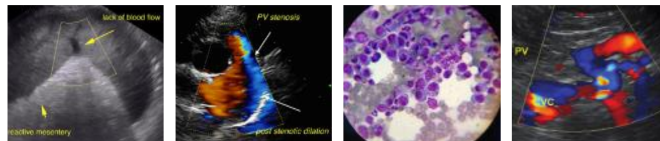

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1-800-838-4268 info@sonopath.com

PATIENT

Bubble Whitsel

SPECIES

Canine

BREED

Dachshund

SEX

Neutered Male

AGE

10 Years

WEIGHT

13.6 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Lupole

INVOICE

17651

DATE

10/11/22

PRESENTING CLINICAL SIGNS

History: Presented at our hospital ; initially in for consult with Dr. Millard for diaphragmatic hernia that may have happened when owner fell on dog 5 days previous. No diaphragmatic hernia noted; concern more for cardiac disease/ infiltrative disease of right lungs; transferred to ER; owner out of town with husband having major surgery; son is here with dog; owner reachable Previous Health Concerns: disc disease Current Medication: carprofen(just today)

Abnormal PE/Chem/CBC/UA Results: Temp: 98.8 Cardiovascular: no obvious m/a; femoral pulses weak(though overweight) Respiratory: increased BV sounds- no crackles or wheezes Abdominal: full/s/np Musculoskeletal: lumbar discomfort; overweight Rads - no diaphragmatic hernia (initial reason for transfer) air bronchograms; enlarged liver vs forward spleen; EPOC SVEC (diffcult to get more blood) K+ 3.1(L) iCa+ 1.05(L0 BUN 81 (H) cr 1.65(H)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended. An anechoic balloon type structure was noted in the trigone, most consistent with a foley catheter, if a foley catheter was in place.

Kidneys are overall normal in size (left kidney measures 6.53 cm, right kidney measures 6.31 cm)and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Small cortical cysts were noted bilaterally.

Adrenal Glands

The left adrenal gland is enlarged (4.6 cm long x 1.9 cm at the cranial pole and 2.3 cm at the caudal pole) with mild heterogenous parenchymal changes with mineralization. Swollen capsular expansion is noted without evident capsular escape or vascular invasion.

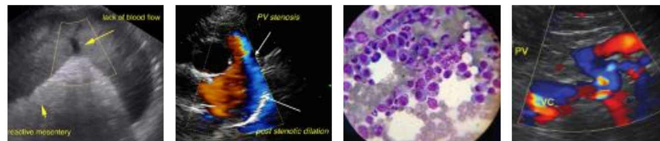
Right adrenal gland is unable to be well visualized in these images.

Spleen

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

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion. A 0.8 cm anechoic cyst like structure is noted deep in the liver.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Gallbladder is moderately distended with anechoic bile as well as 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

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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. 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 and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Left 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.

- Hyperechoic hepatomegaly with a cyst – This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible but considered less likely.

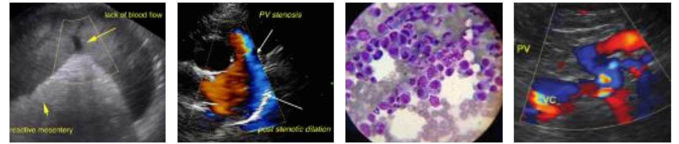
- Gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in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

Secondary Findings

- Age-related kidney changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations for this patient are dependent on clinical signs. Based on the history provided, it



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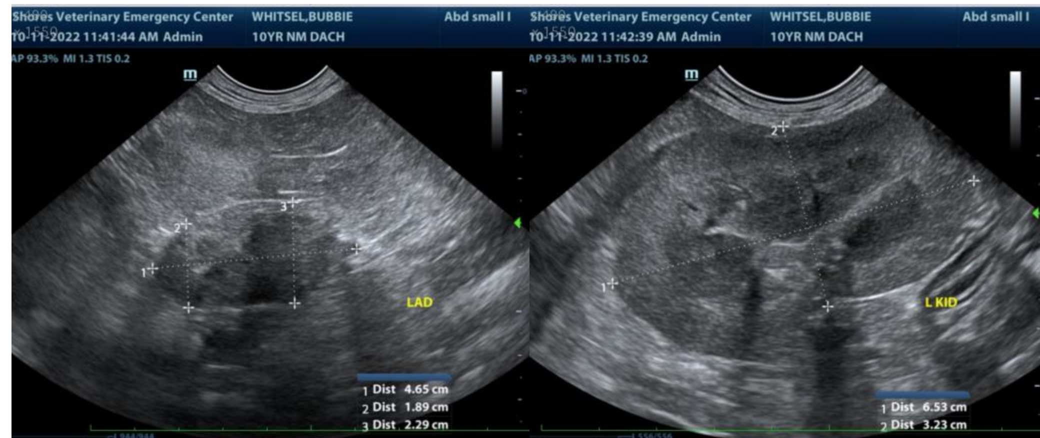
sounds like the clinical signs are potentially cardiopulmonary in nature and therefore, recommendations include three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated +/- an echocardiogram.

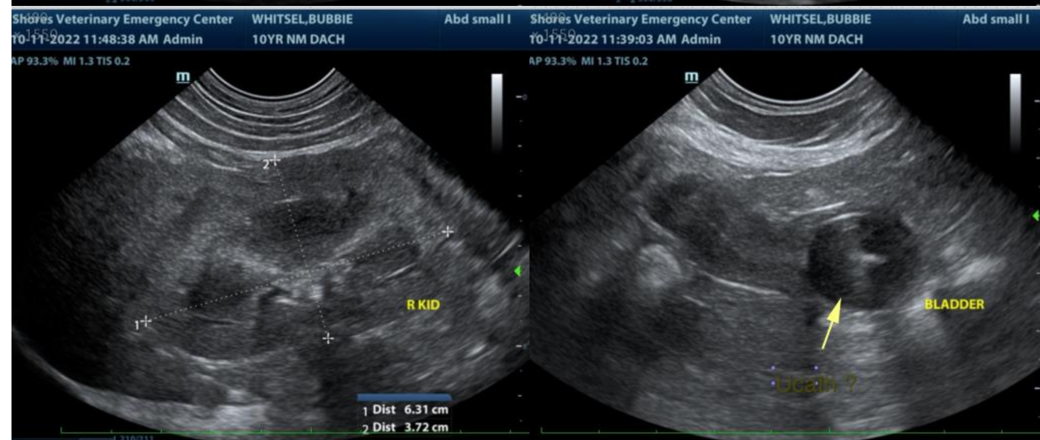
Given the appearance of the left adrenal mass, if clinical signs are respiratory in nature and an underlying cause can't be found, a differential for acute respiratory distress, secondary to an adrenal mass, is pulmonary thromboembolism, which could be considered.

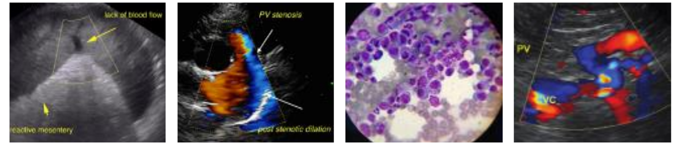
Otherwise, when samples are able to be obtained, CBC/chemistry panel, electrolytes and urinalysis are recommended for further evaluation of this patients azotemia and electrolyte abnormalities, etc.

If clinical signs of hyperadrenocorticism, such as polyuria/polydipsia, panting, etc., are present upon recovery from this acute incident, testing in the form of a low dose dexamethasone suppression test could be considered. If adrenal dependent hyperadrenocorticism is suspected based on testing, ultimately an adrenalectomy may be recommended, in which case a presurgical staging abdominal CT scan should be considered.

Additionally, a blood pressure is recommended if not recently evaluated.







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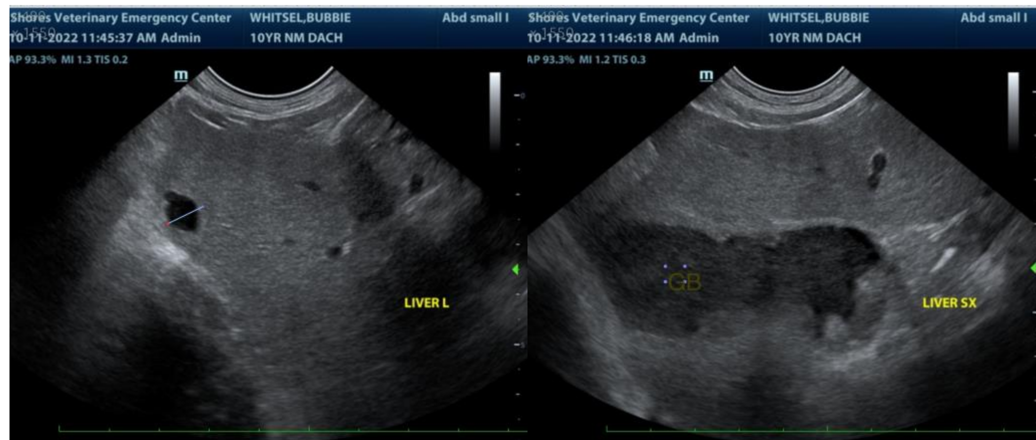

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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