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Clinical Sonography & Telecytology
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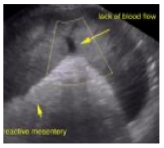
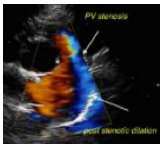
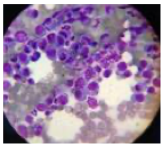
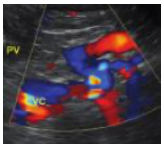

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Mona Bush

SPECIES
Canine

BREED
Boxer X

SEX
Female Spayed

AGE
9 years

WEIGHT
56.4 lbs

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Jessica Bailes

HOSPITAL NAME
All Creatures Gr&Sm VC, Corvallis OR

REFERRING VET
Brent Sadahiro

INVOICE
13669

DATE
7.12.23

PRESENTING CLINICAL SIGNS

History: acute onset lethargy and labored breathing. Just moved here from Florida. Had TPLO Sx (TTA) done 12/22.

Abnormal PE/Chem/CBC/UA Results: Overweight, bilateral rear end mm atrophy w/ thickened stifles; quiet scar L anterior stifle Tachypneic; increased bronchovesicular sounds L side. Thoracic rads: mild generalized bronchointerstitial pattern, otherwise NSF BW: CHEM: hypoglycemia (50), low normal potassium (3.6), otherwise WNL CBC: Leukocytosis (33.1) w/ neutrophilia (30,121) and L shift (bands = 5662) HWAG: negative TT4: decreased @ <0.5 Came back in next day to recheck BG - 100mg/dl on in house glucometer AUS performed today for further evaluation; patient now febrile today @ 103.2 TFAST Today: WNL.

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.

The left kidney is overall normal in size (6.43 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.

The right kidney is overall normal in size (7.55 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.

Adrenal Glands

The left adrenal gland is enlarged (0.86 cm at the cranial pole) with mild heterogenous parenchymal changes. The nodule/mass, involving the caudal pole measures 1.70 cm. Swollen capsular expansion is noted without evident capsular escape or vascular invasion.

The right adrenal gland is small (flattened contour) measuring 0.51 cm at the cranial pole / 0.49 cm at the caudal pole. Corticomedullary structure is unremarkable. 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). No focal nodules or masses are observed. 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. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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.

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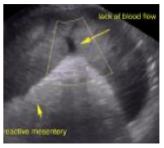
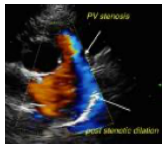
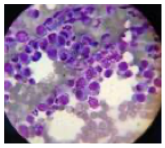
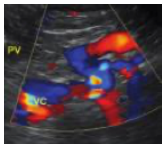

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach contains fluid, with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The proximal duodenum is mildly fluid-distended as well. The remaining bowel is normal 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

- A mildly enlarged left adrenal gland characterized by a caudal pole adrenomegaly with a mildly flat right adrenal gland is concerning for a functional adrenal cortical tumor on the left, which trends in appearance toward benign, as is seen with an adenoma. Adenocarcinoma cannot be ruled out, but is consider less likely.

Secondary Findings

- Age-related kidney changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's fever and lymphocytosis, after originally presenting dyspneic, recheck thoracic radiographs are recommended to look for evidence of pneumonia, which can lag behind radiographically, therefore, explaining why it was not definitive diagnosable when the original x-rays were obtained. Having said that, while this wouldn't explain the fever, other differentials for acute dyspnea, especially given the adrenal gland changes are a pulmonary thromboembolism. Therefore, pending recheck radiographs results, and if pneumonia is ruled out, it may be appropriate to consider further work-up of hyperadrenocorticism, beginning with a low-dose dexamethasone suppression test, as well as a blood pressure and urinalysis and, if indicated based on urinalysis results, urine culture. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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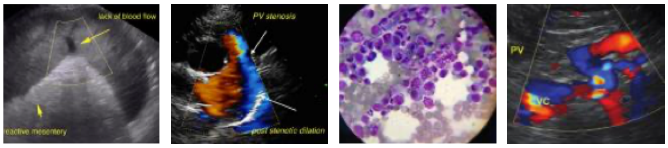

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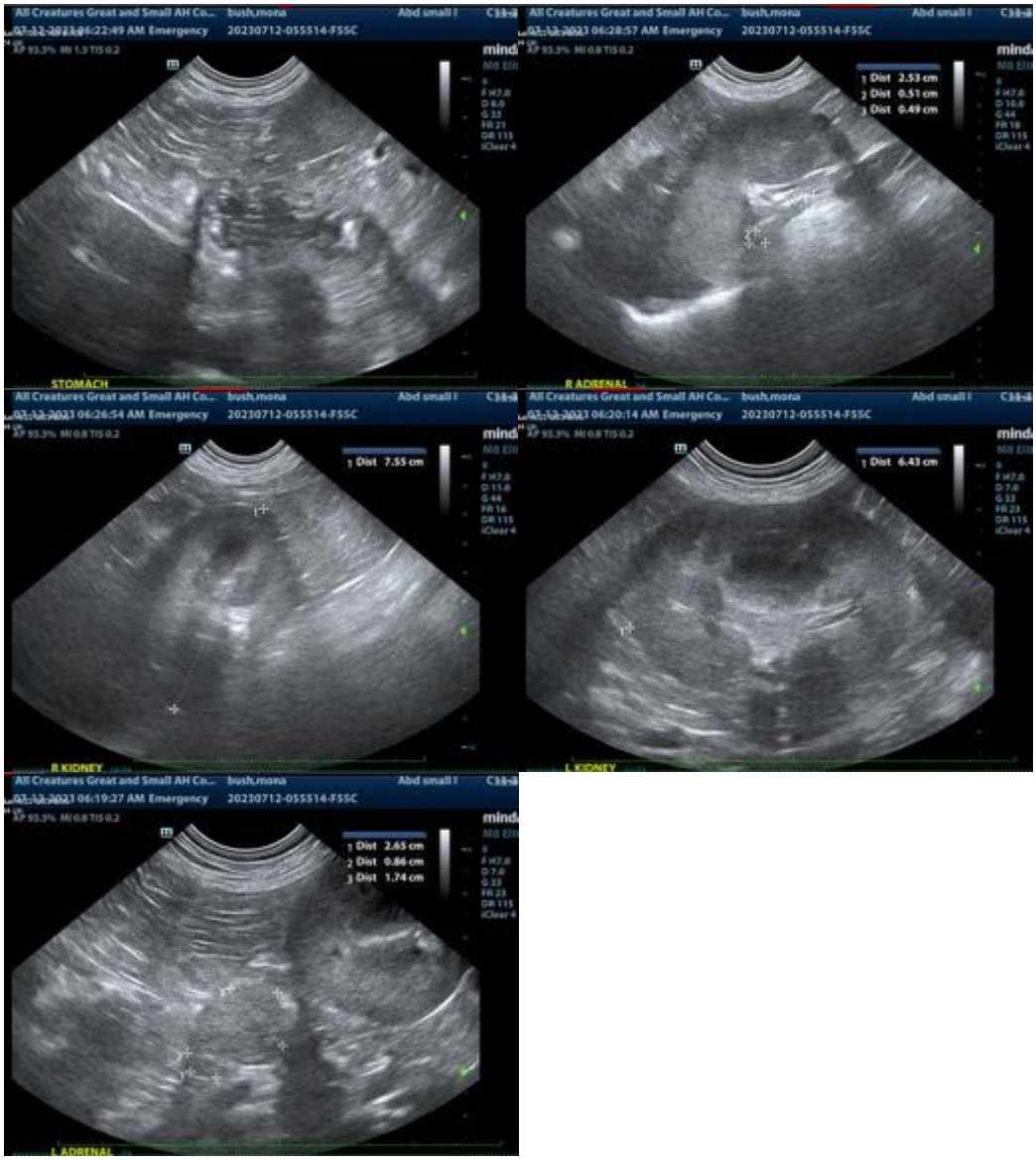

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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