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Clinical Sonography & Telecytology
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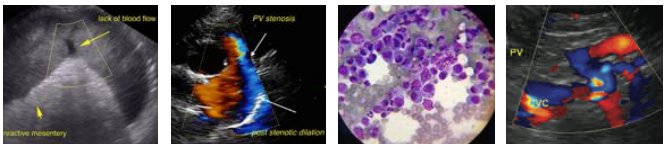

PATIENT
Frank Boline

SPECIES
Canine

BREED
Dachshund

SEX
Male

AGE
14 years

WEIGHT
6.4 kg

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Dr. Peterson

HOSPITAL NAME
Wilvet Salem

REFERRING VET
Dr. Peterson

INVOICE
94449

DATE
12/10/21

PRESENTING CLINICAL SIGNS

History: Patient admitted to hospital due to ADR, recently stopped eating, History of a heart murmur, IVDD, and bad teeth.
Abnormal PE/Chem/CBC/UA Results: BUN 49, significant hypercalcemia >16, globulin 4.8, ALP 837, GGT 15, hypernatremia 176, hyperchloremia 135, slight neutrophilia 12.07 K/uL, monocytosis 2.18 K/uL, thrombocytosis.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** and visible pelvic urethra were unremarkable for the level of repletion presented. The urine, however, did present some mildly echogenic debris consistent with mucous, exfoliated cells from renal or bladder origin, and/or blood clots as these echogenic changes can all present similarly. This is often related to urinary tract infection but may represent simple evidence of exfoliated debris or sterile inflammation. Cystocentesis, urinalysis, +/- culture would be recommended to rule out and define any UTI.

The **prostate** was uniformly enlarged with lobar swelling appeared to impinge upon the urethra and mildly deviate the descending colon. The prostatic tissue was hyperechoic containing focal areas of decreased echogenicity. These changes are suggestive of either chronic inflammatory episodes, benign cystic pathology or both. Underlying neoplasia cannot be completely ruled-out but is lower on the differential list. This presentation is most consistent with benign prostatic hyperplasia with possible active prostatitis. Neutering or off-label Finasteride (Propecia) (0.1-0.5 mg/kg Sid) treatment is indicated +/- FNA or prostatic wash cytology and culture. The prostate measured 3.2 cm in short axis.

The iliac trifurcation was unremarkable.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 5.0 cm. The right kidney measured 5.0 cm.

Adrenal Glands

The left adrenal gland was enlarged and irregular. The left adrenal gland appeared to invade the left phrenic vein and measured approximately 2.0 x 2.0 cm. The left adrenal gland was mildly vascular. The right adrenal gland was mildly enlarged and measured 1.4 cm at the cranial pole and 0.8 cm at the caudal pole.

Spleen

The **spleen** revealed a mixed, echogenic mass at the caudal pole that measured 2.0 cm. There was no evidence of rupture. The remainder of the spleen revealed areas of mineralization.

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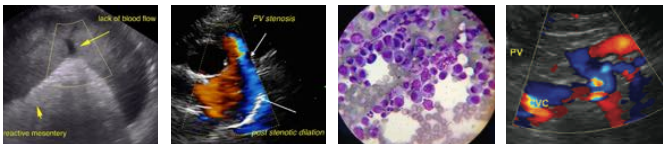

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Liver

The **liver** was uniformly swollen with minor, excessive gallbladder debris and over distension with dependent and suspended bile without evidence of overt mucocele formation. However, excessive sludge was present. The liver presented coarse architecture with mildly increased portal markings and subtle, mixed echogenic changes. This is consistent with vacuolar hepatopathy and some level of remodeling and history of inflammatory component. There was no overt suspicion of neoplasia.

Gastrointestinal

The **gastric** wall presented mild concentric thickening with echogenic, mucosal remodeling. Enhanced mesentery was noted around the stomach. This is suggestive for inflammation.

Pancreas

The **pancreas** revealed diffuse, hyperechoic changes. This is consistent with fibrosis and remodeling.

ULTRASONOGRAPHIC FINDINGS

Left adrenal mass with phrenic vein invasion.

Prominent right adrenal gland.

Gastritis pattern with pancreatic remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I am concerned for pheochromocytoma or adenocarcinoma of the left adrenal gland. This is not a typical pathology that brings hypercalcemia. Therefore, other causes of hypercalcemia such as cranial mediastinal mass, anal gland mass or primary parathyroid tumor should be considered. CT evaluation would be warranted to assess for potential surgical solution for the left adrenal gland. Serial blood pressure measurements +/- urine catecholamine is indicated.

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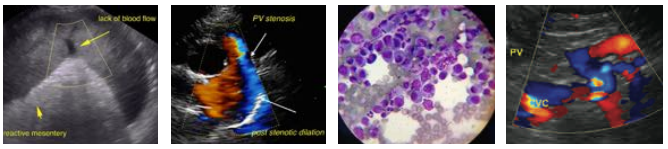

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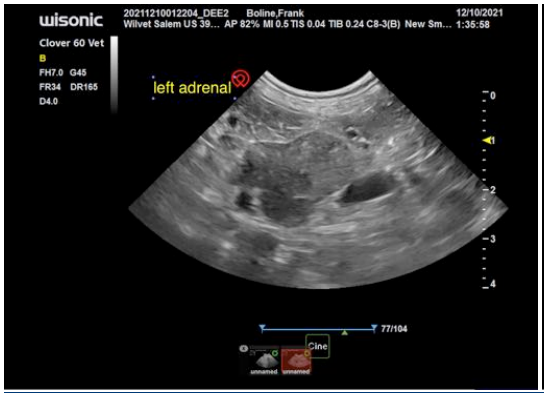

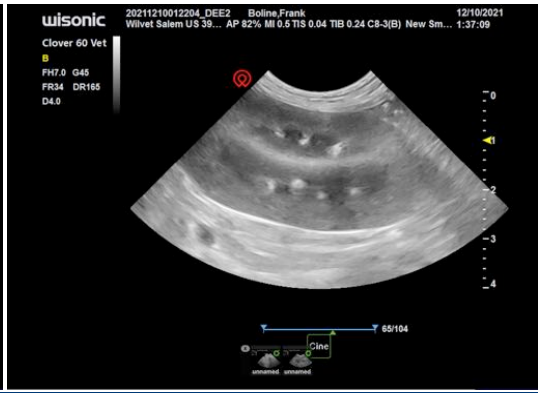

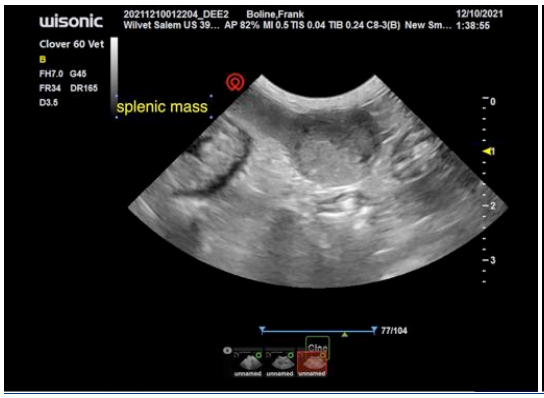

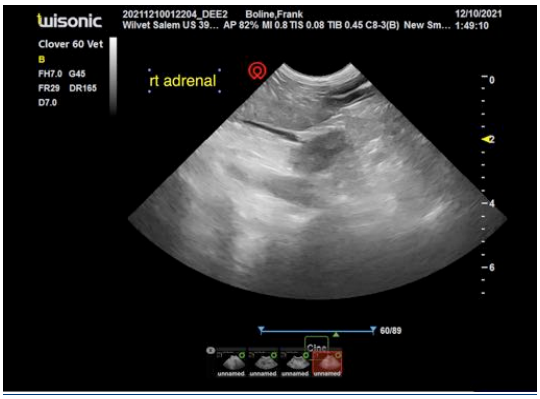

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com