



PATIENT PRESENTING CLINICAL SIGNS

Bito Teke Dog presented polydipsia/ polyphagia etc. Workup revealed Cushing syndrome. LDDST unable to distinguish adrenal vs pituitary. Ultrasound done.

SPECIES ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Canine

Urinary System

BREED

Poodle X

The urinary bladder is well filled. The wall is mildly thickened at 1.4 mm. It is also very mildly irregular. Therefore, a bacterial cystitis is suspected. There is no evidence of sediment, cystoliths, polyps or a mass.

SEX

Neutered Male

The left kidney is within normal limits in size for the patient's weight (4.6 cm). The capsule is smooth. Its overall architecture, including the definition of the cortico-medullary junction, are preserved. The cortex is thickened and mildly hyperechoic. Multiple mineralizations of the renal pelvis are present, without signs of nephroliths or pyelectasia. Fat is noted within the pelvis. The surrounding mesentery is not hyperechoic.

AGE

7 Years 4 Months

The right kidney is within normal limits in size for the patient's weight (approximately 5.3 cm). The architecture of the right kidney is better preserved compared to the left. The cortex is hyperechoic, but it is not as thick compared to the left. Mild mineralizations are present without signs of pyelectasia. Accumulation of fat is present within the pelvis. The surrounding mesentery is not hyperechoic.

WEIGHT

18.9 Pounds

Adrenal Glands

The left adrenal gland measures 0.46 cm at the cranial pole, 0.41 cm at the caudal pole, and 1.5 cm in length. The cranial pole is rounded and is nodular in appearance. There overall architecture, echogenicity and echotexture are within normal limits. There are no signs of neoplasia. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

INTERPRETED BY

Lisa Carioto, DVM,
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ACVIM

The cranial pole of the right adrenal gland is replaced by a hyperechoic mass of mixed echogenicity. The mass measures 1.3 cm in diameter x 1.9 cm in length. The cranial pole also has punctate mineralizations, and three calcifications. It does not appear to be invading the surrounding vasculature. The full length of the adrenal gland is 2.44 cm.

IMAGING PERFORMED BY

Dr. Leal

Spleen

The spleen is within normal limits in size, architecture, echotexture, and echogenicity. It is hyperechoic to both the liver and renal cortex. The capsule is smooth. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

HOSPITAL NAME

Blairstown AH

Liver

There are no obvious signs of hepatomegaly and its borders are smooth and sharp. The liver's echotexture is homogeneous. No abnormalities are observed with its echogenicity, i.e. it is hypoechoic to the spleen and isoechoic to the kidneys. One to two hypoechoic nodules are observed within the liver, however, they appear to be artifact secondary to the shadowing of the rib; these are not clinically significant. No abnormalities are observed with the hepatic vessels.

REFERRING VET

Dr. Clegg

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The gall bladder has a hyperechoic wall and a moderate amount of echogenic material/sludge. The sludge appears to be adhered to the wall, and there are possible mucus strings attaching from the wall to the center of the sludge. The cystic and common bile ducts are not dilated or tortuous.

DATE

3/15/22



PATIENT

Bito Teke

Gastrointestinal

The gastric wall and pylorus are normal in thickness. There is no loss of definition of the normal architecture of the layers of the stomach wall. No obvious abnormalities are observed with its peristalsis.

SPECIES

Canine

The small intestinal wall thickness is within normal limits and there is no evidence of dilation. The definition of the wall layers is preserved. The duodenum is within normal limits. The colonic wall is not thickened and mural detail is considered normal. There are no obvious signs of a mass, foreign body, infiltrative disease or an obstruction.

BREED

Poodle X

Pancreas

Age related changes are visualized in both the left and right limbs of the pancreas, i.e. a coarse echotexture. The surrounding mesentery is not hyperechoic, i.e., there are no signs of pancreatitis.

SEX

Neutered Male

Other

Lymph nodes: No abnormalities are observed.

AGE

7 Years 4 Months

Abdominal effusion is not visualized.

ULTRASONOGRAPHIC FINDINGS

WEIGHT

18.9 Pounds

- Hyperadrenocorticism caused by a tumor of the right adrenal gland. Obvious metastases to the surrounding vasculature is not evident. Differential diagnoses include an adenoma or adenocarcinoma. Calcifications within the mass increases the possibility of an adenocarcinoma, although their presence are not pathognomonic. A pheochromocytoma is another differential diagnosis. The nodule on the cranial pole of the left adrenal gland is not considered malignant and may be due to hyperplasia or a small adenoma. Both poles of the gland are equal and within normal limits.
- The renal changes may be due to glomerulonephritis associated with hyperadrenocorticism. However, pyelonephritis cannot be excluded despite the absence of sonographic signs.
- Gall bladder sludge is common in dogs with hyperadrenocorticism. Treatment with ursodeoxycholic acid is not suggested at the moment, however, a re-evaluation of the gall bladder is highly recommended to ensure further accumulation does not occur or that the sludge does not form a mucocoele.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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A urine culture and sensitivity is recommended. If it is negative, a protein/creatinine ratio is suggested.

An arterial blood pressure is recommended to rule out hypertension associated with hyperadrenocorticism.

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If surgery is pursued regarding the right adrenal tumor, a CT scan and angiogram are recommended prior to surgery. Medical management of adrenal tumors is possible with trilostane or mitotane (Lysodren).

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A re-evaluation of the gallbladder is strongly suggested in 2-3 months, once the hyperadrenocorticism is well controlled.



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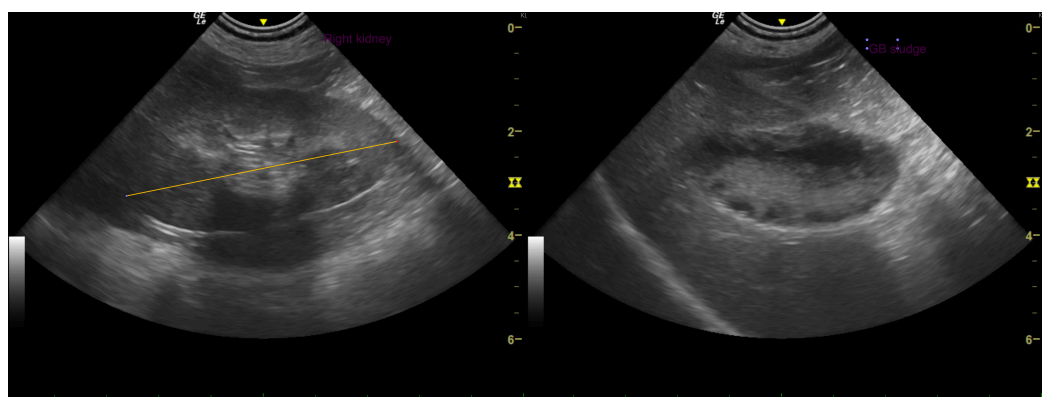
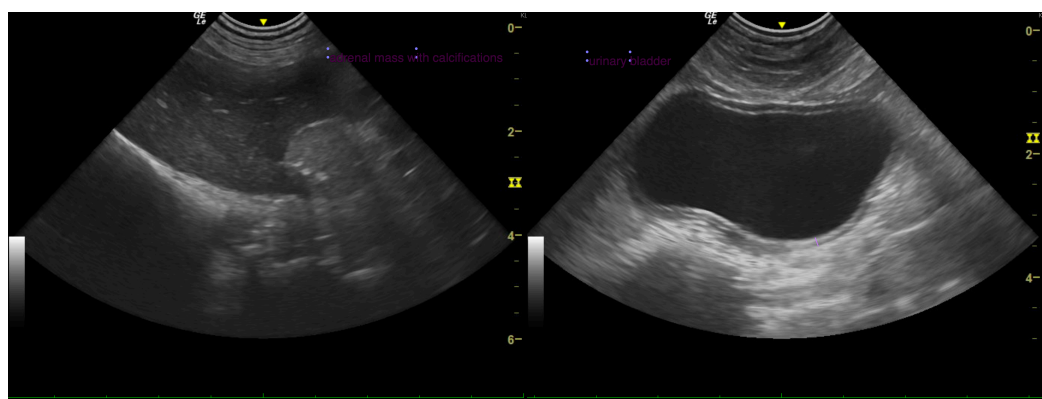
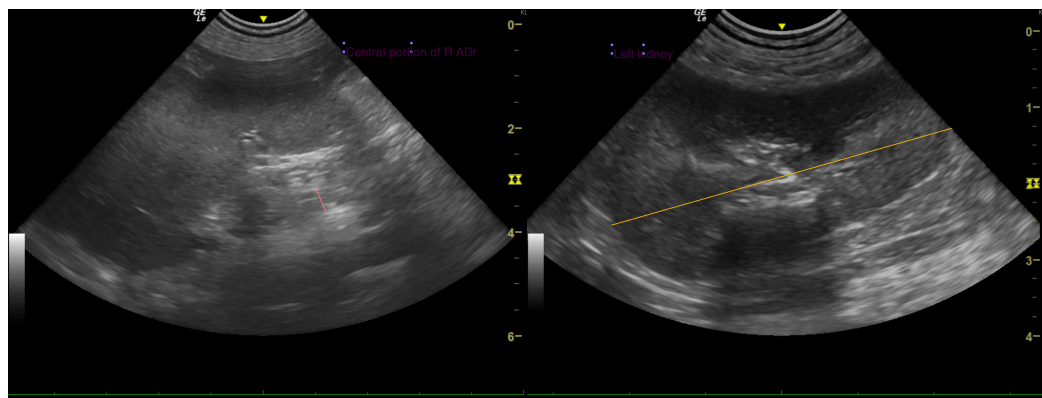
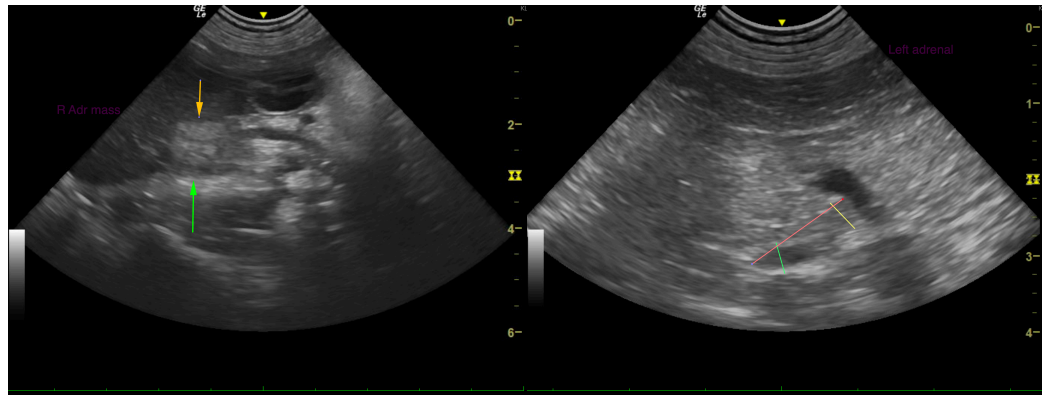
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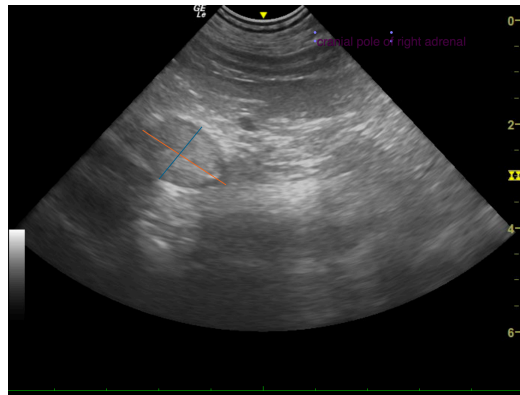
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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