



PATIENT

Amy Ballard

SPECIES

Canine

BREED

Beagle Mix

SEX

Spayed Female

AGE

9 Years

WEIGHT

58 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Carlos Abdul-Chani

HOSPITAL NAME

Byram AH

REFERRING VET

Dr. Carlos Abdul-Chani

INVOICE

17280

DATE

9/13/22

PRESENTING CLINICAL SIGNS

History: Reason for Ultrasound: R/O Abdominal neoplasia; spleen/liver pendulous abdomen Current Meds: Amoxi/Metronidazole

Abnormal PE/Chem/CBC/UA Results: CBC/T4 WNL; Chem: Alk phos 1004; 9/2/22 Abdominal X-ray - enlarged spleen Abnormal U/A findings: WBC 11 - 20 HPF; else WNL Urine Specific Gravity: 1.021

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 (6.85 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 (7.77 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 (4.8 cm long x 1.76 cm at the cranial pole and 2.27 cm at the caudal pole) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted without evident capsular escape or vascular invasion.

Right adrenal gland is small in size (2.58 cm long x 0.46 cm at cranial pole and 0.75 cm at caudal pole) with a flattened contour. Corticomedullary structure is unremarkable. The visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. 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.



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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.

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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.

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Free Abdomen

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

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ULTRASONOGRAPHIC FINDINGS

- Left adrenal mass- most consistent with adenoma given the concurrently subjectively flat right adrenal gland. Hyperplasia is possible but considered less likely. Adenocarcinoma or early pheochromocytoma cannot be ruled out but are considered less likely and this finding should be interpreted in combination with clinical signs of hyperadrenocorticism or other adrenal disease.
- 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.
- Hypersplenism – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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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.

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The described adrenal gland and liver changes are suggestive of hyperadrenocorticism. If clinical signs of hyperadrenocorticism, such as polyuria, polydipsia, polyphagia, panting, hair loss, hypertension, etc. are present, testing for hyperadrenocorticism with a LDDS test is warranted.

If clinical signs are not present, monitoring is recommended with testing pursued when/if clinical signs develop.

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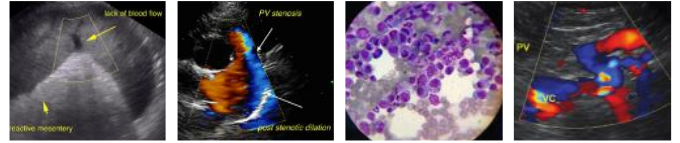
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If not recently evaluated, blood pressure is recommended.

If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture are also recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

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Ultimately, if this is adrenal dependent disease, a left adrenalectomy may be the treatment of choice, in which case a presurgical planning abdominal CT scan may be beneficial to more definitively rule out vascular invasion and/or other evidence of malignant disease.

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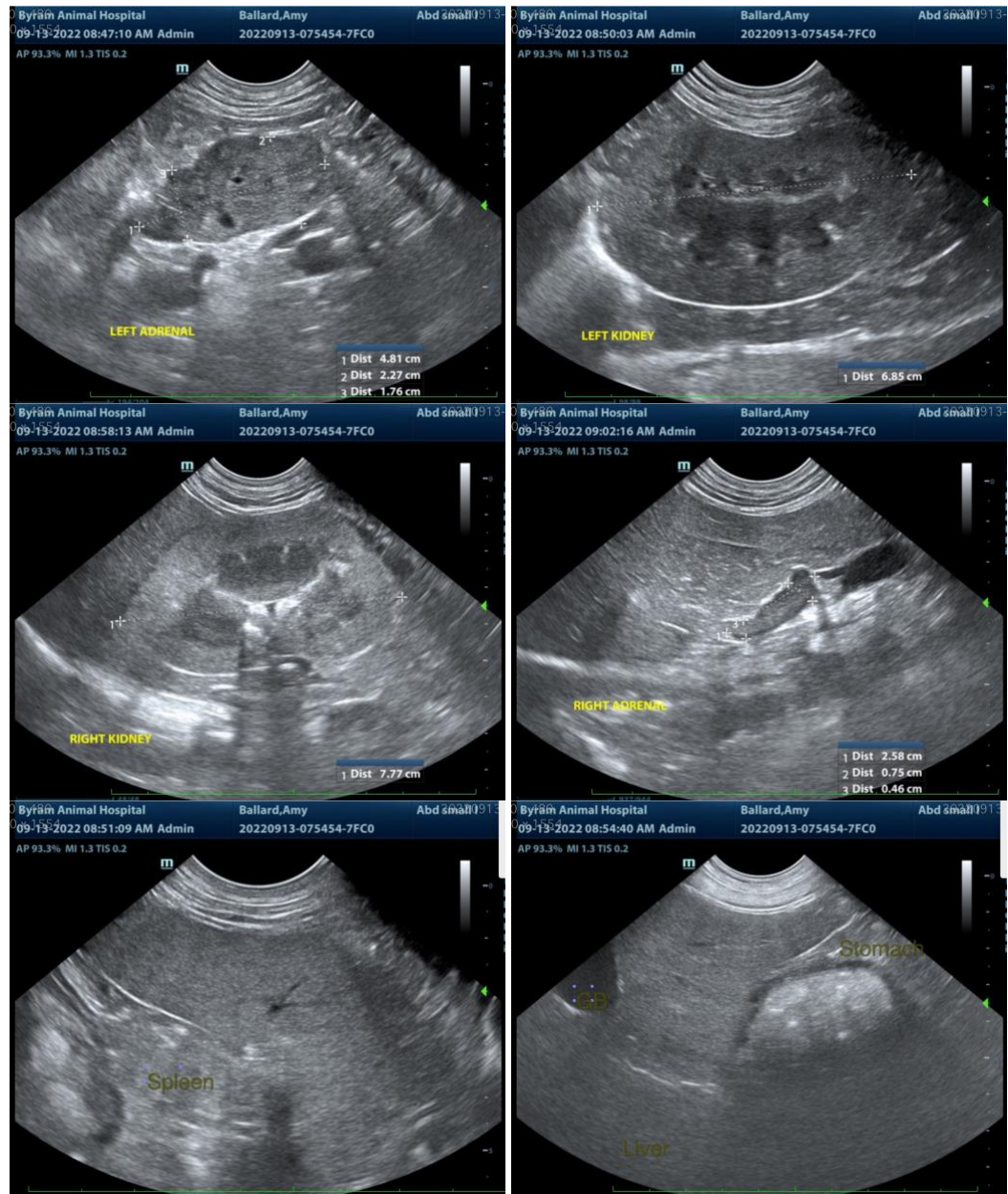
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.



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