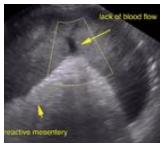
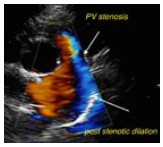
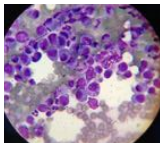
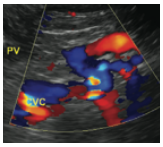
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Riley Gianzero

SPECIES
Canine

BREED
Labrador

SEX
Neutered male

AGE
12.5 years

WEIGHT
108 lbs

INTERPRETED BY
Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY
Dr. Smatt

HOSPITAL NAME
The Pets I Love

REFERRING VET
Dr. Smatt

INVOICE
42524

DATE
11/15/22

PRESENTING CLINICAL SIGNS

History: Patient has hy of PU/PD, besides the LPAR breathing problems. Overweight. Routine blood work revealed elevated Liver Values and Cholesterol (see below) Haven't done LDDST yet
Abnormal PE/Chem/CBC/UA Results: ALT (SGPT) 142 HIGH Alk Phosphatase 574 HIGH CHOLESTEROL 411 HIGH

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The prostate in an intrapelvic location and not definitively visualized.

The kidneys have a smooth capsule and with mild hazing of corticomedullary definition with approximate maintenance of normal ratio (cortex 1/3 of medulla). No evidence of pelvic dilation was present. The right kidney measured 5.6 cm. The left kidney measured 6.5 cm.

Adrenal Glands

The right adrenal gland has a normal parenchyma with no enlargement or masses and is subjectively slightly small. The right adrenal gland measured 2.2 x 0.55 cm at the cranial pole and 0.57 cm at the caudal pole. The left adrenal gland is enlarged and hypoechoic to slightly irregular in echotexture. The left adrenal gland measures 3.4 x 1.5 cm at the cranial and caudal pole. No specific nodules or masses are visualized within the left adrenal gland, but the left adrenal gland is generally enlarged.

Spleen

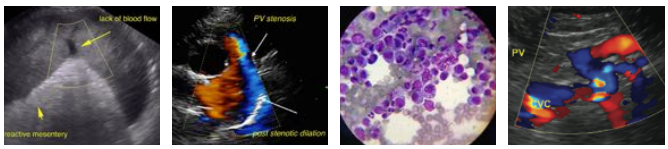
The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule. Peri-vascular hyperechogenicity is noted. This is consistent with benign myelolipoma. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and



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there is no impression of reduced peristaltic activity. No masses or focal lesions were observed. The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Left adrenomegaly with parenchymal changes.
- Liver appears difficult to image likely due to the patient's size and confirmation. However, the visible liver appears overtly normal making a primary hepatic disease unlikely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most likely reason for this patient's clinical signs of PU/PD along overweight status and the biochemistry changes is adrenal dependent hyperadrenocorticism or Cushing's disease given the enlargement of the left adrenal gland. There is no visible vascular invasion in this study and ultimately adrenalectomy may be curative. However, prior to considering adrenalectomy adrenal gland function testing is recommended. Low-dose Dexamethasone suppression test can be used to confirm our suspicion of secreting adrenal tumor. If surgery is to be pursued you should consider a urine metanephrine test to screen for the off chance that this tumor is a pheochromocytoma. Although unlikely, surgical removal of a pheochromocytoma without pretreatment carries a very high perioperative mortality so screening to absolutely rule that out is recommended. CT prior to surgery can be considered as vascular invasion is not always ultrasonographically apparent, but can complicate surgical removal. Alternatively if surgical removal is not desired after confirmation of diagnosis then treatment with Trilostane may control the pets clinical signs. Routine monitoring of the adrenal gland for progression and enlargement of the mass should be considered as up to 50% of these masses can be metastatic.

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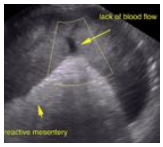

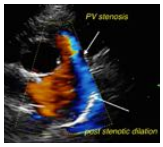

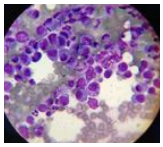
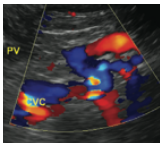

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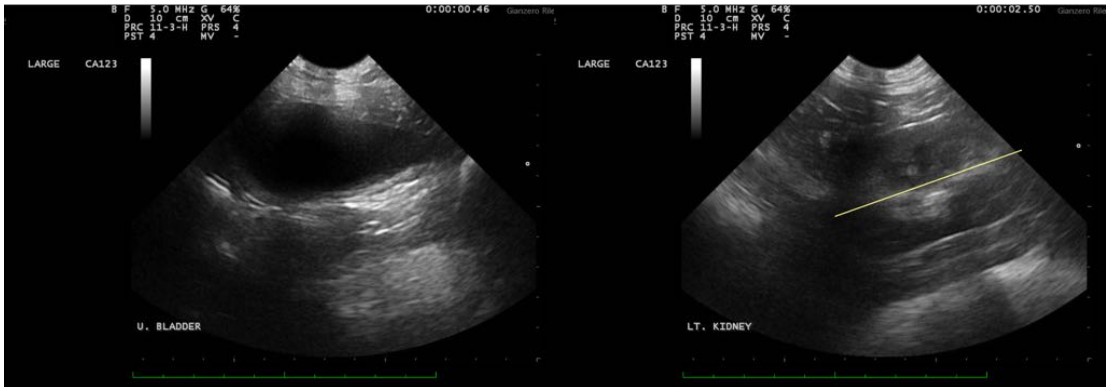

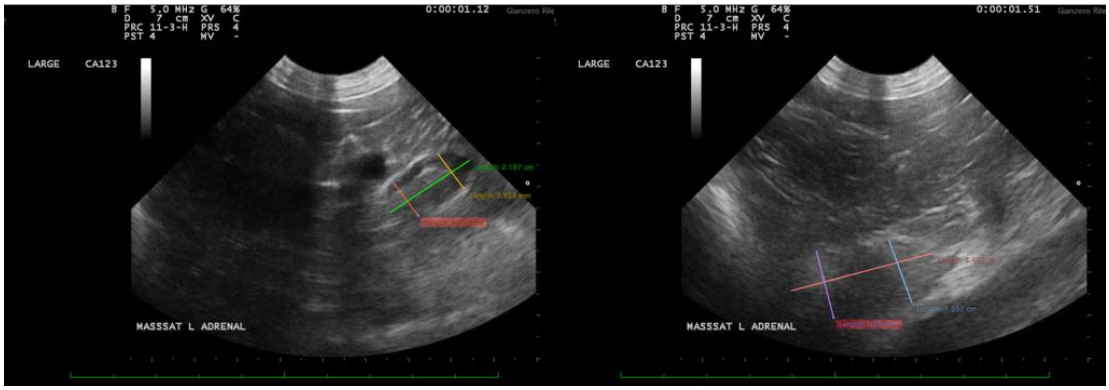

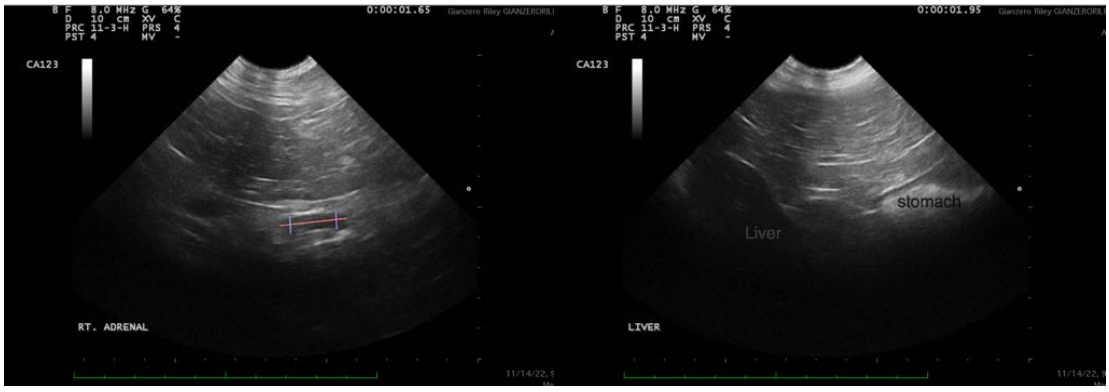

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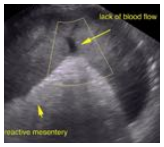

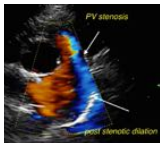

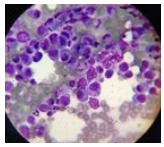
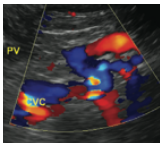

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
info@SonoPath.com