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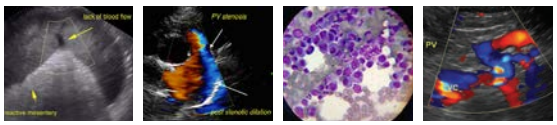

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT
Duffy Phillips

SPECIES
Canine

BREED
Poodle

SEX
Neutered Male

AGE
13 Years

WEIGHT
18.5 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Jenna Walsh, CVT

HOSPITAL NAME
West Hills AH

REFERRING VET
Dr. Remcho

INVOICE
44592

DATE
8/8/23

PRESENTING CLINICAL SIGNS

Hearing and vision changes along with possible cognitive changes. Also hair thinning (symmetrical). P has variable appetite without weight loss. Radiographic Findings From June 2022 This report describes evaluation of three view orthogonal radiographs of the thorax and three view orthogonal radiographs of the abdomen. Eight radiographs are available for review. Radiographs dated February 1, 2019 are available for comparison. Thorax: Diffusely throughout the pulmonary parenchyma there is an increase in soft tissue opacity that follows airways and partially obscures pulmonary blood vessels (old dog lung/chronic interstitial fibrosis). The heart(VHS 10), pulmonary parenchyma and pulmonary blood vessels have normal size, shape and opacity. The trachea has normal diameter and position. The diaphragm has normal shape and contour. Mediastinum and pleural space are within normal limits. Thoracic lymph nodes are not detected. The thoracic musculoskeletal system is within normal limits. Abdomen: The liver, spleen, stomach, small intestine, colon, kidneys and urinary bladder have a normal size, shape and opacity. The peritoneal and retroperitoneal detail is adequate. Abdominal lymph nodes are not detected. The abdominal musculoskeletal system is within normal limits. The hip joints are within normal limits. Assessment: 1. Clinically normal radiographs of the thorax and abdomen. Discussion: A definitive cause of cough is not determined during this evaluation. I cannot exclude an upper airway cause of cough. If clinically warranted, transtracheal wash or BAL with cytology, culture and sensitivity should be considered. This test is negative for cardiomegaly, congestive heart failure, thoracic metastasis, abdominal organomegaly, regional lymphadenopathy and an aggressive bone lesion. Repeat radiographs as clinically indicated. Primary Question/Differential to Be Answered in This Exam liver eval and overall senior screen

Abnormal PE/Chem/CBC/UA Results: ALT 499, AST 93, ALP 495, GGT 19, proBNP 1798, USG 1.020

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

The right kidney is normal in size (4.67 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.

The left kidney is normal in size (4.52 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 right adrenal gland is small (flattened contour) measuring 0.82 cm at the cranial pole and 0.64 cm at the caudal pole. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is enlarged with mild heterogenous parenchymal changes, primarily involving the caudal pole, which measures 2.6 cm wide. The cranial pole measures 0.65 cm. Swollen capsular expansion is noted without evident capsular escape or vascular invasion.

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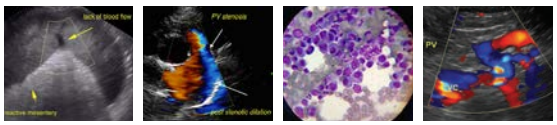

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Spleen

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

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.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. 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 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.

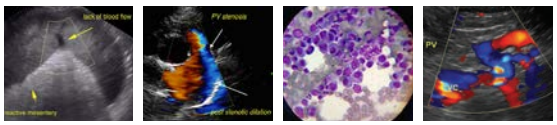
Free Abdomen

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

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Left adrenal mass with a concurrently flat right adrenal gland – consistent with a functional adrenal cortical tumor such as an adenoma. There are no factors of malignancy to support infiltrative neoplasia, but having said that, early or emerging adenocarcinoma cannot be definitively ruled out. Additionally, a pheochromocytoma is a differential. While hyperplasia secondary to pituitary dependent hyperadrenocorticism is less likely with one large gland and one flat gland, given this patient's reported other clinical signs, a pituitary macroadenoma should also be considered.



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- **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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

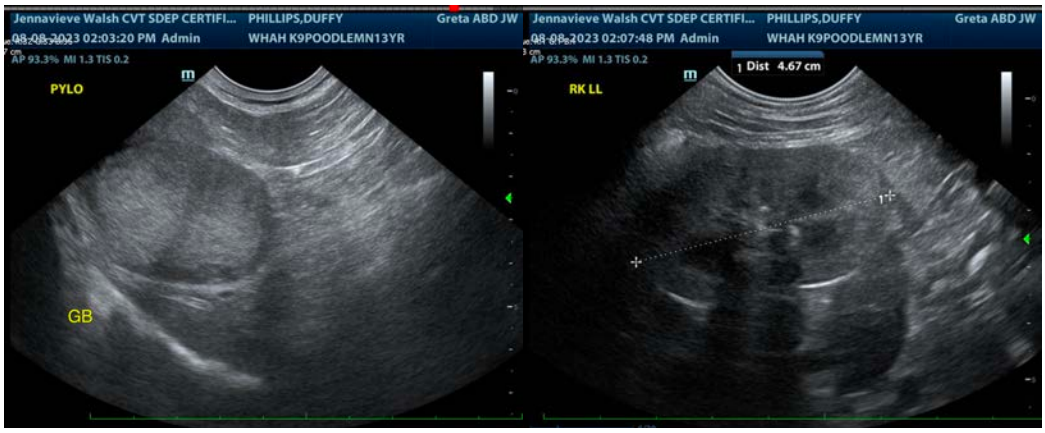
Given this patient's adrenal changes combined with the reported clinical signs, if not recently evaluated a blood pressure is recommended.

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 ratio is recommended.

Further evaluation of adrenal cortical function is recommended, beginning with a low-dose Dexamethasone suppression test.

Finally, while the appearance of the adrenal glands is more consistent with adrenal dependent disease, given this patient's reported possible central nervous system signs, a pituitary macroadenoma should be investigated with advanced imaging such as a CT or MRI.

Additionally, the emerging gallbladder mucocele could be contributing to the patient's liver enzyme abnormalities as well as potentially intermittent appetite changes. Further intervention in the form of either medical management such as Ursodiol +/- broad-spectrum antibiotics and monitoring, up to and including possible surgery for gallbladder removal, could be considered depending on adrenal workup results and patient's continued clinical signs or lack thereof.



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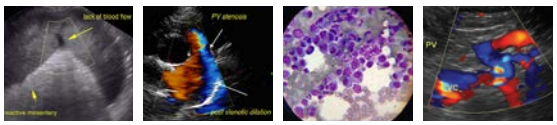

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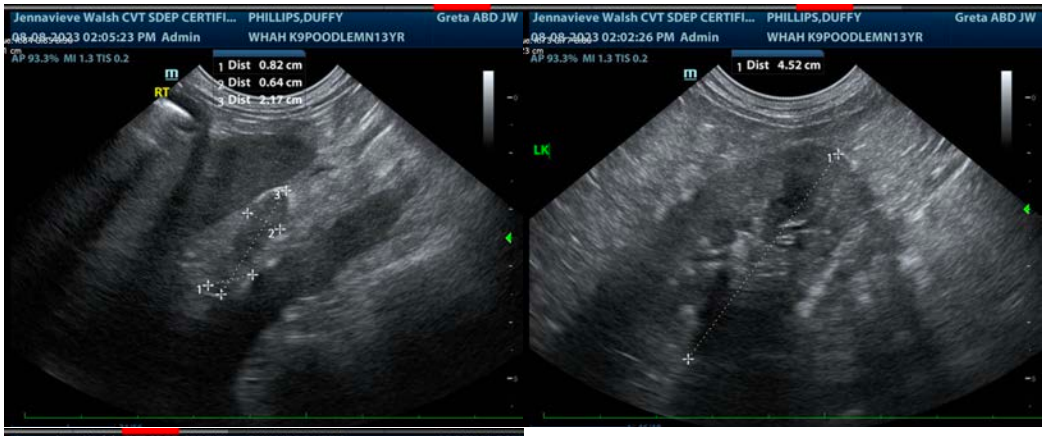

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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