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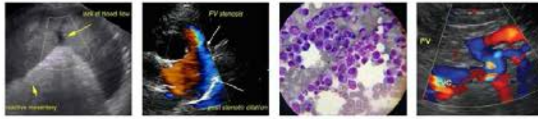


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Leica Convington

SPECIES

Canine

BREED

Beagle

SEX

Spayed Female

AGE

5.5 Years

WEIGHT

54 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

MountRose AH

REFERRING VET

Dr. Katie Weldon

INVOICE

34155

DATE

1/11/22

PRESENTING CLINICAL SIGNS

P came in for a growth removal on December 6, 2021, and had pre-op bloodwork and a pre-op ECG. The ECG was sent to Idexx, where it was noted that she had a sinus arrhythmia, and single VPC's. The surgery was canceled, and it was recommended that P have an echo and an abdominal ultrasound. • In December 2021, her Diet: Rachael Ray Nutrish "Peak" red meat grain free dry, 1 scoop/day (unsure the size of the scoop) but she gets very hungry and eats anything she can find including dog poop. Physical Exam: Weight: 54.8 lbs. T- 102.3 P- 110 R- pant CRT: < 2 sec mm: pink/moist Dehydration: 0% BCS: 4/5 EENT: Teeth; Grade 0-1 Dental Disease, slab fx 4p-mild, tooth OK otherwise. Eyes/Nose; WNL CV/Resp: WNL. No murmurs ausculted, normal bv sounds all lung fields GI: Abdomen palpates WNL, non-painful, no masses or organomegaly Musk: No joint abnormalities. Muscles are symmetrical. No pain elicited on manipulation/exam. Integ: Soft SQ lump 11x12 cm vent. thorax LN: Palpate WNL Neuro: WNL Urogen: WNL, no obvious visible or palpable abnormalities LABORATORY FINDINGS 12/6/21: AlkP = 534 (high) Otherwise labs all normal. REASON FOR ULTRASOUND: • Evaluate for causes of VPC's.
Abnormal PE/Chem/CBC/UA Results: Blood pressures (LF leg, sitting, Osillometric BP machine): 160 122 130 164

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (6.61 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.41 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

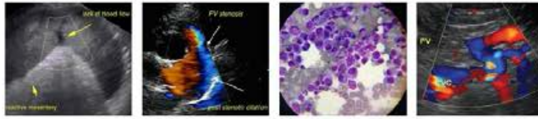
Adrenal Glands

The left adrenal gland is normal in size measuring 0.59 cm at the cranial pole, 0.63 cm at the caudal pole, and 2.3 cm in length. It is observed in its normal position cranial to the left renal artery. It is somewhat abnormal in appearance in that it is normal size and shape, but there is a hyperechoic, shadowing, mineralized focus on the caudal pole measuring approximately 0.51 cm x 0.27 cm. This lesion does not deform the shape of the adrenal gland at all, but should be closely monitored.

The right adrenal gland is normal in size measuring 0.63 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.



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Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are rare, hypoechoic, ill-defined nodules. Two visualized measure 0.93 and 0.83 cm.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and 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. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) 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 pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

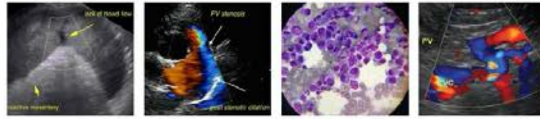
ULTRASONOGRAPHIC FINDINGS

- Mineralized focus on caudal pole of left adrenal gland – The significance of this is currently unclear, but mineralization has been associated with some neoplastic changes in adrenals. There is no mass effective visualized here.

- Heterogeneous liver with ill-defined hyperechoic nodules – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious cause for the VPCs reported is not noted. There is a small focus of mineralization on the caudal pole of the left adrenal gland. Otherwise, this gland appears relatively normal. Recommend close



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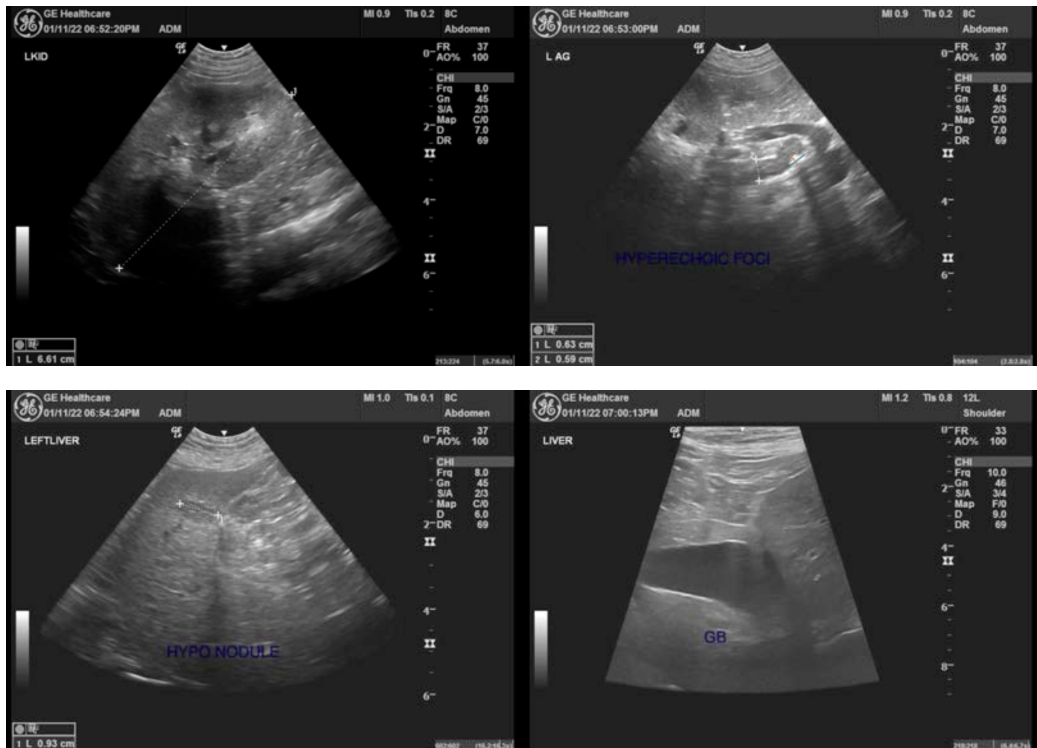
continued monitoring for any change, and consider a blood pressure evaluation in the case of an early adrenal mass effect (none observed). Recommend recheck ultrasound in 4-6 weeks, sooner if any concerns arise.

The changes observed in the liver are non-specific. Some ill-defined focal hypoechoic nodules are visualized, but the appearance of the lesions favors a more benign process.

- Consider the possibility of induction phenoma (has there been any exposure to medications or substances that may elevate ALP – topical or oral steroids, anti-seizure medications, etc.).
- If signs of Cushing's are present, consider endocrine function testing to evaluate for Cushing's disease.
- Consider fine needle aspirate to rule out round cell neoplasia if this a concern.
- If a cause for the ALP elevation is not identified, recheck general bloodwork every 6 months, ultrasound once per year, and bile acids test every 1-2 years based on other results. If ALP continues to climb, a biopsy could be considered.
- Consider long-term use of Denamarin and monitoring for signs of Cushing's.



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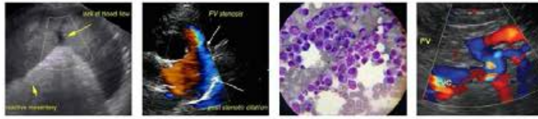

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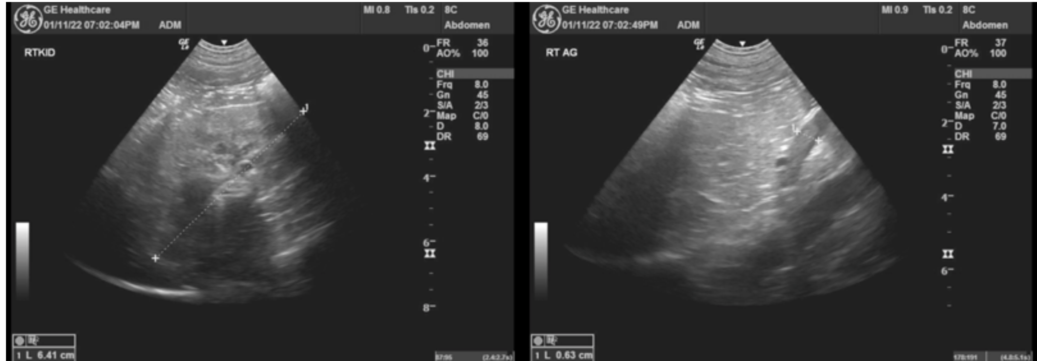

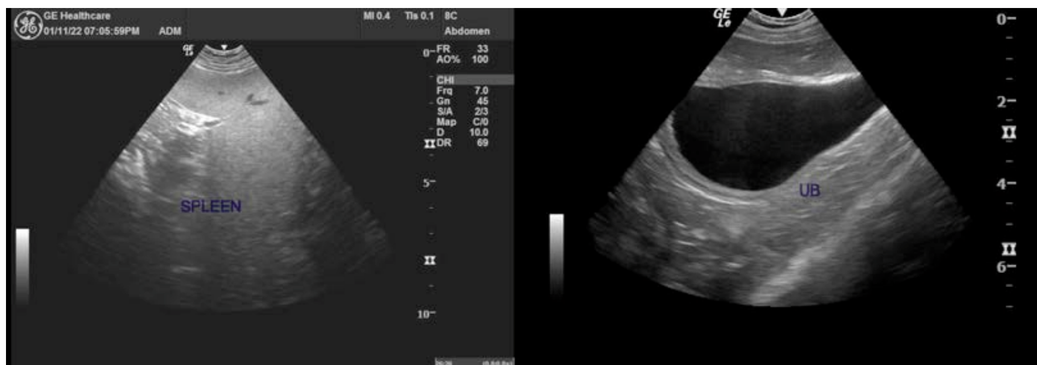

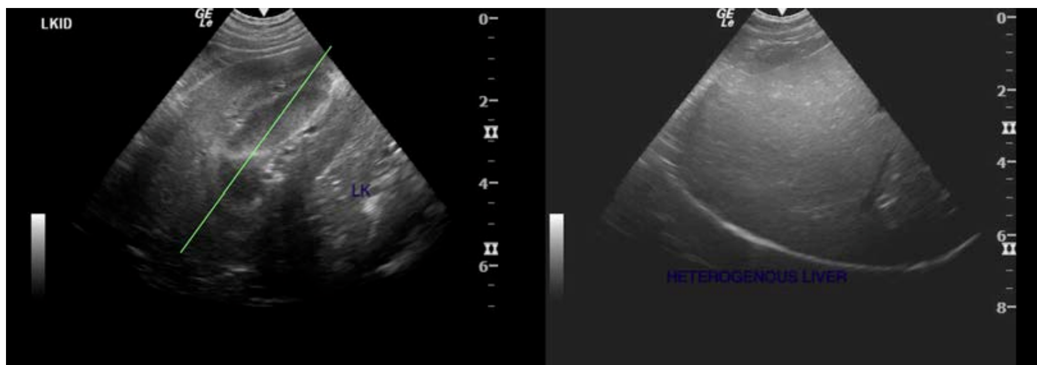

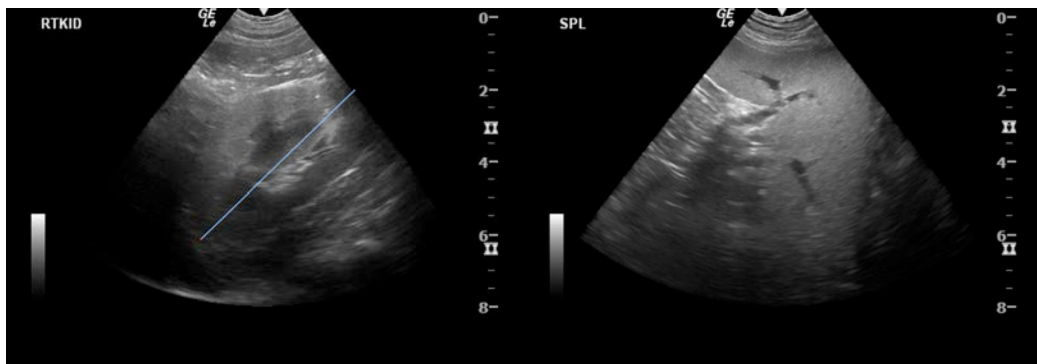

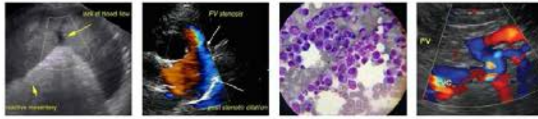

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

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