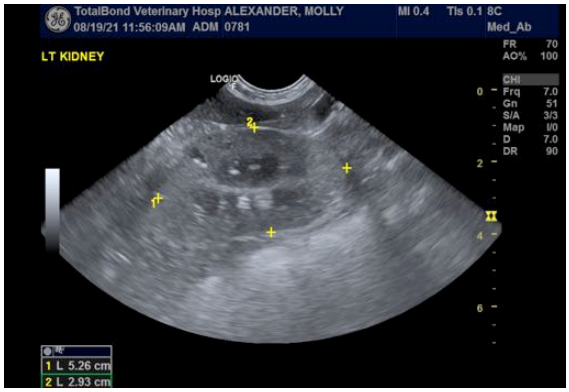

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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