



PATIENT

Daisy Hall

SPECIES

Canine

BREED

Mix

SEX

Spayed Female

AGE

12 Years 6 Months

WEIGHT

32 Pounds

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Ebersole

HOSPITAL NAME

Scanvet

REFERRING VET

Dr. Kaltsas

INVOICE

37693

DATE

5/17/22

PRESENTING CLINICAL SIGNS

Episodes of collapsing, eating more than usual, and an increase in anxiety. Also documented hypoglycemia. History of elevated lipase and suspect pancreatitis recently (4/22/22). Owner reports patient is "off".

Abnormal PE/Chem/CBC/UA Results: BG (5/13/22): 57. BG (4/13/22): 68. CPL and Lipase fasted still elevated.

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 were 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 his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The right kidney measured 4.47 cm. The left kidney measured 4.5 cm.

Adrenal Glands

The **right adrenal gland** was visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 2.56 cm x 1.43 cm at the cranial pole and 0.83 cm at the caudal pole.

The **left adrenal gland** was enlarged at 2.17 cm x 0.58 cm at the cranial pole and 1.44 cm at the caudal pole. Capsular expansion noted without capsular escape or vascular invasion. This is most consistent with adenoma. However, emerging carcinoma or pheochromocytoma cannot be ruled out.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The spleen was folded upon itself cranially. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** was swollen with slightly irregular contour. Mild increased portal markings noted and coarse architecture. The gallbladder was unremarkable.

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. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.



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Pancreas

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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.

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ULTRASONOGRAPHIC FINDINGS

- Non-specific hepatic remodeling with irregular contour – likely a normal variant.

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Mix

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

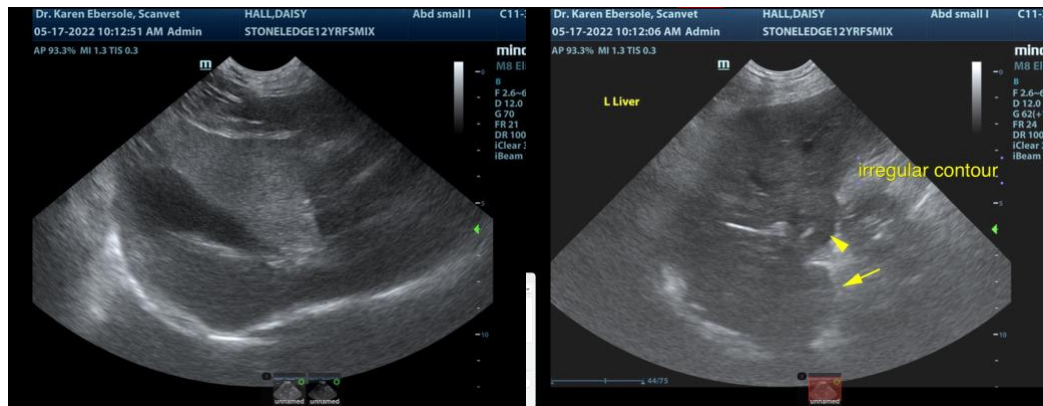
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The left adrenal gland is the most prominent issue in this patient and should be monitored, if not overtly removed, depending upon further workup. Given the patient history, there is a strong potential for a pheochromocytoma of the left adrenal gland. Urine catecholamine warranted, especially if any systemic hypertension is present. The cause of hypoglycemia is unclear. No overt insulinoma presence noted. However, these can be exceedingly small. CT with contrast would be the gold standard to assess for insulinoma, given it is not visible, depending upon insulin/glucose levels.

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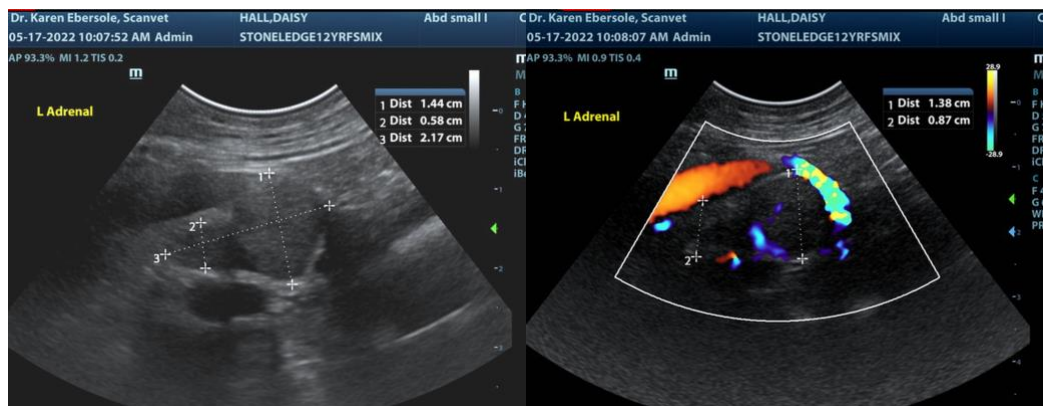
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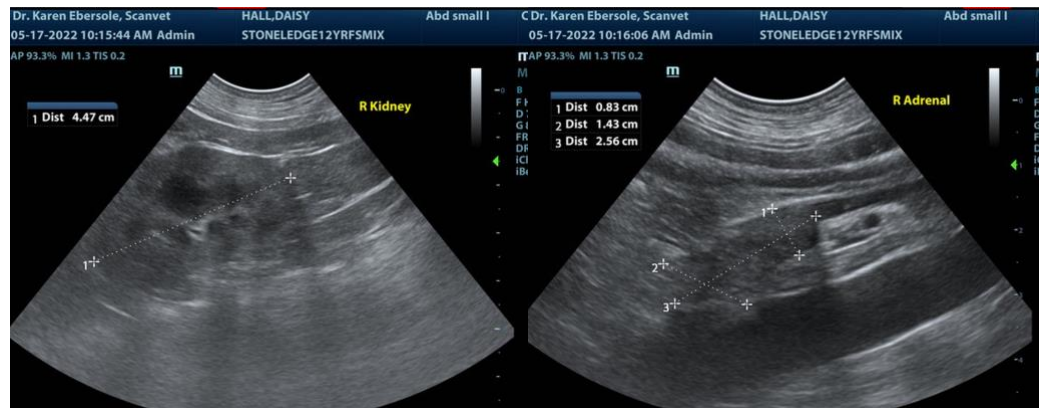
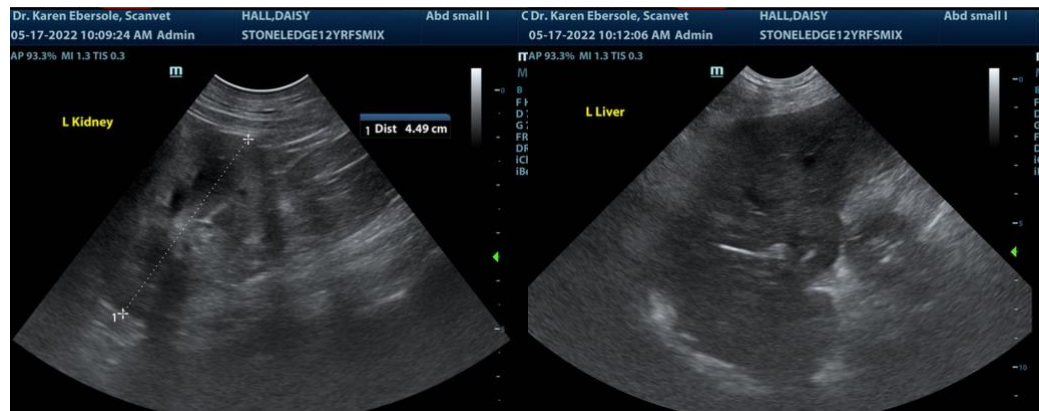
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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