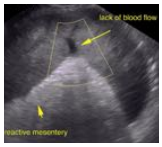

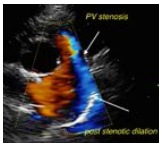

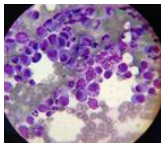
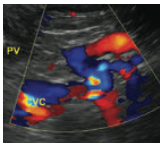

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PATIENT

Jaxin Cannon

SPECIES

Canine

BREED

Lab Retriever

SEX

Neutered Male

AGE

10 years 6 months

WEIGHT

49kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Patti Mayfield, DVM

HOSPITAL NAME

Sunriver Veterinary Clinic

REFERRING VET

Wendy Meredith, DVM

INVOICE

10265

DATE

6/15/2023

PRESENTING CLINICAL SIGNS

6/10/23: -- Presenting History: 10 years and 6 months old MN Labrador Retriever presented for excessive panting. P has been panting for about 1 year. --The panting has gotten excessive and heavy in the last month. O also noticed a lump on P's chest about 1 month ago. -- P does occasionally cough that sounds like he wants to bring something up but does not produce anything. It has occurred throughout his life. -- Patient's behavior, energy level, eating, drinking, urination, and defecation are within normal limits. -- Past Pertinent History: Subcutaneous MCT removal 01/2018 -- Medications / Supplements (drug, dose, and frequency): Omega 3s, Dasuquin, Gabapentin 300 mg PRN -- Diet: Blue Buffalo.

Abnormal PE/Chem/CBC/UA Results: 6/10/23: PE: -- BCS: 8/9 -- Integument: Medial aspect of RF 4mm dermal mass. Multiple dermal mass consistent with warts and SQ lumps previously noted as lipomas. Soft SQ mass on cranial left thorax 4cm^3 -- Oral: MM pink/moist, CRT < 2 seconds. Clean dentition -- Musculoskeletal: P is ambulatory. No lameness appreciated. Muscle wasting in pelvic limbs. Slight decreased ROM in hips. Medial buttressing at stifles. Stiff gait reported at home. DIAGNOSTICS: -- FNA of mass on left cranial chest: lipid/adipocytes -- Senior Wellness to Idexx: results pending -- Thoracic and Abdominal X-Ray: Mass effect in cranial abdomen (spleen or liver?)

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 right kidney is normal in size (9.37 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 (8.08 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 enlarged (3.6 cm x 4.5 cm) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted without evident capsular escape or vascular invasion.

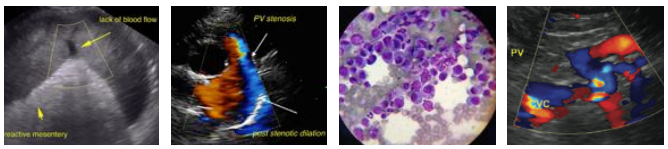
The left adrenal gland is small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. It measures 2.96 cm long, cranial 0.7 cm, caudal 0.57 cm.

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. A 4.5 cm to 5 cm in diameter homogenous iso to slightly hypoechoic



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mass in the mid caudal liver is noted. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is mildly distended with fluid, as well as echogenic non shadowing luminal contents and gas consistent with normal ingesta/chyme. 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 (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 or foreign material.

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

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is markedly heterogenous and coarse, especially in the right limb. 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.

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Due to patient confirmation and mildly dark images a right adrenal mass can't be definitively diagnosed but in several videos the structure described above is in the area of the right adrenal gland and not believed to be an atypical view of the adjacent, but nearby liver mass. Having said that the liver mass in the areas of the right adrenal gland cannot be definitively ruled out. Having said that a right adrenal mass with a concurrently subjectively flat left adrenal gland is suggestive of a functional adrenal tumor with both benign adenoma, as well as malignant adenocarcinoma being differentials. There are no criteria of malignancy to support malignancy over benign mass, but malignancy cannot be ruled out.

- Homogenous iso to slightly hypoechoic liver nodules/mass. Could very well represent a benign lesion such as a hepatoma/adenoma, nodular hyperplasia, etc. Having said that infiltrative neoplasia such as hepatocellular carcinoma, and round cell neoplasia, versus other, cannot be ruled out without tissue sampling.

- **Moderate to marked pancreatic age-related remodeling –** These irregularities can be consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs. Infiltrative neoplasia while considered less likely cannot be definitively ruled out.

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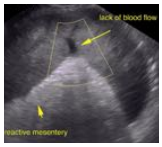
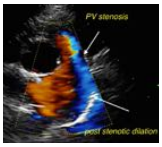
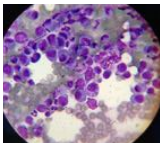
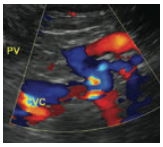

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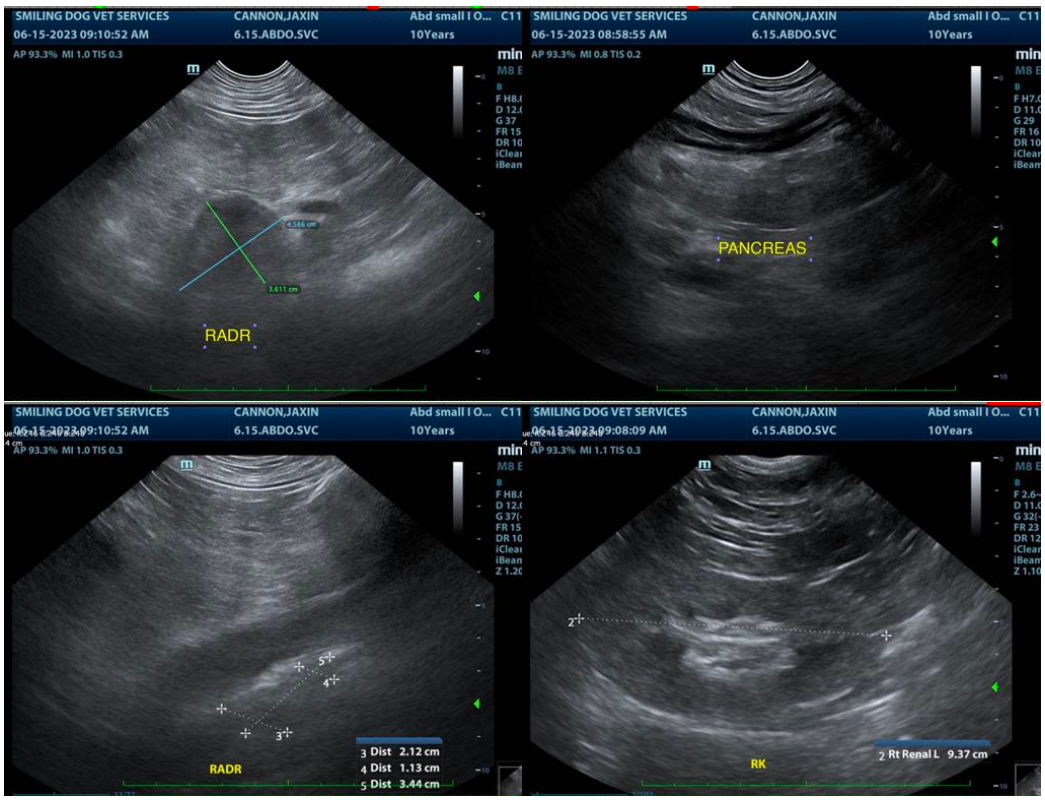
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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. Especially given this patient's reported history of excessive panting. Further evaluation, giving the panting, of possible hyperadrenocorticism i.e., adrenal dependent could be considered beginning with a low dose Dexamethasone suppression test.

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

A fine needle aspirate of the liver mass is also recommended if it can safely be reached and if patient's coagulation status is appropriate. Finally, these patients' clinical signs the panting and spitting up may ultimately not be related to the pathology described in this ultrasound and could be secondary to GERD or early or emerging laryngeal paralysis. There for while awaiting results and completing the work up empirical antacid therapy as well as further evaluation for possible larpar could be considered.



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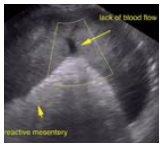
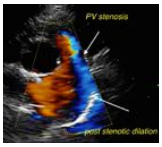
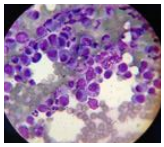
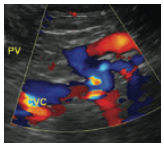

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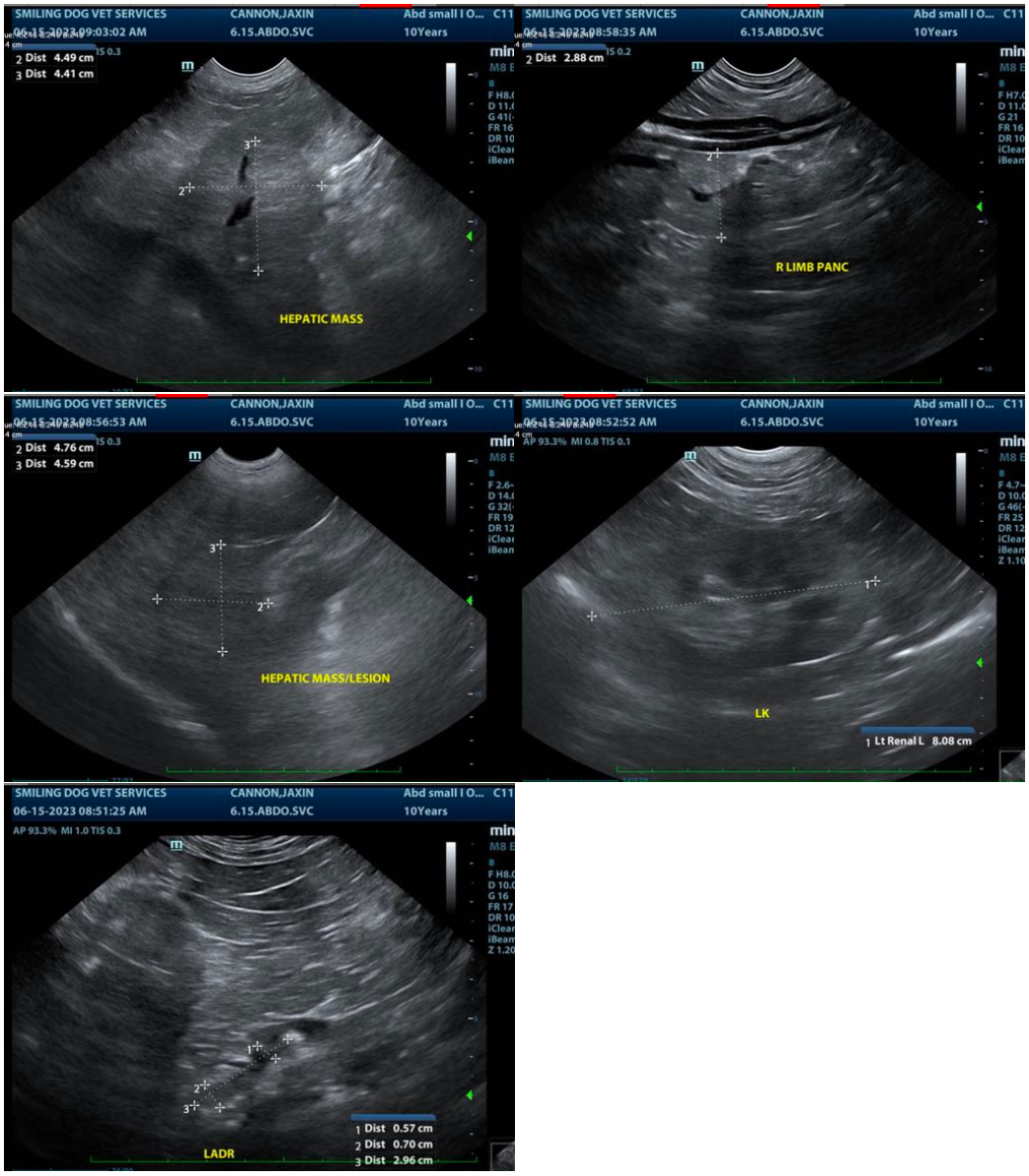

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com