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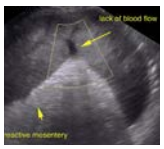
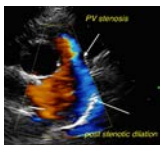
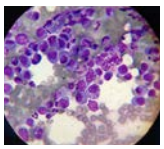
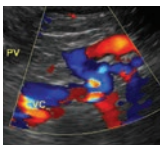

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1-800-838-4268 info@sonopath.com

PATIENT

Toby Spagnolo

SPECIES

Canine

BREED

West Highland White Terrier

SEX

Neutered Male

AGE

14 Years

WEIGHT

19.8 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Carlos Abdul-Chani

HOSPITAL NAME

Byram AH

REFERRING VET

Dr. Maria Cruz

INVOICE

39462

DATE

7/13/22

PRESENTING CLINICAL SIGNS

Decreased appetite, Abd. tense and gassy ; soft stools
Abnormal PE/Chem/CBC/UA Results: Current Meds: Metronidazole 250 mgs @ 1/2 BD CBC/Chem: T4 = WNL / CBC = WNL ; CHEM: Alk Phos. = 646 ; all else WNL Urinalysis: Not done

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.

Prostate (neutered) is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal in size (5.66 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 echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (4.75 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 echogenicity and mild loss of corticomedullary distinction. There is no evidence of mineral or infarcts observed. Mild pyelectasia is noted as well as cortical cysts .

Adrenal Glands

The right adrenal gland is normal in size (1.59 cm long x 0.76 cm at the cranial pole and 0.42 cm at the caudal pole), shape and contour. A hyperechoic nodule is noted in the cranial pole. Nodule does not disrupt normal shape and/or architecture. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (1.72 cm long x 0.39 cm at the cranial pole and 0.52 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen is generally normal in size and shape with a smooth capsular contour. Parenchyma is diffusely nodular in appearance characterized by small discrete hypoechoic nodules. 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 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.

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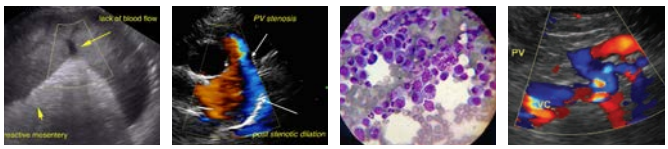

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Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is 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 (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.

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

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.

Free Abdomen

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

There is no apparent lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Hyperechoic right adrenal nodule in the caudal pole – 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.

- Splenic micronodular hyperplasia – This nodular change is often associated with benign aging nodular hyperplasia. Infiltrative neoplasia, however, including both early hemangiosarcoma as well as round cell neoplasia cannot be ruled out.

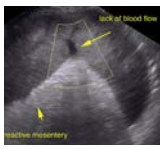
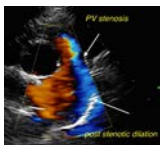
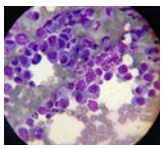
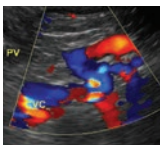
- Gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in 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

This patient's distended abdomen and increased ALP could be secondary to hyperadrenocorticism, given the presence of the right adrenal nodule. Therefore, if other clinical signs of hyperadrenocorticism including polyuria, polyphagia, panting, hair loss, etc. are present, testing could be considered in the form of a low-dose Dexamethasone suppression test in the future. However, hyperadrenocorticism

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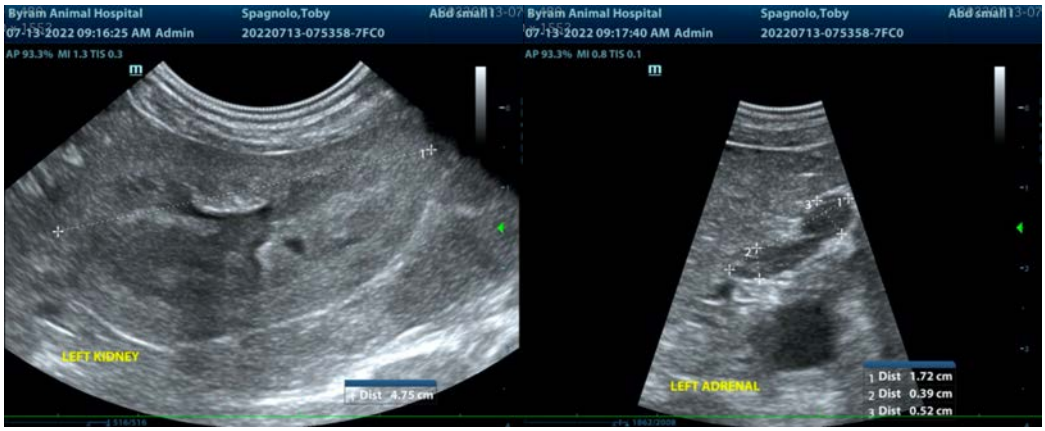
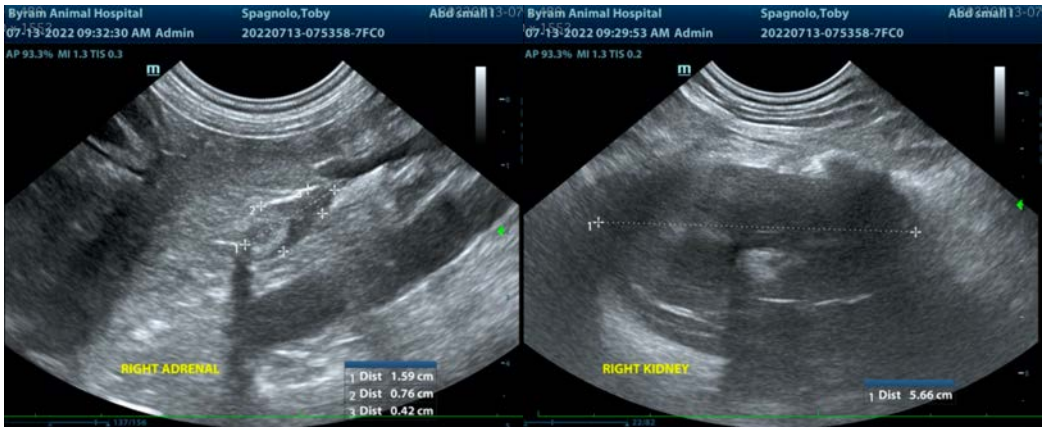
typically does not result in a decreased appetite, except in the rare instance of a pituitary macroadenoma, in which case advanced imaging of the brain such as CT or MRI may be warranted to rule in/out.

However, given the rarity of pituitary macroadenomas, recommendations are to further evaluate occult gastrointestinal or pancreatic disease prior to pursuing advanced imaging of the brain, with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

In the meantime, supportive medical management of potential acute nausea with antiemetics as well as mild gastritis with gastroprotectants +/- appetite stimulants and potentially a transition to a bland, easy to digest or low-fat, or even hypoallergenic diet, could be considered.

Given the suspicion for possible hyperadrenocorticism, blood pressure is recommended if not recently evaluated, as is a 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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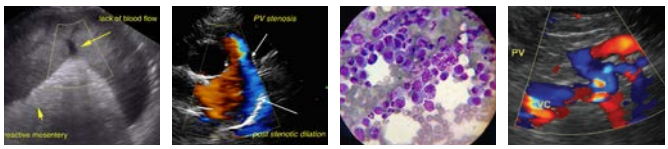

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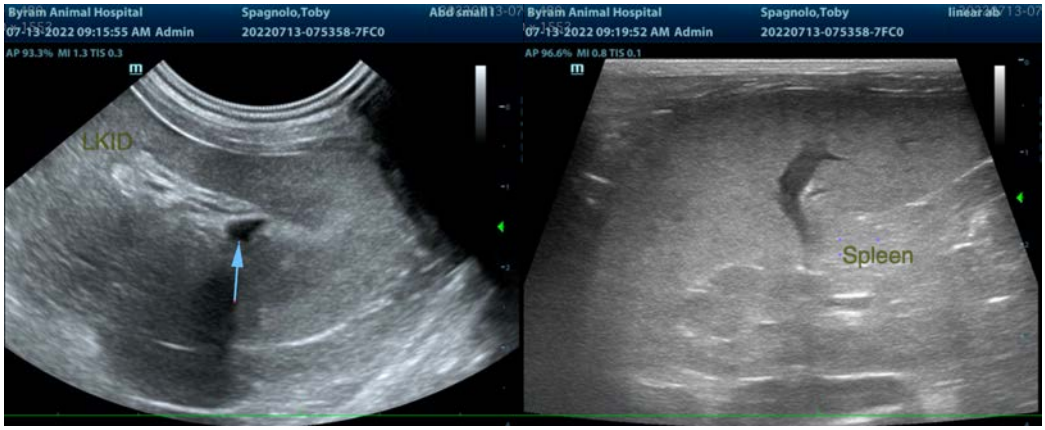

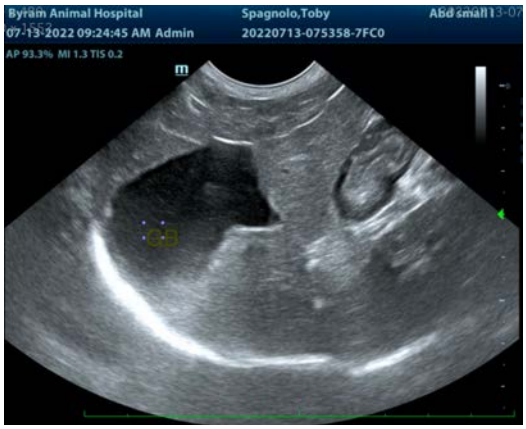

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com