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Clinical Sonography & Telecytology
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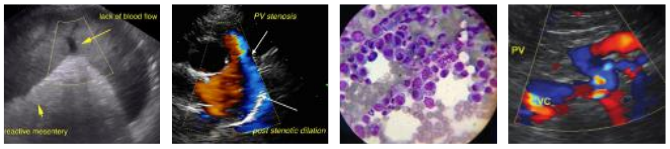


PATIENT
Sierra Burgess

SPECIES
Canine

BREED
Lab/Pitbll

SEX
Spayed Female

AGE
12 years

WEIGHT
62 lbs

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

IMAGING PERFORMED BY
Chaley Hunt, LVT

HOSPITAL NAME
Columbia AC

REFERRING VET
Dr. Laura Baker

INVOICE
10642

DATE
4/1/22

PRESENTING CLINICAL SIGNS

History: Had a syncopal/seizure like episode on 3/17. Prolong post-icteric period. Collapsed on 3/29. Had arrhythmia and non-regenerative anemia on exam on 3/30. Had been weak in the back end. Suspect gallbladder edema from ultrasound on 3/30, mild increase in BUN and ALT compared to historic values. Chest rads WNL, 3 sec CRT. Started on Ursodiol, Amoxi, and Metronidazole on 3/30. Seems to be perkier starting yesterday.

Abnormal PE/Chem/CBC/UA Results: RBC = 5.18, HCT = 32.4

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone is normal.

The left kidney is normal size (6.00 cm in length); with a slightly irregular shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A 2.28 x 2.00 anechoic cyst is observed at the lateral aspect. The cyst causes capsular expansion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (6.09 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.54 cm at cranial pole) (0.45 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.

In the region of the right adrenal gland, a 2.98 x 2.39 cm, slightly irregular, echogenic nodule/mass is observed.

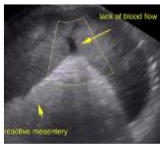
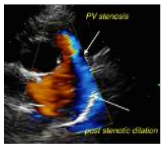
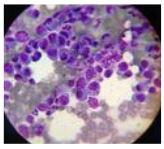
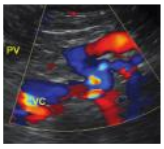
Spleen

The spleen is normal in size (1.19 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 subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of echogenic-to-mineralized, gravity dependent debris is observed within the lumen. The

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cystic and common bile ducts are normal. *See below for results from 3/30/22*.

Gastrointestinal

The gastric lumen is distended with ingesta and shadowing material. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with gas and chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portion of the right limb, the pancreas is visible with minimal deviation from the normal peripheral contours. The parenchyma is hyperechoic relative to surrounding omental fat and slightly rounded in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

Lymph nodes

(See right adrenal gland)

Gall bladder Images from 3/30/22

The gall bladder on this day is diffusely thickened (up to 0.27 cm) and edematous with a "double-walled" effect. A small amount of echogenic-to-mineralized debris is observed within the lumen. Trace free fluid is observed adjacent to the gall bladder.

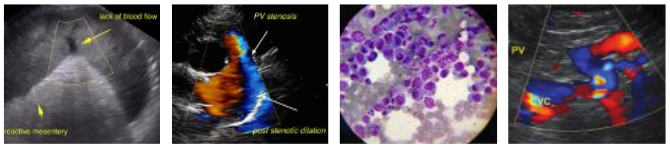
ULTRASONOGRAPHIC FINDINGS from 3/30/22

- Gall bladder wall edema. Differentials include increased hydrostatic pressure (i.e., secondary to congestive heart failure), cholecystitis, anaphylaxis, autoimmune disease, other.
- Trace ascites

ULTRASONOGRAPHIC FINDINGS from 4/1/22

Primary Findings

- The origin of the nodule/mass in the region of the right adrenal gland is unclear. It may be arising from the right adrenal gland, lymph node, mesentery, other. Differentials include tumor, granuloma, nodular hyperplasia, other. The lesion's significance with regard to the patient's clinical signs is unclear. If the lesion us arising from the right adrenal gland, it may be associated with the arrhythmia/collapse episodes, particularly if it is a pheochromocytoma. However, it may be unrelated to the patient's current issues.
- The gall bladder wall edema and ascites from 3/30/22 appear to have resolved.



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Secondary Findings

- The hepatic parenchyma changes are nonspecific and could be associated with a benign age-related process (i.e., regenerative nodular hyperplasia, vacuolar hepatopathy). However, an underlying hepatopathy (i.e., infiltrative neoplasia), cannot be completely excluded.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Minor age-related renal changes with a left cortical cyst

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's clinical signs and sonographic changes, consider the following:

1. An echocardiogram, ECG, and blood pressure measurement are recommended to further assess for underlying cardiac disease.
2. Pre-and postprandial serum bile acids to assess for occult hepatic dysfunction
3. Serial monitoring of the patient's hematocrit, along with a reticulocyte count (to assess for regenerative anemia) are also recommended.
4. Given the nodule/mass in the region of the right adrenal gland, consider a low-dose dexamethasone suppression test and urine/blood catecholamine levels (Marshfield Laboratory) to assess for a functional adrenal tumor.
5. A neurologic examination should be considered to assess for evidence of neuro deficits.
6. Depending on the results of the above diagnostics, consultation with a board-certified neurologist and/or cardiologist may be warranted.

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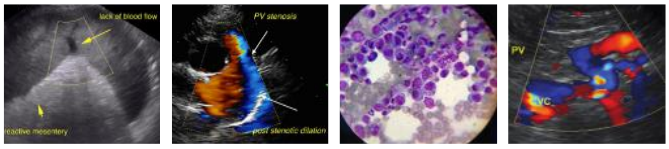

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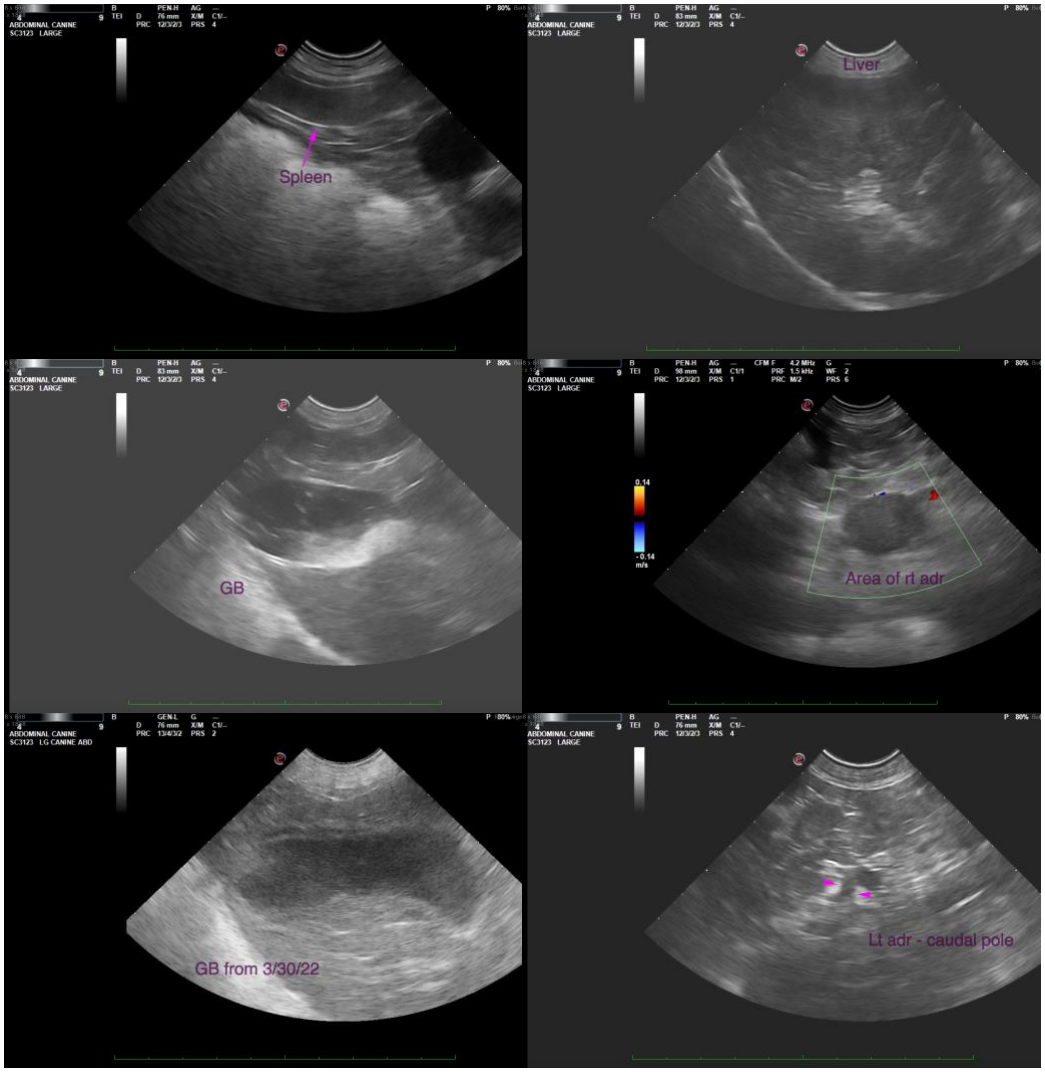

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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