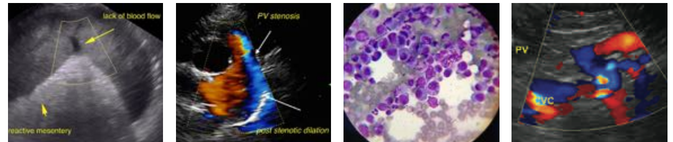


SonoPath.com
1-800-838-4268 info@sonopath.com

**PATIENT**

Meadow Harris

**SPECIES**

Canine

**BREED**

Lab Mix

**SEX**

Spayed Female

**AGE**

13 years

**WEIGHT**

48.6 lbs

**INTERPRETED BY**

Eric Lindquist, DMV
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Marti Williams

**HOSPITAL NAME**

Limestone VH

**REFERRING VET**

Dr. Wieczorek

**INVOICE**

99303

**DATE**

4/14/22

## PRESENTING CLINICAL SIGNS

PUPD, urinary accidents in house x one month. Stopped having urinary accidents on enrofloxacin but then immediately started again once abics were stopped.
Abnormal PE/Chem/CBC/UA Results: ALT 429, SAP 2467, GGT 36, BUN 72, Creat 2.4, Choles 442, Amylast 1312, PPSL 690, Plates 579, USG 1.011, blood trace

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The pelvic urethra was imaged 3.0 cm beyond the cystourethral junction. 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** presented a relatively uniform cortical hyperechogenicity when compared to the renal medulla, spleen and liver. No overt masses were noted. Corticomedullary definition was nebulous and the ratio favored the cortex slightly. The ureters were not visible and assumed to be normal. These changes are most consistent with chronic interstitial nephritis yet infiltrative disease could not be entirely ruled out without biopsy though neoplasia is not suspected. The left kidney measured 6.24 cm. The right kidney measured 5.0 cm.

### *Adrenal Glands*

The left **adrenal gland** was enlarged and irregular measuring 1.9 cm with early left phrenic vein invasion and pericapsular inflammatory pattern. The caudal pole of the left adrenal gland was unremarkable.

### *Spleen*

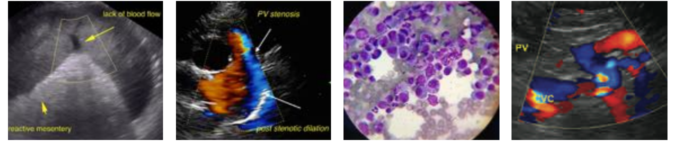
Generalized splenomegaly was noted with minor heterogenous changes with multifocal hyperechoic areas of mineralization. This is a benign change; however, can be related to Cushing's disease or other endocrinopathies.

### *Liver*

The **liver** was uniformly swollen. 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. The gallbladder was over distended with suspended debris. This is consistent with emerging mucocele.

### *Gastrointestinal*

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Retention of ingesta was noted in the stomach with transit of chyme into the small intestine. This is most consistent with post prandial presentation. Small and large intestine demonstrated normal luminal chyme and stool consistency



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respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

### *Pancreas*

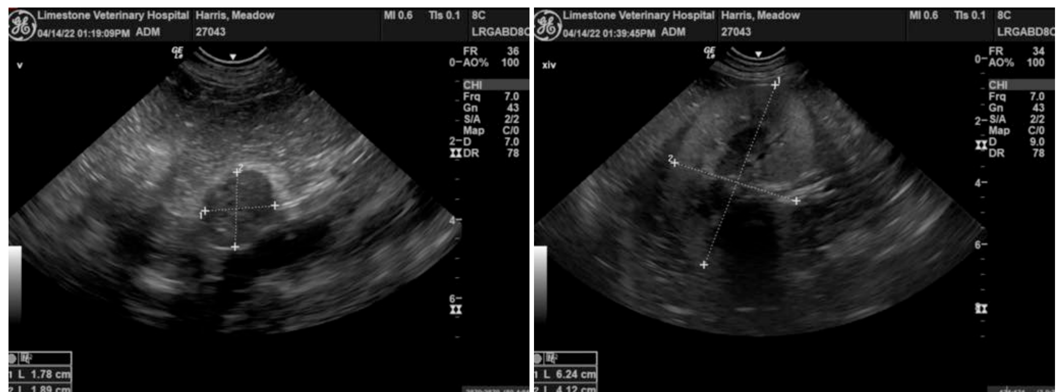
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

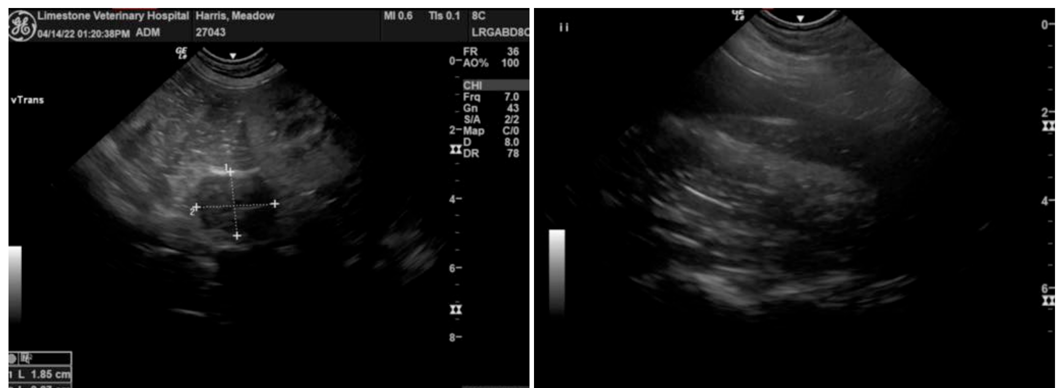
## ULTRASONOGRAPHIC FINDINGS

Left adrenal mass. Differentials include pheochromocytoma versus adenocarcinoma with early phrenic vein invasion.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left adrenal gland appears resectable. There was no obvious invasion into the vena cava. If the renal values can be corrected with fluid therapy and medical management then eventual left adrenalectomy and manual expression of the gallbladder would be indicated. However, long term viability of the kidneys is in question.



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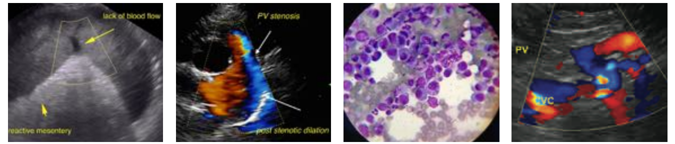


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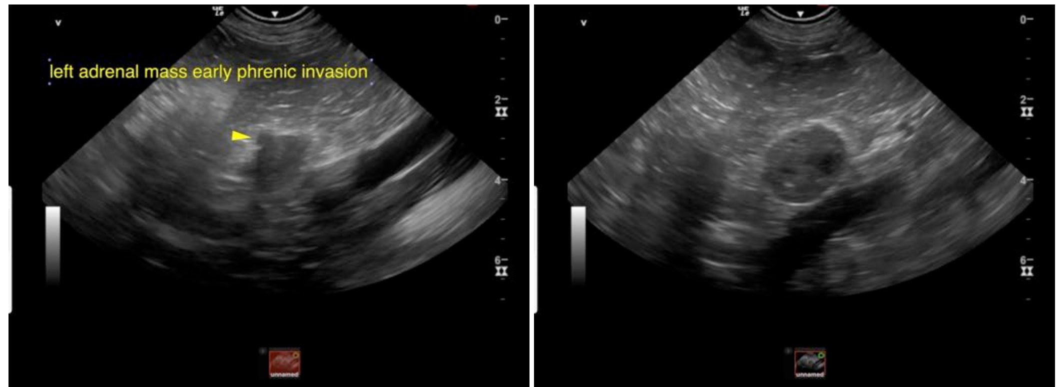


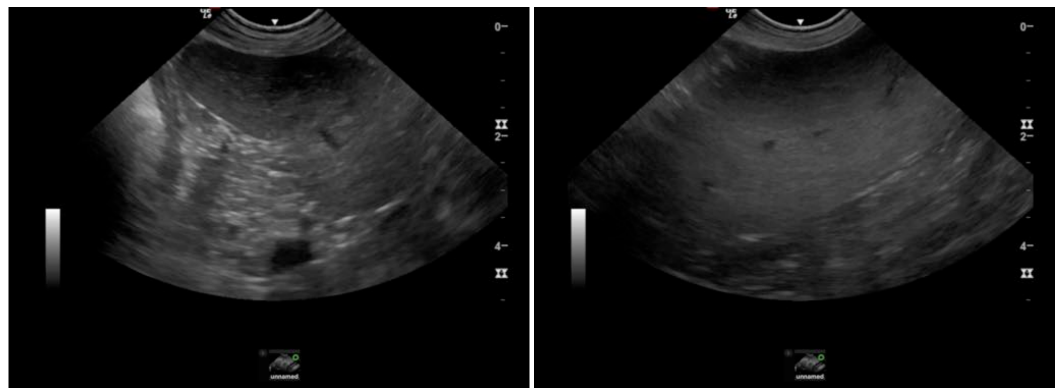

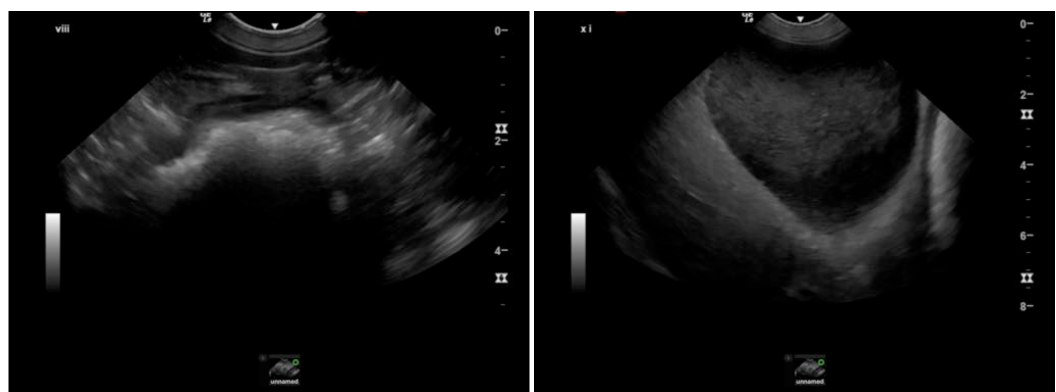

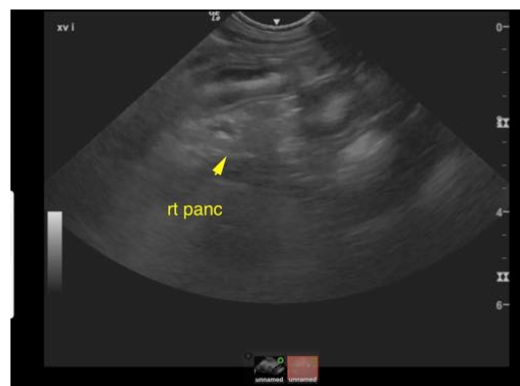

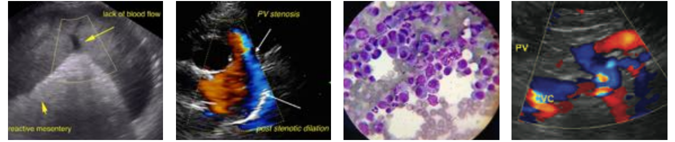



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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

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