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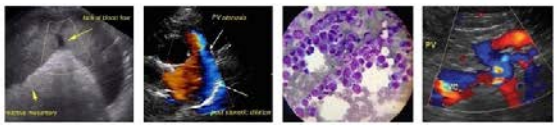

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Daisy Duke Weigel

SPECIES

Canine

BREED

Lhasa X

SEX

Spayed Female

AGE

12 Years

WEIGHT

8.7

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Buck Animal Hospital

REFERRING VET

Dr. Galbraith

INVOICE

26723

DATE

10/28/21

PRESENTING CLINICAL SIGNS

DM, pancreatitis since the summer. - Friday a lot of diarrhea- every few hours, did not eat much - sat only ate breakfast, sat night to Monday am- diarrhea every few hours - has not eaten since Sunday am - over the weekend they took her BG and adjusted the insulin- no insulin since sunday am because not eating well - this am- BG was 23.7 mmol/L at 8:30 this am, was 13 something last night - no vomiting through this - hospitalized July 2021 and Sept 2021 for Pancreatitis currently on caninsulin 3 units BID Abnormal PE/Chem/CBC/UA Results: ALT 162, ALKP 216, AMYL 417. Abnormal cPl 7/13/21 and 10/25/21

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is minimally distended with anechoic urine. The Bladder wall appears diffusely thickened and slightly irregular at 0.37 cm. The area of the trigone and proximal urethra (to a depth of 2cm) appeared free of any mass effects or calculi. The findings are most consistent with either cystitis or lack of urine distention, causing artifactual thickening.

The right kidney has a normal shape and size (4.88 cm). Overall echogenicity is slightly hyperechoic with poor 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 left kidney has a normal shape and size (4.64 cm). Overall echogenicity is slightly hyperechoic with poor 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 large in size. The cranial pole measured 0.98 cm. The caudal pole measured 0.55 cm. It is 2.63 cm in length. It is observed in its normal position cranial to the left renal artery. It is somewhat irregular in appearance, in that there is a hyperechoic nodule in the cranial pole measuring 0.99 cm x 1.3 cm. The shape of the adrenal is relatively normal other than that the cranial pole is enlarged. There is no evidence of vascular invasion or fluid/inflammation in the area.

The right adrenal gland is normal in size measuring 0.59 cm. 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 echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The spleen is subjectively normal in size with no focal parenchymal abnormalities. The blood flow through the hilus and splenic parenchyma appears normal.

Liver

The liver is subjectively normal in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder 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.

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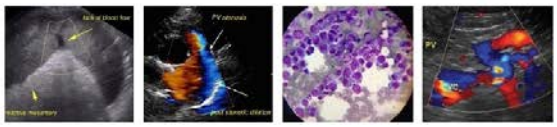

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Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering is adequate and there is no impression of reduced peristaltic activity.

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. Jejunum wall measures 0.29 cm. 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 prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of regional mesenteric inflammation or fluid. In the right cranial abdomen, in the area of the pancreas, the tissue almost appears nodular. This could be consistent with chronic scarring of the pancreas, a focal nodule, or an abnormal lymph node.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. No lymphadenomegaly present. 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.

PRIMARY FINDINGS

- Hyperechoic nodule in the cranial pole of the left adrenal gland – Left adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.
- Irregular, hypoechoic and prominent pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Thickened, irregular urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Hyperechoic liver – The diffuse hepatic changes are non-specific and can be seen with vacuolar hepatopathy, reactive change, nodular hyperplasia or, less likely, inflammatory/immune-mediated disease, infiltrative neoplasia, or other hepatopathy.
- Significant gastric distention with fluid and shadowing material – correlate these findings with history of eating or drinking. If patient recently ate or drank, this could be normal for this individual, and foreign material could be pills, etc. If this patient has had a long fast is not drinking, then consider delayed gastric emptying, or partial gastric outflow obstruction (none observed). Correlate with abdominal radiographs.

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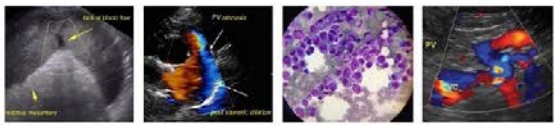

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SECONDARY FINDINGS

- Mildly decreased corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

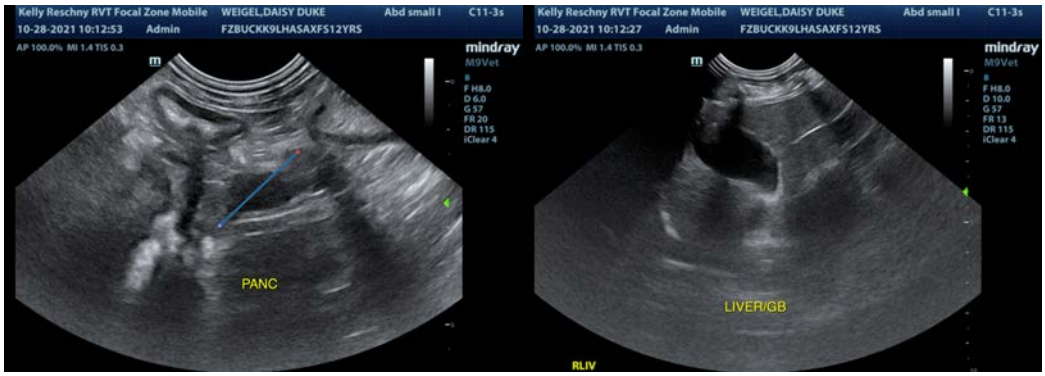
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Some of the abnormalities observed are relatively common/normal for a diabetic patient. The liver changes are likely consistent with a diabetic hepatopathy. Recommend urinalysis and culture to look for evidence of a urinary tract infection, and a quantitative PLI to further evaluate the pancreas for active inflammation. There is some nodular looking tissue in the region of the pancreas. This could be consistent with chronic pancreatitis or less likely a mass effect. You could consider fine needle aspirate if the patient continues to not feel well.

There is a nodule present in the cranial pole of the left adrenal gland. This nodule is relatively small and is not deforming the adrenal gland significantly. It does not have any appearance of vascular invasion. These nodules can be benign or malignant and can secrete hormones or be non-active. It is possible that this would make diabetic regulation more of a challenge. Options moving forward include:

- If signs of cushings are present, consider adrenal function testing. I prefer an ACTH stimulation test combined with an adrenal panel to the University of Tennessee's endocrine lab to look for atypical adrenal hormones as well as cortisol. (other testing can suffice)
- If adrenal dependent cushings is suspected and supported by adrenal function testing consider medical therapy with lysodren or trilostane or consider surgical removal (recommend referral to a board certified veterinary surgeon and possible pre op CT)
- Recommend blood pressure evaluation-if hypertensive consider testing catecholamine levels for a possible pheochromocytoma
- If no symptoms of cushings are present, consider either referral for surgery or continued monitoring with ultrasound (in 3-4 months).
- Many of these nodules can be benign and incidental in nature, unfortunately that is difficult to determine with a single ultrasound.

Correlate the stomach distention described with feeding history and radiographs. There is some shadowing material, which looks like possible medication, etc., but foreign material cannot be excluded as a possibility.



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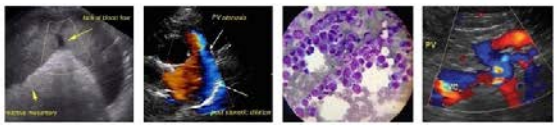

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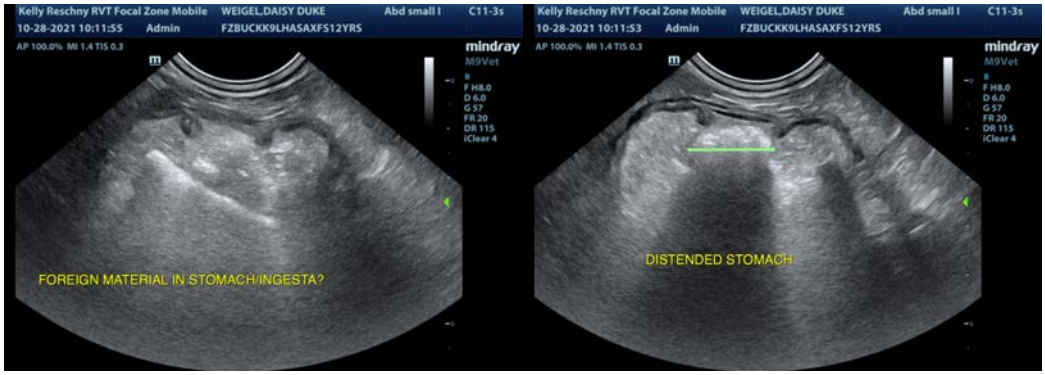

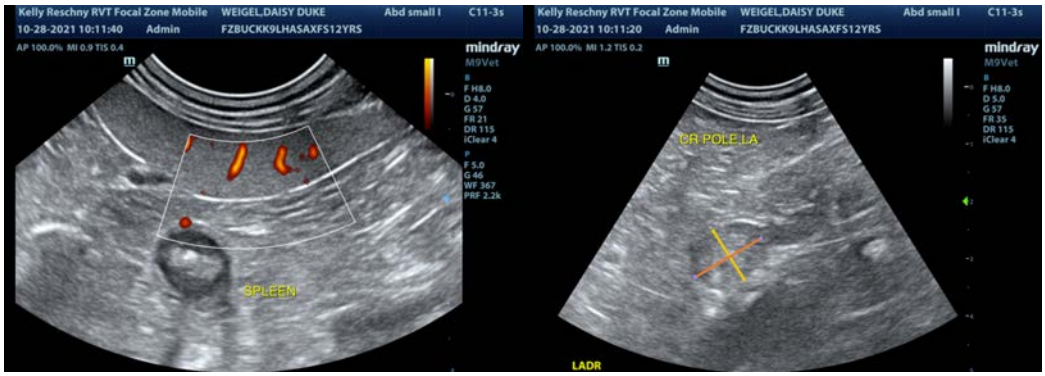

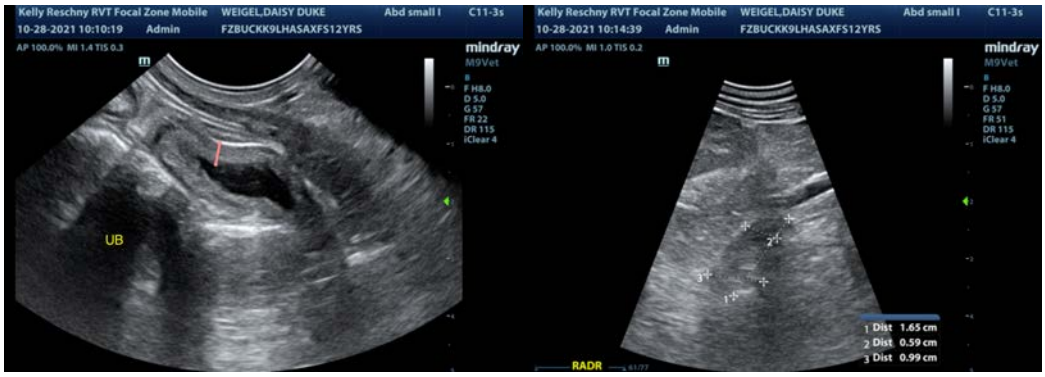

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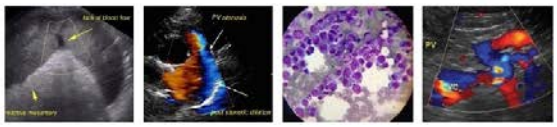

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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