

Report Requested By: report requested by
VDC-Schaumburg
Referring User: Jeffrey Bloomberg DVM
Submitted By: Jeffrey Bloomberg DVM
Email: Schaumburg@vdc.vet
Phone: 3127367757 1365 Wiley Road,
Schaumburg, IL, USA

Patient: [REDACTED]
Canine | Dachshund | 11 years old | Spayed Female
| 24 lbs.



Services

Report Provided By: report provided by
Tara Ghormley DVM DACVIM, Internist

[REDACTED]
20 Towne Drive, Suite 170
Submitted: 02-May-2025 01:45 PM
Appointment Date: 02-May-2025
Closed: 02-May-2025 04:57 PM

VDC - Ultrasound Review and Consultation (<24 hour, 60 images or less)

Report

Case Summary

[REDACTED] is an 11-year-old spayed female Dachshund with proteinuria. The patient presented 4/7/25 for a several week history of polyuria and polydipsia. Her physical examination was unremarkable. An in-house urinalysis showed a specific gravity of 1.005 with 3+ proteinuria. Referral labs showed unremarkable CBC and chemistry panels. Her urine specific gravity was 1.007 with 3+ proteinuria and inactive sediment. Urine culture was negative and urine protein: creatinine ratio was 12.3. Systolic blood pressure via Doppler was an average of 158

mmHg.

The patient is currently eating K/D diet and is not on any medications. She underwent a dental procedure in March with multiple extractions.

A recent POC test was negative for vector-borne diseases.

Ultrasound Findings

Ultrasound Findings

An abdominal ultrasound dated 5/2/25 with 57 images and cinematic loops is available for review.

Urinary Bladder: The bladder is moderately distended with urine. No cystic calculi are seen. The bladder wall is normal in thickness. No masses are seen.

Left Kidney: Normal size (5.0 cm in length) with normal shape and architecture. Decreased corticomedullary distinction. Mild pyelectasia (0.30 cm) with mild proximal ureteral dilation (0.25 cm). No nephroliths.

Right Kidney: Normal size (5.4 cm in length) with normal shape and architecture. Decreased corticomedullary distinction. Mild pyelectasia with no ureteral dilation. No nephroliths.

Left Adrenal: Normal shape and architecture. Normal thickness measuring 0.42 cm at cranial pole and 0.59 cm at caudal pole.

Right Adrenal: Irregular shape and markedly enlarged measuring 1.5 cm at cranial pole and 1.2 cm at caudal pole. The maximum dimensions are 1.7 cm in

width and 2.8 cm long. No obvious vascular invasion.

Spleen: Normal size, shape, margination, and echogenicity. There are several well-defined hyperechoic nodules throughout the parenchyma.

No masses.

Liver: Mildly enlarged with smooth and rounded lobar margins. Mildly hyperechoic with normal echotexture. No focal lesions are seen.

Intrahepatic bile ducts are not distended. Normal vascular pattern.

Gallbladder: Normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention noted.

Pancreas: The visible pancreas is normal in size and echogenicity. No peri-pancreatic inflammation.

Stomach: Mildly gas distended. Gastric wall has normal layering and thickness.

Small Intestines: The duodenum was not visualized. The jejunal wall has normal layering and thickness (3.0-3.5 mm). There is no evidence of intestinal obstruction.

Colon: Gas and fecal material. The visible colon wall is normal.

Lymph Nodes: Moderately enlarged mesenteric nodes, largest 1.4 x 0.40 cm.

Other: No abdominal effusion

Conclusions

Initial problem list:

1. Marked proteinuria
2. Borderline hypertension
3. Hyposthenuria

Ultrasound assessment:

1. Degenerative renal changes consistent with chronic kidney disease/interstitial nephritis.
2. The bilateral pyelectasia with mildly dilated left ureter may be due to significant polyuria, pyelonephritis/ureteritis, or less likely an obstruction.
3. Marked right adrenomegaly is concerning for neoplasia with the top differentials being pheochromocytoma and adenocarcinoma. Hyperplasia cannot be excluded.
4. The hyperechoic splenic nodules are consistent with benign myelolipomas.
5. Enlarged and hyperechoic liver, suspected to be secondary to vacuolar deposition.
6. The lymphadenopathy may be reactive or neoplastic.

Clinical Assessment

Assessment:

Ultrasonographic findings raise suspicion that the observed proteinuria may be secondary to the enlarged right adrenal gland. Differential diagnoses include a pheochromocytoma or a hormone-producing adrenocortical adenoma or carcinoma, potentially resulting in hyperadrenocorticism. Both hyperadrenocorticism and pheochromocytoma are known to contribute to proteinuria, systemic hypertension, and polyuria/polydipsia.

The pyelectasia and mildly dilated left ureter are suspected to reflect polyuria associated with early chronic kidney disease in conjunction with polyuria secondary to the adrenal mass.

The significance of the observed mesenteric lymphadenopathy remains undetermined. While often associated with gastrointestinal disease, the presence of a confirmed adrenal tumor raises concern for metastatic neoplasia.

Recommended Diagnostics:

1. Low-Dose Dexamethasone Suppression Test (LDDST): Primary screening test for hyperadrenocorticism.
2. If LDDST is negative, urinary catecholamine analysis (e.g., metanephrines/normetanephrines) is recommended to evaluate for pheochromocytoma.
3. Thoracic radiographs are indicated for metastatic screening.
4. Abdominal CT with angiography is recommended to better characterize the adrenal mass and associated lymphadenopathy, and to assess for vascular invasion.

Treatment Plan:

If hyperadrenocorticism is diagnosed, initiate trilostane therapy at a starting dose of 10 mg PO q12h (approx. 1 mg/kg). Monitor cortisol levels via ACTH stimulation testing at 2 weeks post-initiation, then at 4 weeks, 3 months, and every 6 months thereafter if therapy continues long-term. Trilostane should be instituted, even if surgical intervention is planned for improved pre-operative health.

If LDDST is negative and adrenalectomy is planned:

Pre-operative alpha-adrenergic blockade is essential. Options include:

Prazosin: 1 mg PO q12h (1 mg/dog, up to 2 mg/dog; commercial capsule).

Phenoxybenzamine: Starting dose 5 mg PO q12h (approx. 0.5–2 mg/kg; requires compounding).

Initiate therapy for at least 7 days preoperatively. Recheck blood pressure in 3–5 days and monitor closely for signs of hypotension. If surgery is not pursued:

Depending on endocrine test results, telmisartan at 10 mg PO q24h (approx. 1 mg/kg, must be compounded) may be prescribed to reduce proteinuria and improve blood pressure. Recheck blood pressure one week after initiation. Assess UPC ratio and renal panel two weeks postinitiation. If a pheochromocytoma is present, the patient may develop progressive hypertension, necessitating the addition of amlodipine (2.5 mg po q 24h, approx. 0.25 mg/kg). The etiology of the proteinuria is suspected to be pre-renal, although the addition of a renal diet may be added for medical management.

Client communication:

The prognosis is variable and depends on the etiology of the adrenal mass. Prognosis is more guarded if adrenal neoplasia is confirmed, with overall better results if surgical excision is possible. Medical management for adrenal-dependent hyperadrenocorticism has a median survival time of 1 year.

Consulting Specialist

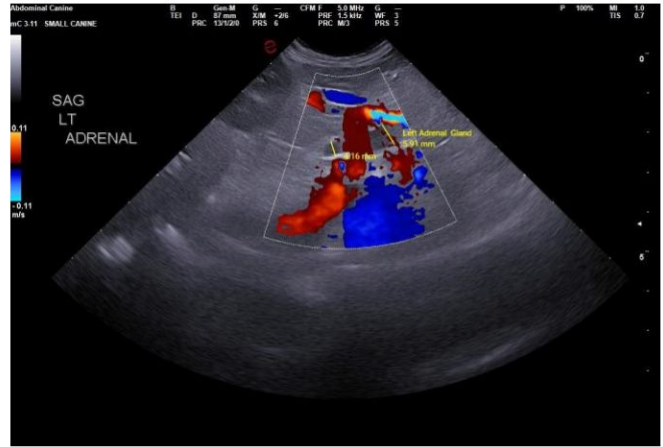


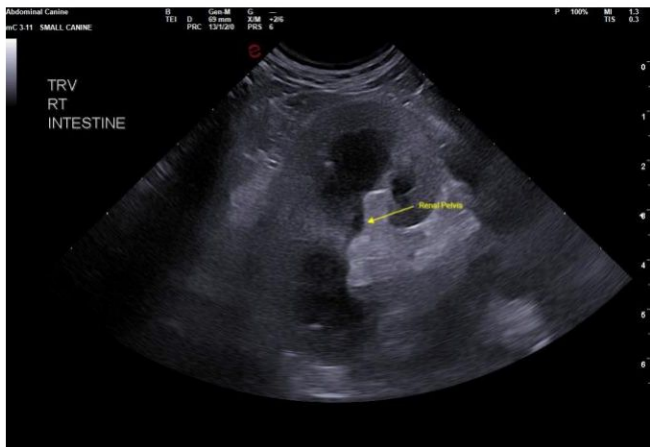
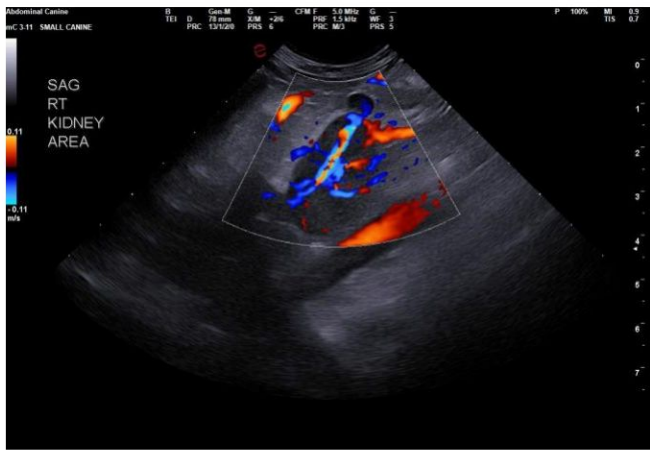
Tara Ghormley DVM, DACVIM (SAIM)

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Note: Assessments made and clinical thoughts are based on the data provided. The treating clinician remains responsible for determining the final treatments and applicability of the information herein. As clinical changes occur in patient status or clinical/laboratory values, the recommendations may need to be altered or removed.

VETERINARY DIAGNOSTIC CENTERS





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