

**DATE PRESENTING CLINICAL SIGNS**

8/14/23 History: Geriatric screen – PU/PD.

PATIENT

Chunk Lynch

Current Medications: None.
 Lab Results: See attached.
 Date of Previous IntraPet Ultrasound: No previous.
 Sedation: Not required to complete full diagnostic ultrasound.
 Stat Report: Not requested.
 Imaging Performed By: Rachel Brillhart, RDMS.

SPECIES

Canine

BREEDAmerican
Staffordshire**SEX**

Neutered Male

AGE

2/1/13

WEIGHT

63 Pounds

INTERPRETED BYBeth Johnson, DVM
DACVIM**HOSPITAL NAME**

Stay Pet Vet

REFERRING VET

Dr. Klimovitz

INVOICE

23952

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.

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

Left kidney is normal is size (6.6 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 small (flattened contour), the cranial pole measures 0.28 cm and caudal pole measures 0.42 cm. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.6 cm at cranial pole and 0.58 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal. A hyperechoic nodule is noted in the cranial pole of the right adrenal gland. Nodule does not disrupt normal shape and/or architecture.

Spleen

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. Additionally, multifocal well demarcated hyperechoic nodules are noted. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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.

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 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 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. The medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Other

There is no evidence of heart base or pericardial pathology noted in these images at this time. If cardiac function evaluation is desired a full echocardiogram is recommended.

ULTRASONOGRAPHIC FINDINGS

- A right adrenal nodule with a concurrently flat left adrenal gland is concerning for a functional adrenal cortical disease, i.e., adrenal dependent hyperadrenocorticism. There are no visible characteristics of malignancy to support adenocarcinoma vs an adrenal adenoma. Having said that, adrenal hyperplasia, secondary to pituitary dependent hyperadrenocorticism or even normal patient variant are also possible, as the changes are relatively mild.
- Splenic micronodular hyperplasia – This nodular change can be associated with benign aging nodular hyperplasia, however, infiltrative neoplasia, including both early hemangiosarcoma as well as round cell neoplasia should be ruled out. The hyperechoic nodules are most consistent with benign myelolipomas.
- Heterogenous Liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

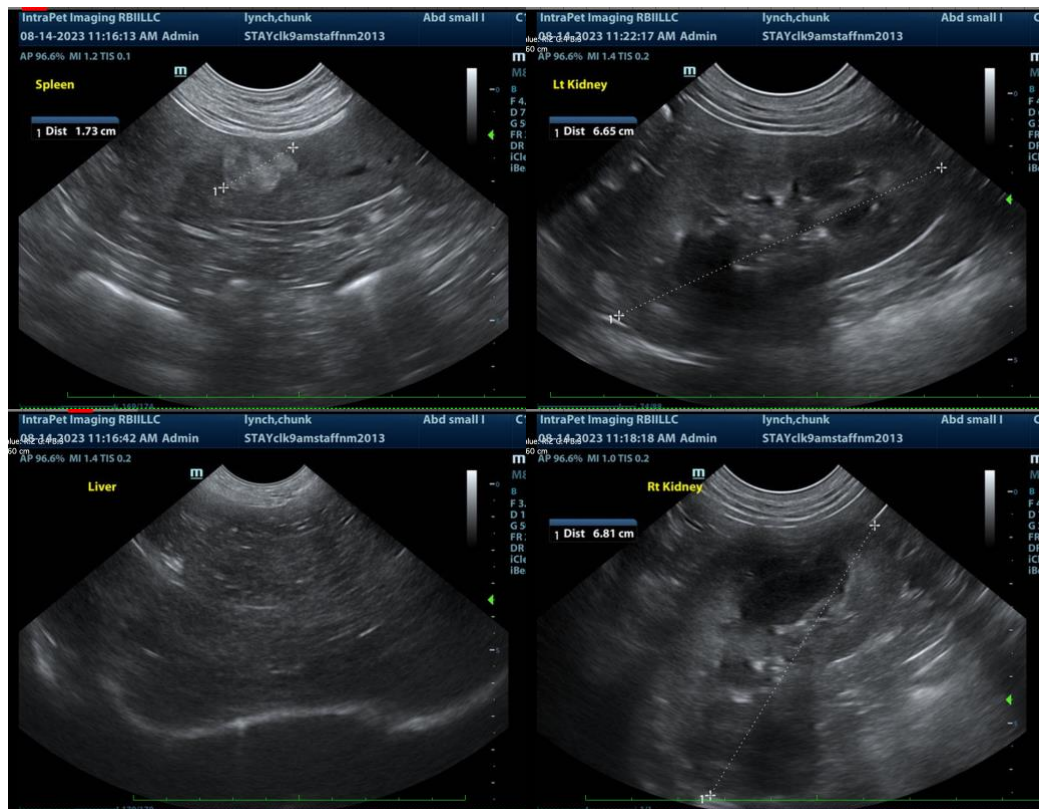
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

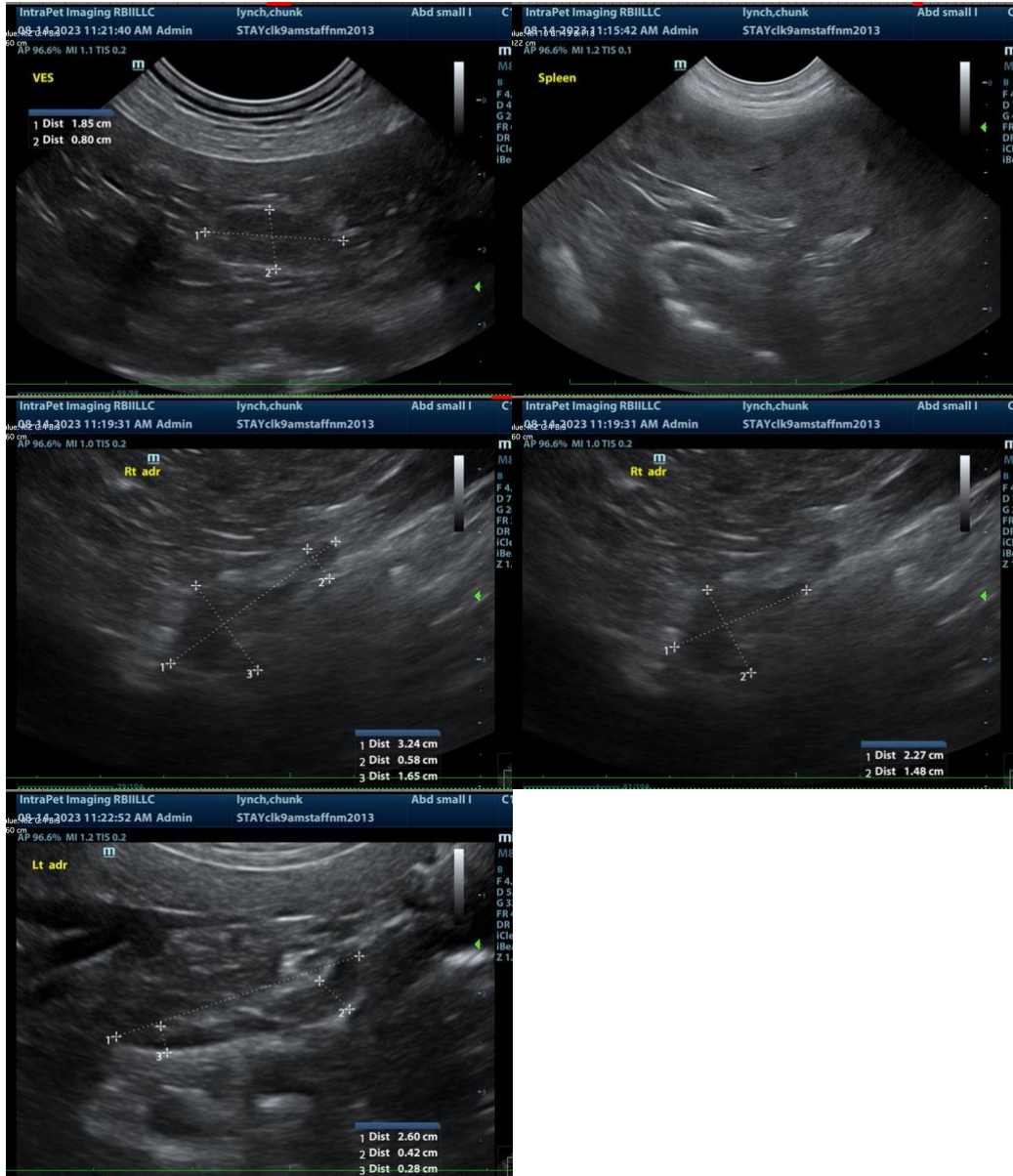
If not recently evaluated, three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

A fine needle aspirate of the spleen is recommended if patient coagulation status is appropriate.

A thorough rectal and perianal exam is recommended if not recently evaluated given the medial. Iliac/sublumbar lymphadenopathy, and pending results, fine needle aspirate of that lymph node could also be considered, if it can safely be reached, which may be difficult.

Finally, pending results of above, if other more serious illness is ruled out, further testing for hyperadrenocorticism could be considered beginning with a LDDST to help determine best course of treatment.





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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