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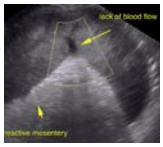
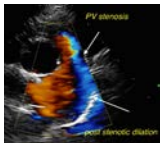
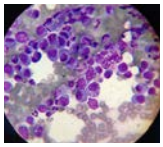
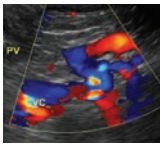

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1-800-838-4268 info@sonopath.com

PATIENT
Harvey McInnis

SPECIES
Canine

BREED
Poodle X

SEX
Neutered Male

AGE
10 Years

WEIGHT
17.4 kg

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Dr. Trudeau

HOSPITAL NAME
Petworks Vet Hospital

REFERRING VET
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INVOICE
44318

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PRESENTING CLINICAL SIGNS

Acute onset of inappetence, did vomit once, pu/pd, no weight loss

Abnormal PE/Chem/CBC/UA Results: CBC/Chem: elevated Creatinine 405 umol/L and Urea 27.3 umol/L otherwise NSF; CBC NSF, 4DX neg, CPL- normal; TT4 low -Xrays- loss of detail cranial abd

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The prostate is unable to be well visualized in these images.

The right kidney is normal in size (8.32 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of mineral or infarcts observed. Pyelectasia is noted at 0.33 cm in the sagittal view.

The left kidney is normal in size (7.58 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of mineral or infarcts observed. Pyelectasia is noted at 0.34 cm in the transverse view.

Adrenal Glands

The right adrenal gland is enlarged (1.55 cm at the cranial pole and 0.69 cm at the caudal pole) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted without evident capsular escape or vascular invasion.

The left adrenal gland is normal in size (0.57 cm at the cranial pole and 0.55 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

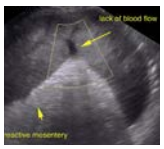
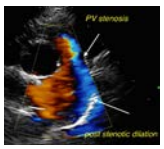
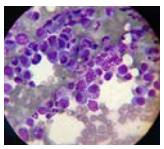
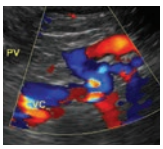
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as mild suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

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The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

At the root of the mesentery, there is an approximately 1.6 cm x 3.0 cm irregular, primarily hypoechoic, partially cavitated mass that appears to be an enlarged mesenteric lymph node.

The sublumbar lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

PRIMARY FINDINGS

- **Mild to moderate bilateral pyelectasia –** Differentials for pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.
- **Right adrenal mass –** consistent with adenoma or possibly hyperplasia. Early pheochromocytoma cannot be ruled out. Interpret in combination with clinical signs of hyperadrenocorticism or other adrenal disease.
- **Mass at the root of the mesentery** – Appears to an enlarged, partially cavitated lymph node. Both reactive lymphadenopathy as well as infiltrative neoplasia are differentials and cannot be differentiated without tissue sampling.
- **Reactive sublumbar lymph nodes –** infiltrative neoplastic disease cannot be ruled out but is considered less likely.

SECONDARY FINDINGS

- **Mild gallbladder debris -** Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

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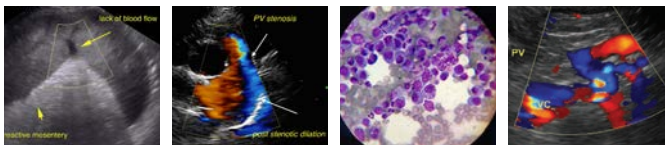

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's right adrenal mass and reported PU/PD, adrenal dependent hyperadrenocorticism could be contributing to that clinical sign. However, hyperadrenocorticism does not result in vomiting or loss of appetite, and therefore, further evaluating the other pathology is recommended prior to testing for hyperadrenocorticism.

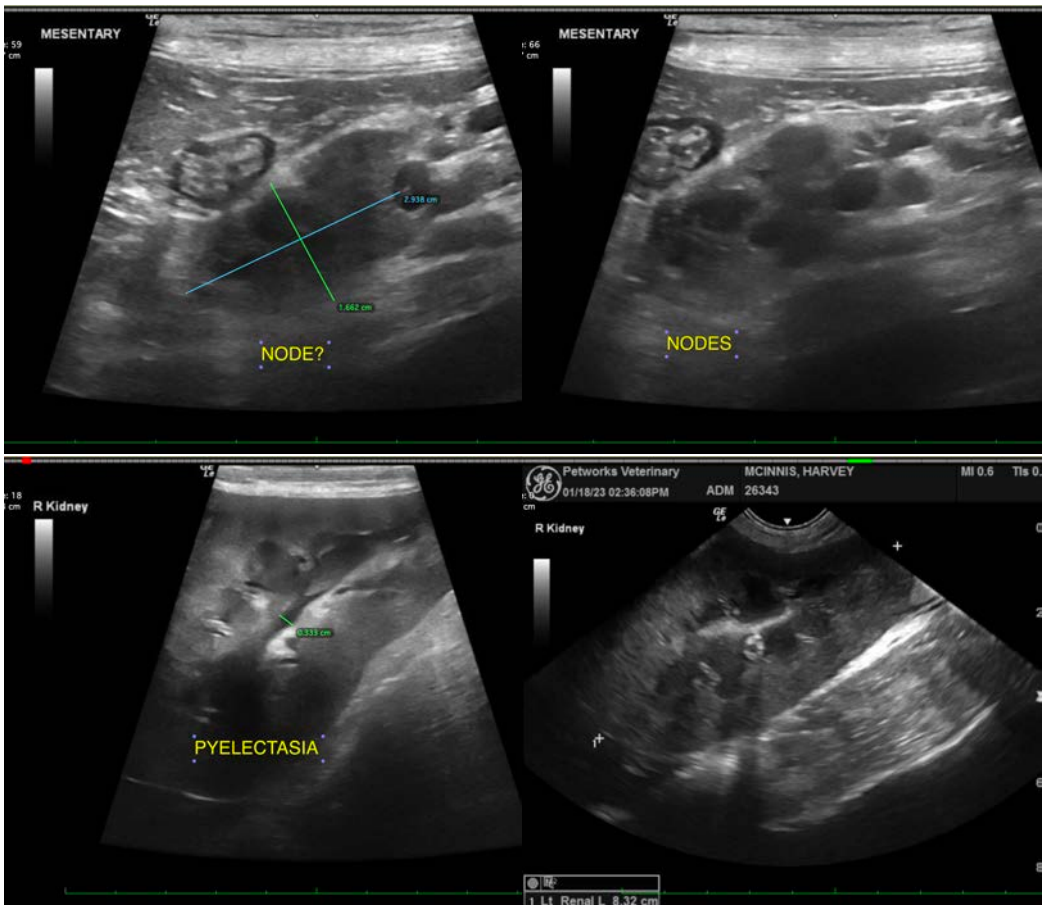
The bilateral pyelectasia may be secondary to the PU/PD, or could indicate pyelonephritis, especially given the reported azotemia. Therefore, a urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Also due to the reported azotemia, testing for Leptospirosis is recommended.

Blood pressure is recommended if not recently evaluated.

Additionally, a fine needle aspirate of the enlarged mesenteric lymph nodes/mesenteric root mass is recommended if it can safely be reached and if patient's coagulation status is appropriate. Only then, pending the results of that workup and patient's clinical signs, should further testing of hyperadrenocorticism be considered in the form of an LDDS test.

In the meantime, supportive/symptomatic medical management of clinical signs, as well as the azotemia, is recommended in the form of fluid therapy, antiemetics, and gastroprotectants, appetite stimulants if necessary, broad-spectrum antibiotics +/- pain management, if indicated.



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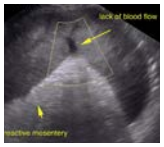
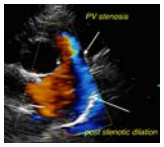
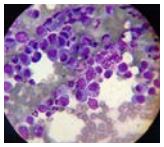
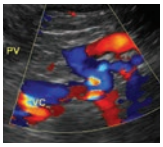

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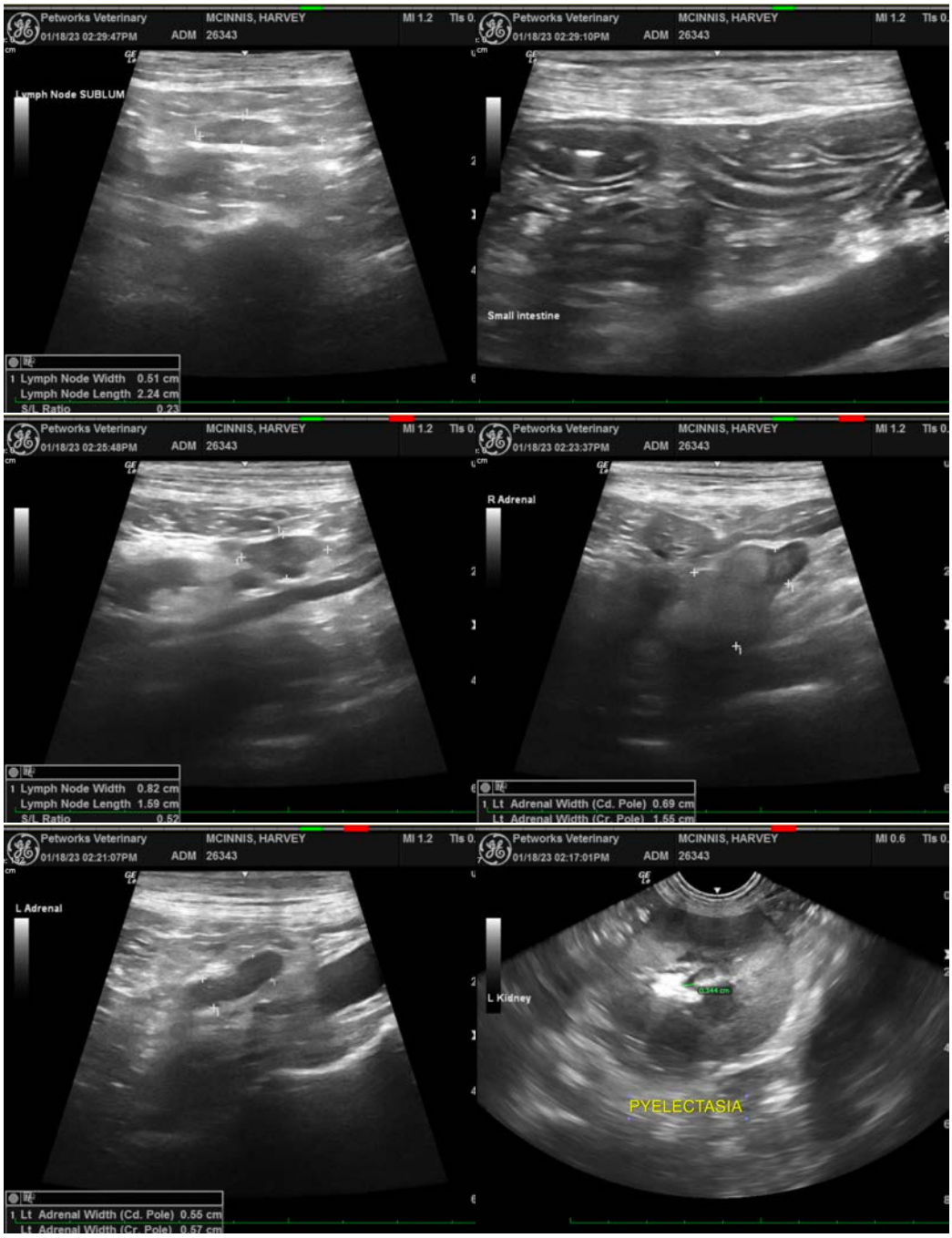

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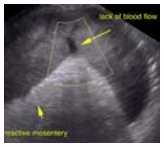
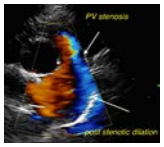
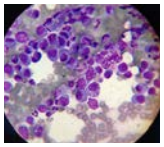
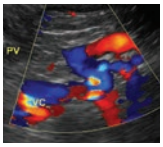

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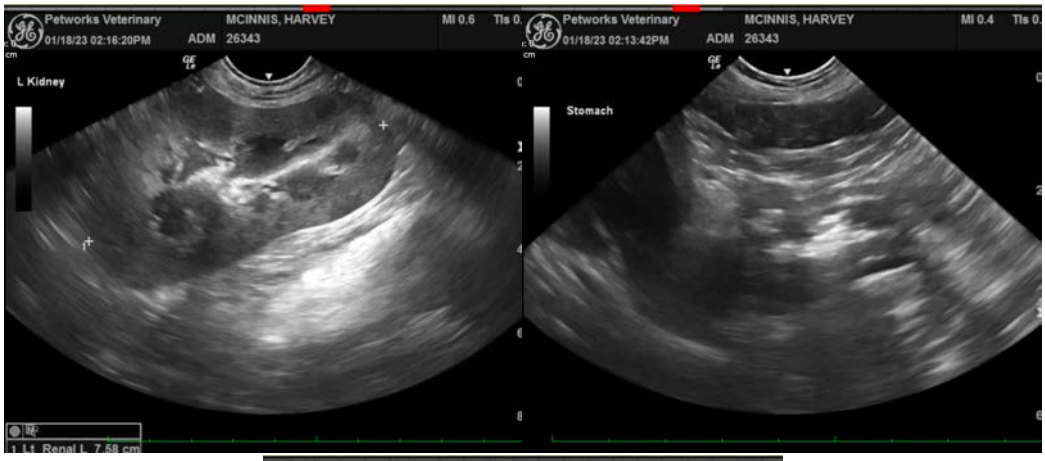

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com