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Clinical Sonography & Telecytology
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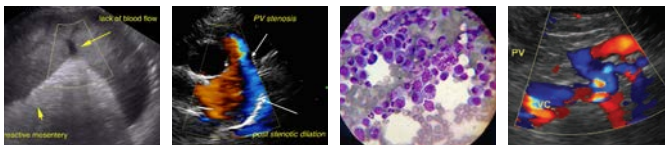

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1-800-838-4268 info@sonopath.com

PATIENT
Zoey Jerry

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
Spayed Female

AGE
10 Years

WEIGHT
7 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Harold Mike Beard

HOSPITAL NAME
Animal Care Vet Center

REFERRING VET
Dr. Chris Ward

INVOICE
40284

DATE
8/10/22

PRESENTING CLINICAL SIGNS

Eats and drinks ok but not as well as normal. Belly is big, but has lost weight.
Abnormal PE/Chem/CBC/UA Results: Survey radiographs reveal a right side cranial abdominal mass. CBC WNL. Chemistry reveals increased BUN, Phos, TBili, lipase. UA dilute urine.

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.

Kidneys are overall normal in size 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. The left kidney measured 4.3 cm. The right kidney measured 4.5 cm. Non-obstructive areas of mineralization/nephroliths are noted bilaterally. Mild pyelectasia is noted on the right kidney.

Adrenal Glands

Adrenal glands are plump/swollen in size (for this size patient) The left adrenal gland measures 0.58 cm thick. The right adrenal gland measures 0.62 cm thick. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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

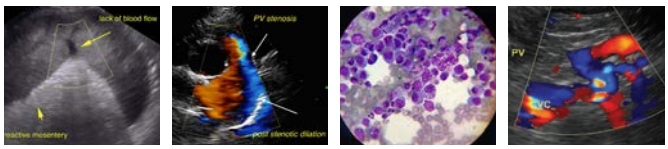
Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. The gallbladder measures 2.0 cm x 3.0 cm. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

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.

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 mildly distended with echogenic



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non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 hepatomegaly -** This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.

- **Emerging mucocele –** 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.

- **Mild bilateral adrenomegaly –** consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism vs stress or normal variant. Interpret in combination with clinical signs of hyperadrenocorticism.

SECONDARY FINDINGS

- Age related kidney change with non-obstructive nephrolithiasis bilaterally

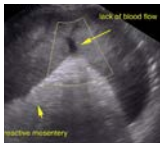
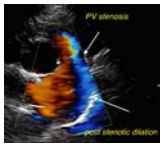
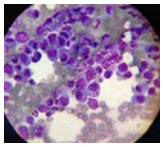
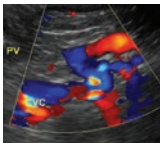
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no evidence of an abdominal mass present in these images. However, hepatomegaly may have mimicked and abdominal mass radiographically.

Given this patient's reported clinical signs of possibly decreased appetite and weight loss combined with laboratory changes, 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.

In the meantime, supportive/symptomatic therapy for the gastrointestinal signs combined with possible mild acute pancreatitis, which isn't always apparent ultrasonographically, as well as the emerging mucocele, with antiemetics, gastroprotectants, appetite stimulant if necessary, and hepatic nutraceuticals include Ursodiol, is recommended. Broad-spectrum antibiotics may also be helpful.

If gastrointestinal signs persist beyond medical management and/or progress, and/or total bilirubin increase persists and/or progresses, recheck fasted abdominal imaging is recommended, and ultimately recommendations may include a cholecystectomy if the emerging mucocele progresses. Incidentally,

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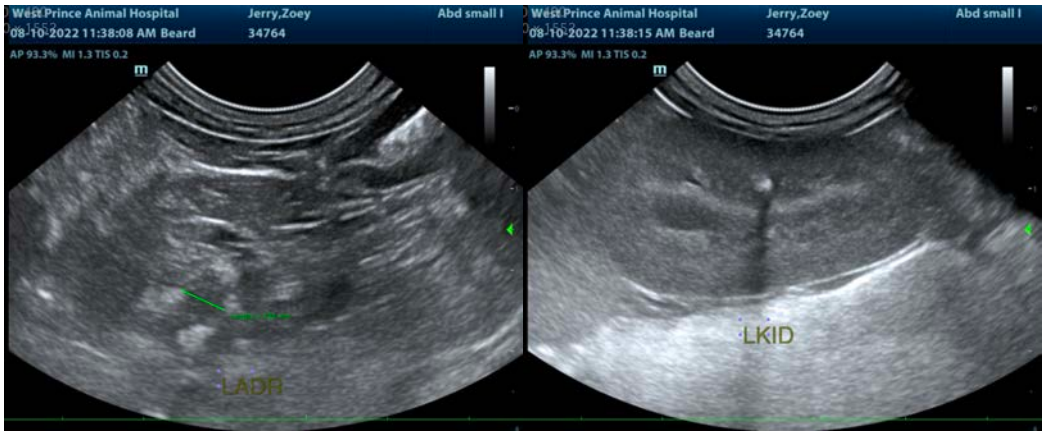
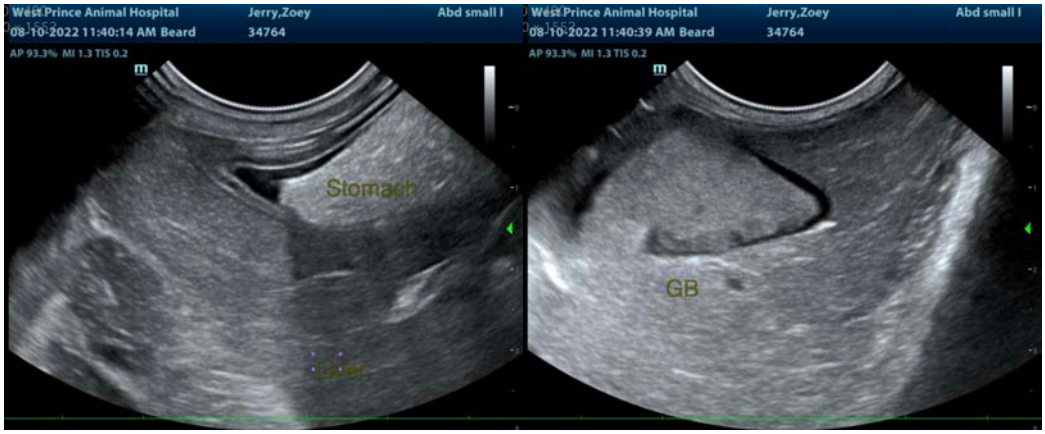
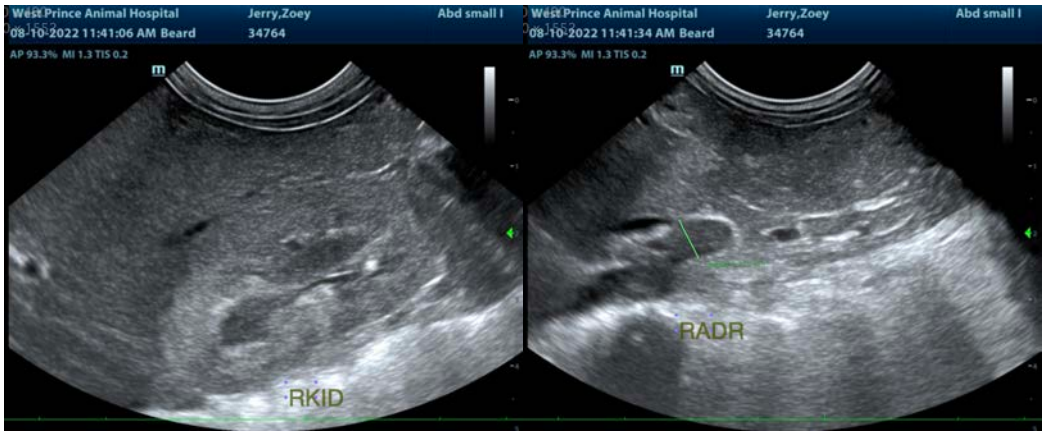
the abdominal changes described in these images are often all seen concurrently with hyperadrenocorticism. Testing for hypoadrenocorticism is not indicated without clinical signs, especially in the face of other illness like the decreased appetite and weight loss being seen now. However, if or when clinical signs of hyperadrenocorticism develop in the future, testing in the form of a low-dose Dexamethasone suppression test may be warranted.







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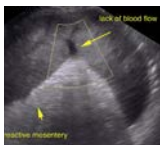
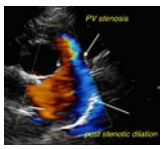
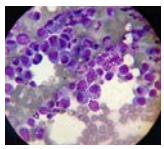
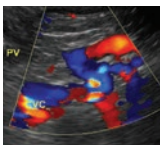

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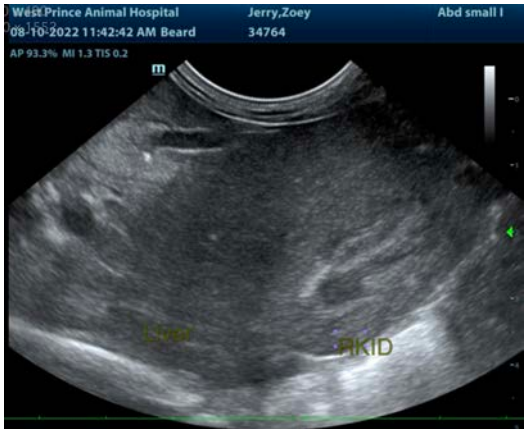

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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