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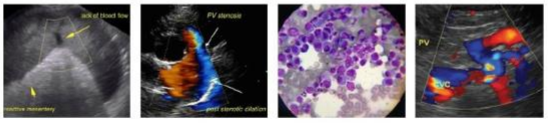

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Rosalie Matheny

SPECIES

Canine

BREED

Pit Mix

SEX

Spayed Female

AGE

11.5 Years

WEIGHT

57 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Incline VH

REFERRING VET

Dr. Kris Moger

INVOICE

18870

DATE

11/28/22

PRESENTING CLINICAL SIGNS

History: Sedation: dex/otrb 0.05ml each IV Lifelong history of atopy, food allergies, dental disease; more recent history of mast cell tumor removal (12/21), anal sacculitis (left anal sacculectomy performed 11/2021), right anal sacculitis (treated medically 9/22), multiple UTIs, vaginitis, arthritis. Seen 11/19/22 to check new lumps found on LF leg and near right anal sac. Pt was found to have mod dental calc and gingival hyperplasia with possible gingival mass, and another COHAT was recommended. Pre-anesthetic bloodwork showed mild elevations in ALT (226) and Alk Ph (327) Current meds: Apoquel 16mg SID-BID, Cytopoint 60mg during spring/ summer, Deracoxib 50mg SID, HP diet (currently Hill's Z/D). Recently finished 10-day course of Amoxi/ Clav acid Abd US was recommended due to elevations in ALT and ALk Ph

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately 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.

Kidneys are overall normal in size 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. The left kidney measured 6.68 cm. The right kidney measured 6.3 cm. Multiple small cortical cysts are noted in the right kidney. A 1.26 cm in diameter cortical cyst was present in the left kidney.

Adrenal Glands

Left adrenal gland is normal in size (0.82 cm at cranial pole and 0.66 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal. A hyperechoic nodule is noted in the cranial pole. Nodule does not disrupt normal shape and/or architecture.

Right adrenal gland is normal in size (0.91 cm at cranial pole and 0.61 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

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. A discrete focal primarily hyperechoic nodule is noted in the left liver, measuring approximately 2.0 cm in diameter. Multiple other much smaller hyperechoic nodules are noted throughout the parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

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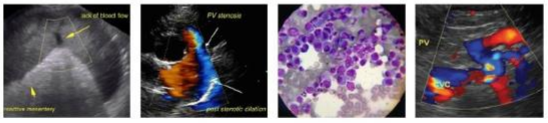

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Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is 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. 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

- Liver nodules – Differentials for discrete liver nodules include primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, myelolipomas, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.
- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- Age-related kidneys with cortical cysts
- Hyperechoic left adrenal nodule – Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.
- 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

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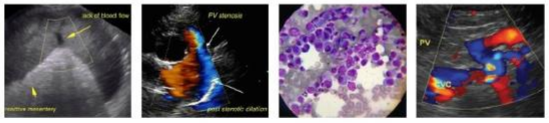

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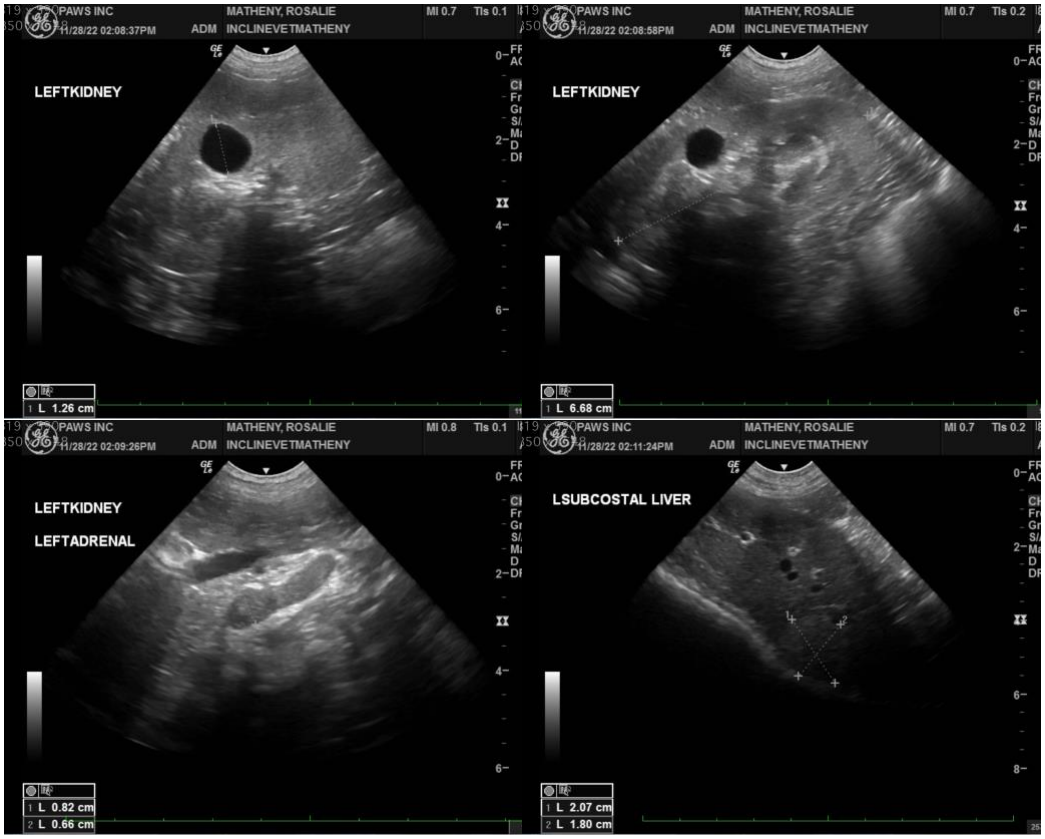
abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious cause for the reported increased liver enzymes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, infiltrative neoplasia (considered unlikely), etc. cannot be definitively ruled out.

Testing for Leptospirosis could be considered if not already evaluated, followed by a fine needle aspirate of the liver if patients coagulation status is appropriate. In the meantime, empirical therapy with hepatic nutraceuticals including ursodiol given the gallbladder debris +/- broad spectrum antibiotics with monitoring of liver enzymes for improvement could be considered. If liver enzymes improve on antibiotics, antibiotics should be continued until the values either normalize or plateau, however, if improvement is not noted, antibiotics should not be continued long term.

Additionally, given the mild adrenal gland changes, if clinical signs of hyperadrenocorticism such as polyuria/polydipsia/polyphagia, etc., are present, testing for hyperadrenocorticism in the form of a low dose dexamethasone suppression test could be considered, however, testing is not necessarily indicated without supporting clinical signs. If not recently evaluated, 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.



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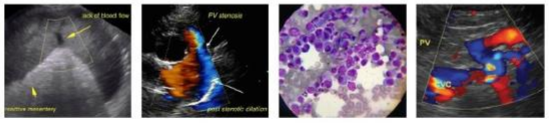

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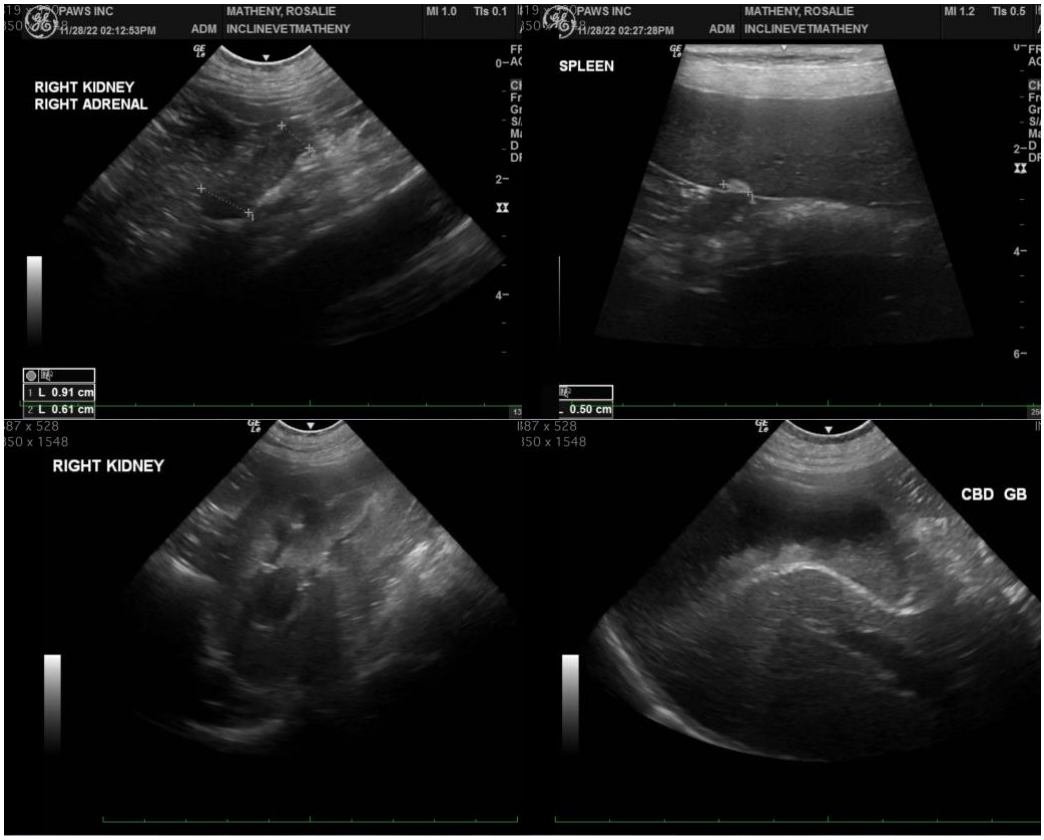

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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