

**DATE**

2/3/22

**PRESENTING CLINICAL SIGNS**

History: This patient presented on emergency on 1/28/22 for ingestion of 1/2 of a pound of Cosequin without magnesium the night before. The patient had vomited 2 times overnight (unsure if it was food or the product). Poison control was contacted and there was a concern for potential foreign body issues and possible hepatotoxicity. Further, the owner noted that the pet has been excessively eating over the past few months. She will eat anything she can get ahold of. This is not like her at all. The patient was treated with fluid SQ, Cerenia, Famotidine and sent home with Denamarin. Clinically the patient is eating and doing OK. Unsure if lab elevations are really due to ingestion of Cosequin or if they are due to some other underlying pathology that has been going on for a few months.

**PATIENT**

Lune Hurley

**SPECIES**

Canine

**BREED**

Labrador Retriever Mix

**SEX**

Spayed Female

**AGE**

8/23/09

**WEIGHT**

63.4 lbs

**INTERPRETED BY**Eric Lindquist, DMV  
DABVP, Cert. IVUSS**HOSPITAL NAME**Noah's Ark Veterinary  
and Boarding Resort**REFERRING VET**

Dr. Gostyla

**INVOICE**

95800

Current Medications: Cosequin – years, Simparica Trio.

Lab Results: (1/28/22) - ALT 185 (10-125) ALP 1598 (23-212). (2/1/22) = ALT 255 (10-125) ALP 1696 (23-212).

Radiographs: 1/28/22 - abdominal radiographs - no significant finding.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Rachel Brillhart, RDMS.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

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 6.0 cm. The right kidney measured 5.47 cm.

**Adrenal Glands**

The **adrenal glands** appeared slightly enlarged and swollen. This is considered likely a hyperplastic change associated with stress or adrenal endocrinopathy (PDH). If isosthenuria is persistently present and the patient morphologically suggests Cushing's disease then ACTH testing would be indicated. Swelling was noted at the left phrenic vein, yet color flow revealed no evidence of deficits. The left adrenal gland measured 3.0 x 1.13 cm at the cranial pole and 0.97 cm at the caudal pole. The right adrenal gland measured 3.35 x 1.02 cm at the caudal pole and 1.19 cm at the cranial pole.

**Spleen**

The **spleen** was largely smooth with subtle heterogeneous parenchymal changes while maintaining normal echogenic relationship to the liver and kidney. These changes are consistent with normal age-related alteration. The capsule was smooth without noticeable impingement from within the spleen or from pathology in the adjacent abdomen. The splenic vasculature demonstrated normal volume without signs of congestion or significant contraction. No evidence of active acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

**Liver**

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically

significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

### **Gastrointestinal**

The **stomach** revealed a mild amount of gastric wall thickening with anechoic fluid. There was no overt loss of mural detail noted. A rounded, hypoechoic, intramural cyst or mass measuring 1.78 x 1.74 cm was noted. This impinges upon the intestinal lumen. This is adjacent to the pylorus. There was no capsular escape noted.

### **Pancreas**

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

### **Free Abdomen**

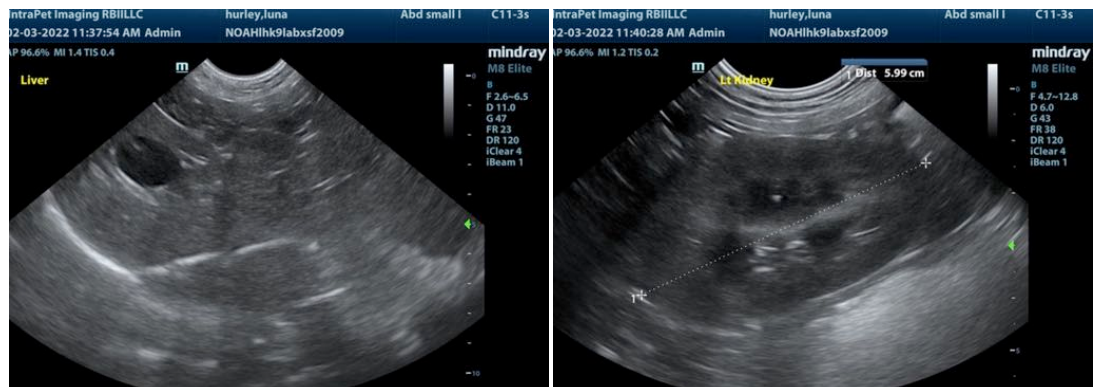
Sublumbar lymph node was slightly enlarged and measured 1.17 x 0.68 cm.

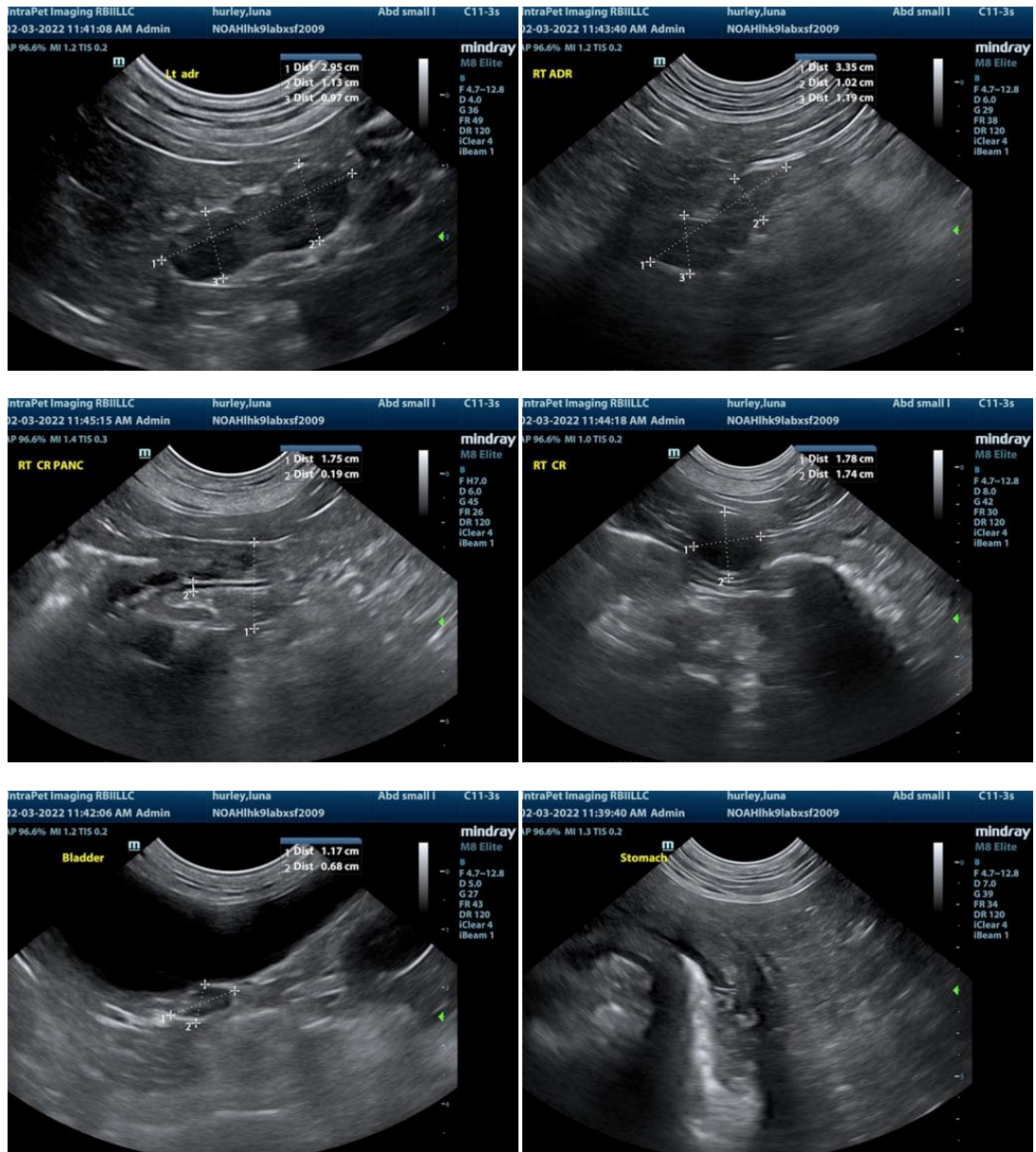
## **ULTRASONOGRAPHIC FINDINGS**

Bilateral adrenal hypertrophy with slight swelling at the left phrenic vein. This area should be monitored. Pyloric mass, appears resectable. Differentials include mural cyst, carcinoma, leiomyosarcoma, and round cell neoplasia. Concurrent gastritis pattern.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

I recommend exploratory surgery in this patient with gastric wall resection +/- left adrenalectomy and liver biopsy would be recommended given the convenience of the procedure and the remodeling that was noted. If the urine specific gravity is less than 1.020 in this patient and the patient appears Cushingoid then work-up for PDH is warranted. Recheck sonogram of the GI tract and left adrenal gland is recommended in a month to assess for any progression. Chest radiographs are warranted prior to surgery. There is no evidence of foreign bodies.





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.

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