



PATIENT

Lucy Louis

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

11 Years

WEIGHT

55 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Scott

HOSPITAL NAME

Ho Ho Kus VH

REFERRING VET

Dr. Scott

INVOICE

16625

DATE

7/15/22

PRESENTING CLINICAL SIGNS

History: Weight loss- about 8 lbs since March. No change at home otherwise. Hx of allergies and pyoderma.

Abnormal PE/Chem/CBC/UA Results: CBC/CHem WNL chest rads 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.

Left kidney is normal is size (6.5 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.

Right kidney is normal is size (6.8 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 left adrenal gland is enlarged (2.0 cm thick) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted without evident capsular escape or vascular invasion.

Right adrenal gland is normal in size (1.6 cm at cranial pole and 0.95 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). A (0.6 cm- 0.8 cm) hypo- to anechoic, non-capsule disrupting nodule is present in the mid body. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mottled by multifocal discrete hypoechoic nodules of varying sizes "moth-eaten". Visible vasculature and biliary tree appear normal without distension or congestion. The mid liver has an almost emerging mass like appearance, measuring 3.0 cm x 3.5 cm in size and it is hypoechoic in appearance.

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 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.



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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.

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

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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

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There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

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Primary Findings

- Nodular Liver - This finding is concerning for infiltrative disease such as round cell neoplasia or metastatic neoplasia. Benign disease (nodular hyperplasia) cannot be ruled out but is considered less likely. The mid liver appears to be forming an early mass.
- Left adrenal mass – consistent with adenoma or possibly hyperplasia. Early pheochromocytoma cannot be ruled out. Interpret in combination with clinical signs of hyperadrenocorticism or other adrenal disease.

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Secondary Findings

- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A fine needle aspirate of the liver is recommended, if patient coagulation status is appropriate, given the nodular mass likely appearance of the liver. However, the infiltrative process creating the abnormal appearance to the liver may or may not be the cause of the patients weight loss. Therefore, other recommendations to work up the weight loss include:

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To rule out proteinuria as a source of weight loss: 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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To further assess Gi disease: A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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Hyperadrenocorticism is not typically associated with weight loss, therefore, further working up, evaluating and treating the cause of the weight loss is recommended prior to further pursuing the left adrenal mass. At that time, if clinical signs of hyperadrenocorticism, such as polyuria/polydipsia, etc., are present, testing for hyperadrenocorticism, in the form of a low dose dexamethasone suppression test, could be considered. In the meantime, blood pressure is recommended, if not recently evaluated.

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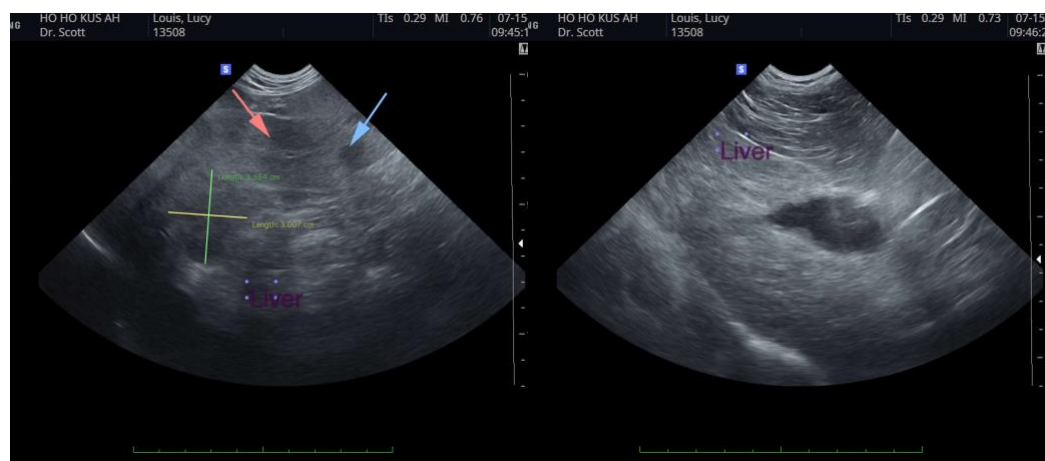
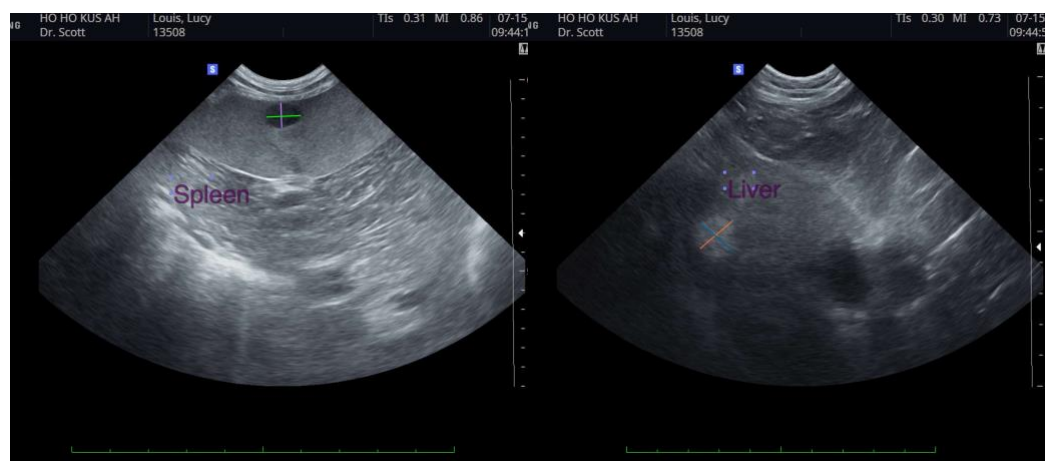
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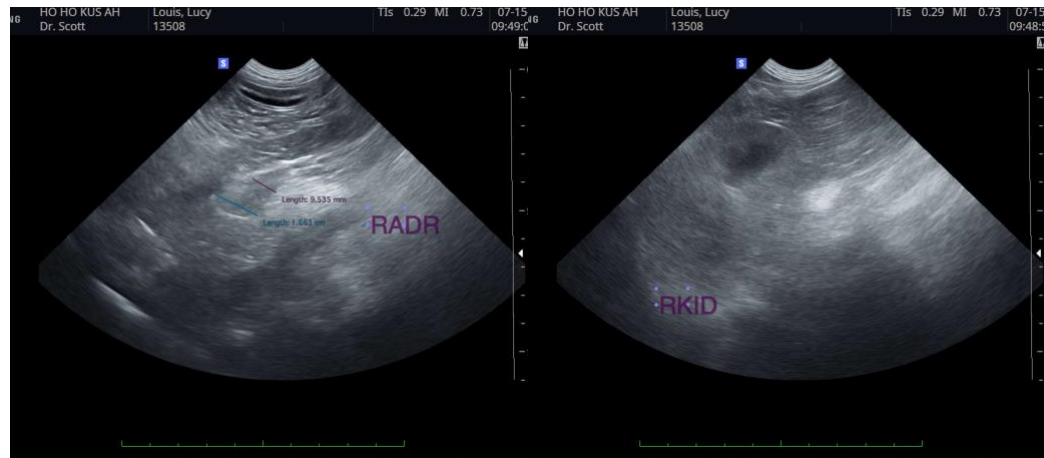
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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