



**PATIENT**

Kylie Sytz

**SPECIES**

Canine

**BREED**

Labrador

**SEX**

Spayed Female

**AGE**

12 Years 6 Months

**WEIGHT**

58.9

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Ashley Whitesell

**HOSPITAL NAME**

Dickson Animal Clinic

**REFERRING VET**

Dr. Rick Hovis

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44800

**DATE**

2/7/23

**PRESENTING CLINICAL SIGNS**

Gallbladder was removed after last ultrasound, enlarged left adrenal gland seen previously, wasn't taken out during surgery for gallbladder, rechecking adrenal mass.

Abnormal PE/Chem/CBC/UA Results: no recent bloodwork, repeating today. muscle loss generalized

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.54 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The right kidney is normal in size (6.7 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 pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (7.12 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 pyelectasia, mineral or infarcts observed.

**Adrenal Glands**

The right adrenal gland is normal in size (1.4 cm at the cranial pole and 0.75 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is enlarged (1.9 cm at the cranial pole and 1.2-1.4 cm at the caudal pole) with mild heterogenous parenchymal changes with a hyperechoic nodule noted in the cranial pole. Swollen capsular expansion is noted without evident capsular escape or vascular invasion.

**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**

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.

The gallbladder was reportedly removed.

**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.



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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.

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

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**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.

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**Free Abdomen**

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

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There is no apparent lymphadenopathy noted in these images.

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**PRIMARY FINDINGS**

- **Left adrenal mass** – Better visualized in these images than on the previous study, and there is evidence of a small nodule on the cranial pole not previously seen, but the cranial pole was not well visualized on the last study, so it is not believed to be a progression. Differentials still include possible adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism, or potentially an adrenal adenoma on this left side. Early pheochromocytoma is also a differential. An adenocarcinoma also has to be considered but is considered less likely.

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**SECONDARY FINDINGS**

- **Chronic Cystitis** - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- **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.
- This patient's gallbladder has been removed.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given the lower sensitivity of an ACTH stimulation test compared to a low-dose Dexamethasone suppression test, if further evaluation of adrenal functionality is elected, a low-dose Dexamethasone suppression test is recommended to look for evidence of hyperadrenocorticism. Additionally, urine catecholamine testing could be considered to look for evidence of a pheochromocytoma. If not already evaluated, a blood pressure is also recommended. The appearance of the adrenal gland does not appear to have significantly changed or progressed since the previous study. Therefore, if there are no clinical signs of adrenal disease, and monitoring is elected, a recheck ultrasound is recommended in 3 months.

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Additionally, if not recently evaluated, 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.



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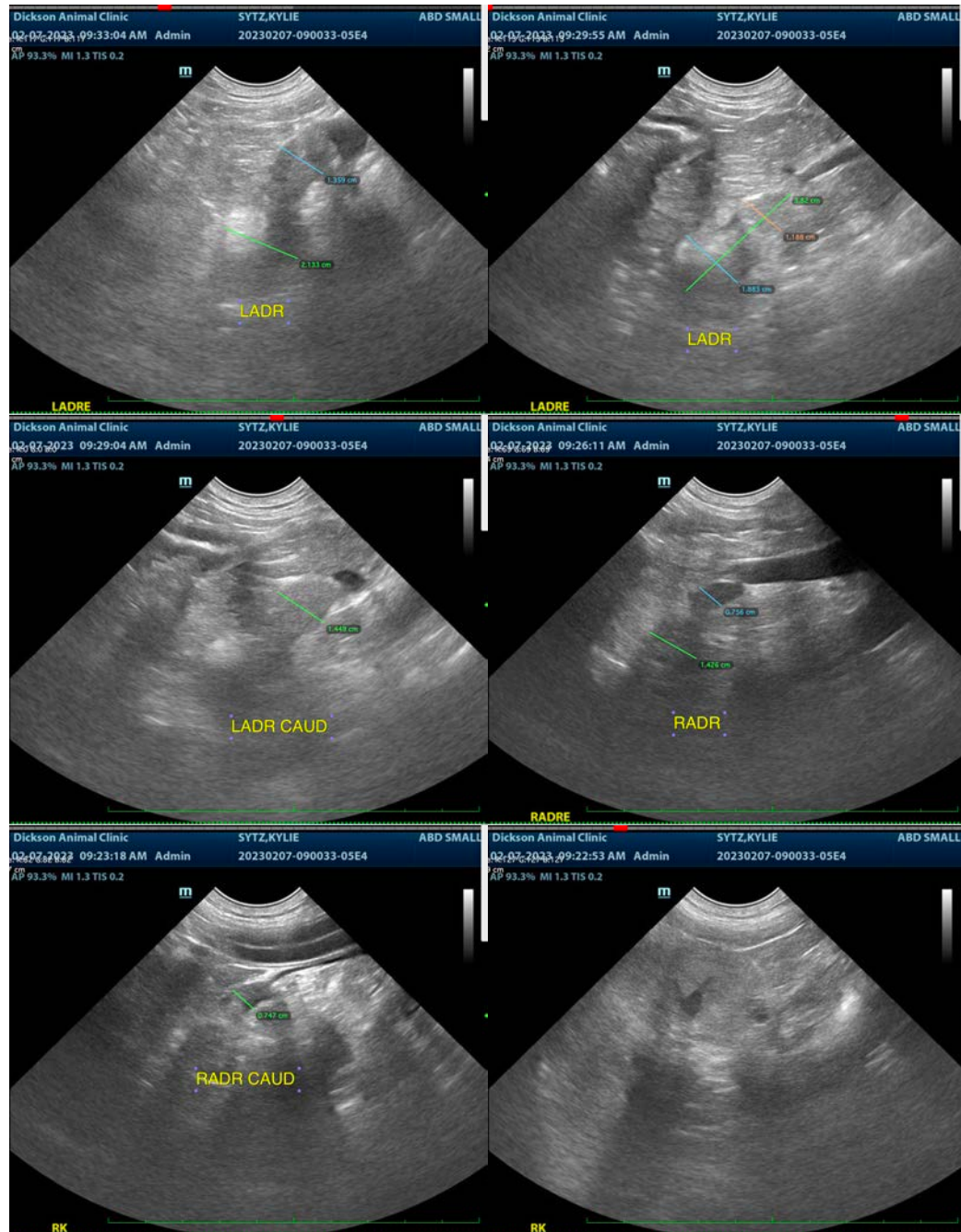
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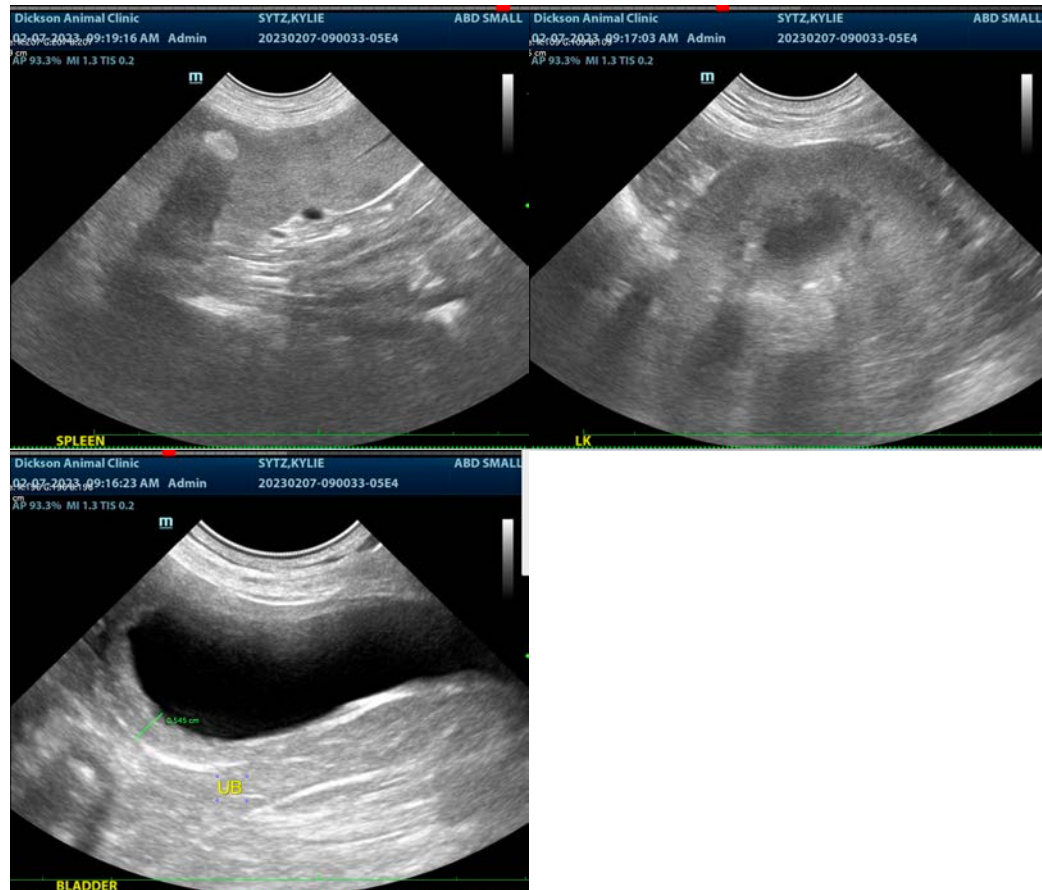
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**  
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