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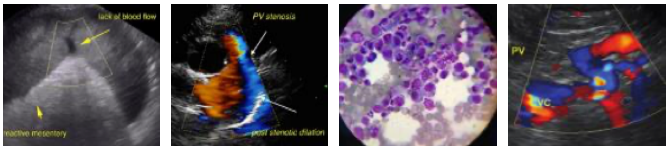


PATIENT
Lola Galindo

SPECIES
Canine

BREED
Labrador Retriever

SEX
Female, spayed

AGE
12.5 Yrs.

WEIGHT
39.5 kg.

INTERPRETED BY
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY
Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Dr. Keith

INVOICE
14266

DATE
11/23/22

PRESENTING CLINICAL SIGNS

History: Lola presented to the MVS Emergency Service on Nov 22, 2022, at 4:10pm, for evaluation of non-ambulatory paraparesis - elevated renal and hepatic values. Lola and her family drove up here from Texas on Saturday. She was fine on Saturday and that night they stopped in Missouri and stayed overnight. Sunday morning they noticed that Lola was more stiff than normal but she has a history of arthritis and so they assumed it was a flare up. Sunday night they got into Madison and they noticed that she was struggling to get out of the care. Monday into today she progressively became less ambulatory until she was unable to stand at all for the owners. Lola has also been uninterested in eating or drinking since Sunday night. She is normally really excited to see the son of the owner, but wasn't excited at all when they saw each other. No vomiting or diarrhea. Current medications: Gabapentin 300mg PO q24h - at night, last given last night Prednisone 20mg - 1/2 tab PO q48h - last given this morning Cephalexin 500mg - 2 cap PO q12h - last dose given Saturday evening Fish oil PO q24h Dasuquin PO q24h Abnormal PE/Chem/CBC/UA Results: ALT 191 ALP 1475 Na 171 K 3.3 Gl 127

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is contracted. A Foley catheter bulb is observed within the lumen. No obvious pathology is seen.

The left kidney is normal size (7.92 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (7.58 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is enlarged (3.57 cm at cranial pole) (1.64 cm at caudal pole) (5.38 cm in length) with a mass effect, most pronounced at the cranial aspect. The mass is heterogeneous with cavitated areas. There is no obvious evidence of vascular invasion.

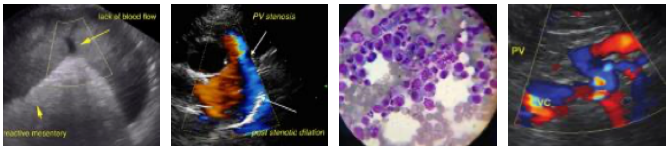
The right adrenal gland is normal size (0.62 cm at cranial pole) (0.56 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.97 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen. A small, hyperechoic nodule (0.91 x 0.71 cm) is observed in the left side. Vascular and biliary tracts are of normal volume with no evidence of



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congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is normal in size with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no obvious evidence of free fluid. A few prominent mesenteric lymph nodes are also seen, the largest measuring 1.65 cm in length. There is no evidence of inflammation or effusion. A 2.67 x 0.72 cm right medial iliac lymph node is visible. The nodes are normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Left adrenal mass. Neoplasia (i.e., adenocarcinoma, pheochromocytoma, hemangisarcoma) is suspected with a lower possibility of a benign process (i.e., excessive nodular hyperplasia).

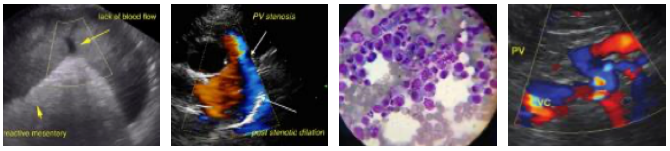
Secondary Findings:

- The bilateral renal changes are most consistent with chronic interstitial nephrosis/nephritis.
- The hyperechoic hepatic nodule likely represents a benign process (i.e., regenerative nodule), lipogranuloma, myelolipoma with a lower possibility of an emerging tumor.
- Age-related pancreatic remodeling.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

*It is unclear whether the patient's clinical signs are associated with the left adrenal mass (i.e., metastatic disease to the spinal cord, vascular accident) or if the clinical signs are unrelated.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the left adrenal mass, consider the following:
  1. Three-view thoracic radiographs to assess for pulmonary metastatic disease, if not already performed.
  2. Baseline blood pressure measurement to assess for systemic hypertension.



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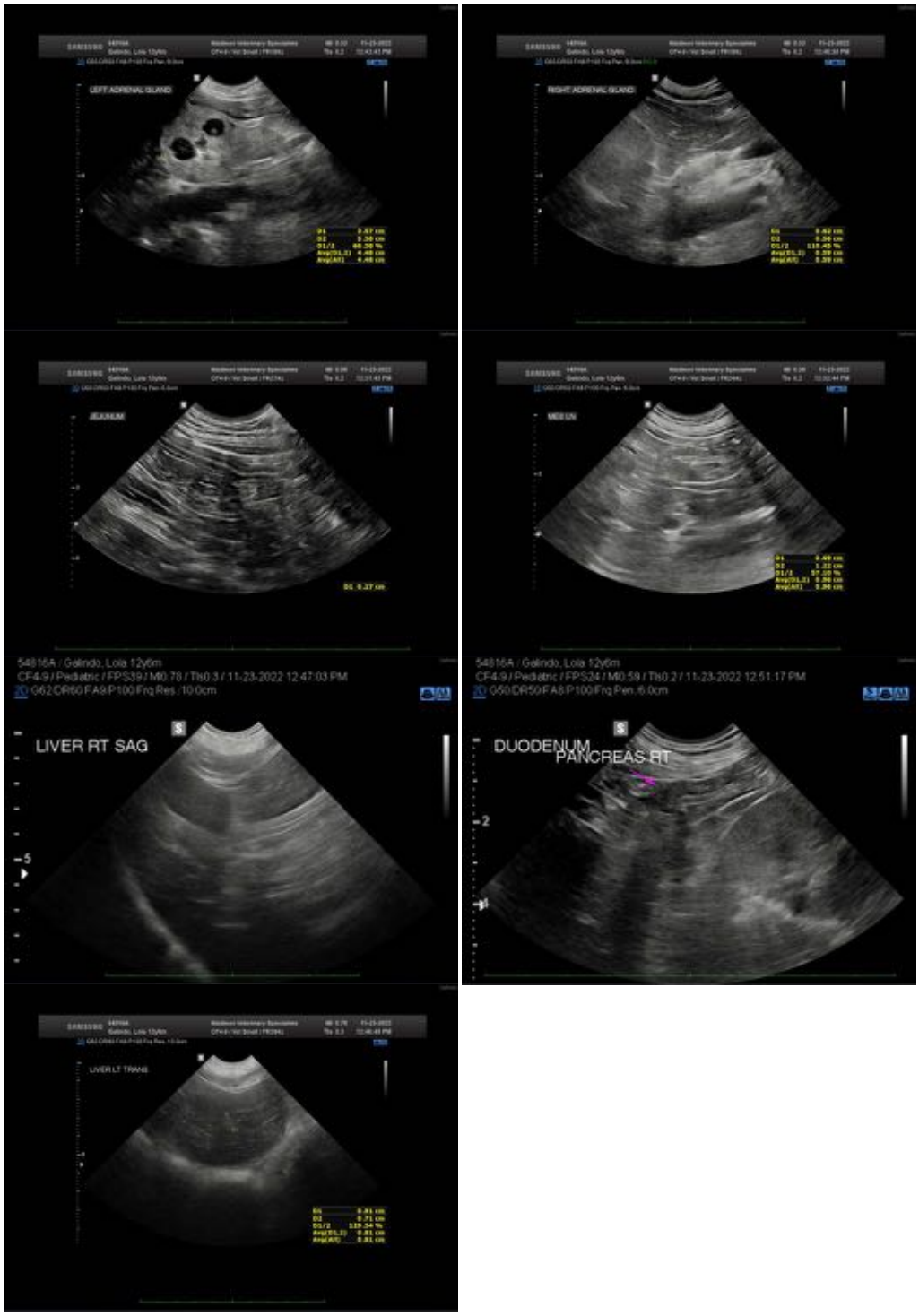
3. Further testing (i.e., low-dose dexamethasone suppression test, urine/blood catecholamine levels) to evaluate for a functional tumor.

- Regarding the patient's clinical signs, a thorough neurologic examination and consultation with a board-certified neurologist is recommended. An MRI of the spine may be warranted.



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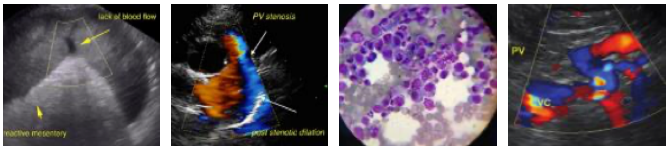

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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