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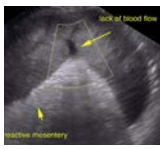
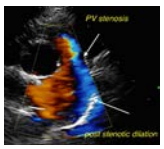
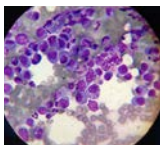
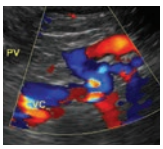

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Margarita Mclerney

SPECIES

Canine

BREED

Havanese

SEX

Spayed Female

AGE

13 Years

WEIGHT

14.5 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Pascucci

HOSPITAL NAME

American AH

REFERRING VET

Dr. Stockmal

INVOICE

42675

DATE

11/10/22

PRESENTING CLINICAL SIGNS

3 days of acute anorexia. Vomiting on first day but has not since cerenia and fluids. Still won't eat.
Abnormal PE/Chem/CBC/UA Results: ALP 2638, ALT 2691, AST 432, GGT 130, Amy 2091, BUN 37, Creat 1.0

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 (4.5 cm) with numerous small cortical cysts. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (4.34 cm) with numerous small cortical cysts. The largest cyst visualized measures 1.02 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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, irregular, and hypoechoic, measuring 1.79 cm at the cranial pole, 0.88 cm at the caudal pole, and 2.1 cm in length. It is observed in its normal position cranial to the left renal artery. It is abnormal in appearance in that it is large and irregularly shaped. There is no evidence of vascular invasion visualized.

The right adrenal gland is large, measuring 1.3 cm at the caudal pole, 0.50 cm at the cranial pole, and 2.43 cm in length. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is abnormal in that it is large and has a distinctly rounded caudal pole. There is no evidence of vascular invasion visualized.

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.

Liver

The liver is large in size, and normal in 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. No focal nodules or cystic lesions are observed.

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

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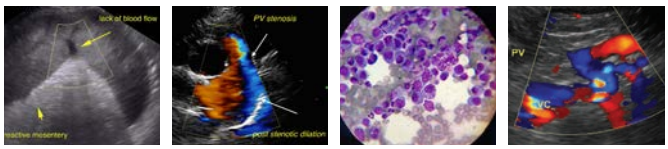

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Gastrointestinal

The stomach is mildly 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. 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. Jejunum wall measures 0.42 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 mottled compared to the surrounding isoechoic 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.

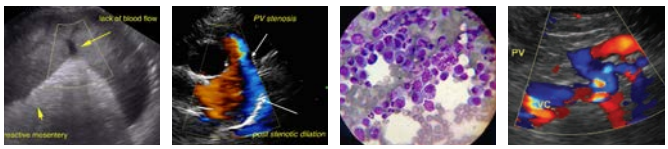
ULTRASONOGRAPHIC FINDINGS

- Bilaterally enlarged and irregularly shaped adrenal glands – Findings could be consistent with bilateral adrenomegaly or concurrent adrenal masses.
- Decreased corticomedullary distinction in both kidneys with diffuse small cortical cysts
- Prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Large, heterogeneous liver – 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.
- Mild shadowing debris visualized within the gastric lumen – Findings are most consistent with a small amount of ingesta. Correlate with feeding history.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both adrenal glands are large and irregular in shape. It is somewhat difficult to differentiate between bilateral adrenomegaly and concurrent adrenal nodules/masses. These lesions are unlikely associated with the anorexia reported, since if they are active lesions, they would be most likely be causing PU/PD, polyphagia, etc. I would recommend some initial workup for these lesions, but adrenal function testing would need to wait until this patient is feeling better.

- Recommend blood pressure evaluation.



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- Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

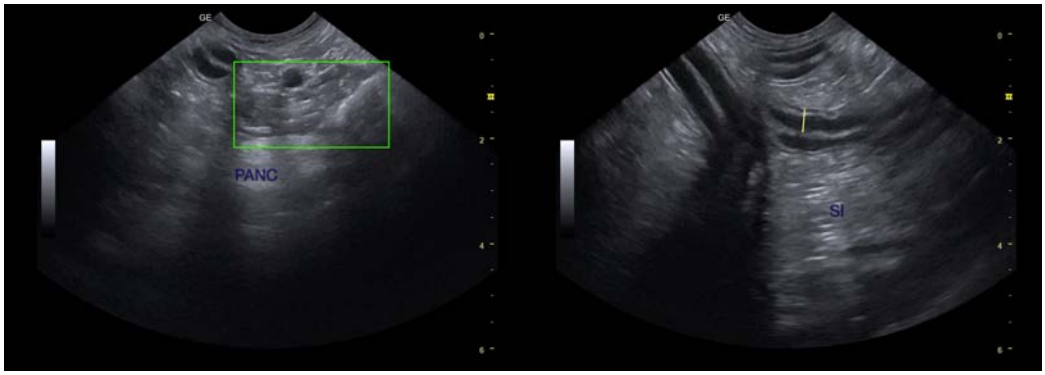
Once this patient is feeling better, you could consider advanced imaging (contrast CT scan) to further evaluate the adrenal glands, and possibly adrenal function testing to evaluate for cortisol excess.

The changes observed in the kidneys are most consistent with chronic age related renal disease. Recommend baseline blood pressure (as recommended above), urinalysis, and culture.

The pancreas is visible and possibly mildly inflamed. Correlate this with a cPL level and consider treatment for pancreatitis, as sometimes the ultrasonographic appearance of the pancreas does not correlate with the clinical signs.

The liver is large and heterogeneous. With both an elevation in ALT and ALP reported, I'm concerned that this could be related to the lack of appetite. Consider the following:

- Consider close evaluation of history for possible toxic changes examine medications, diet, dietary indiscretion etc...
- Consider PCR on urine/serum for leptospirosis (if not on antibiotics)/serology if recent antibiotic history
- If not already done, consider pre and post prandial bile acids to evaluate liver function
- If the ALP is significantly elevated relative to the ALT and symptoms consistent with Cushing's are present, consider adrenal function testing (ACTH stim)
- Consider Fine needle aspirate if round cell neoplasia is on your differentia list (25 g needle, normal coags)
- If no response to supportive care (Denamarin, fluids, antibiotics, +/- ursodiol etc.) Consider liver biopsy with samples obtained for histopathology, culture, and copper levels.



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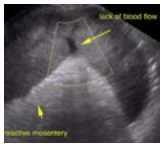
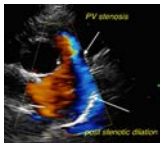
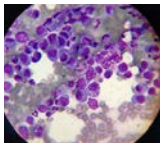
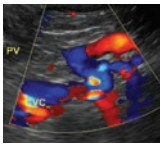

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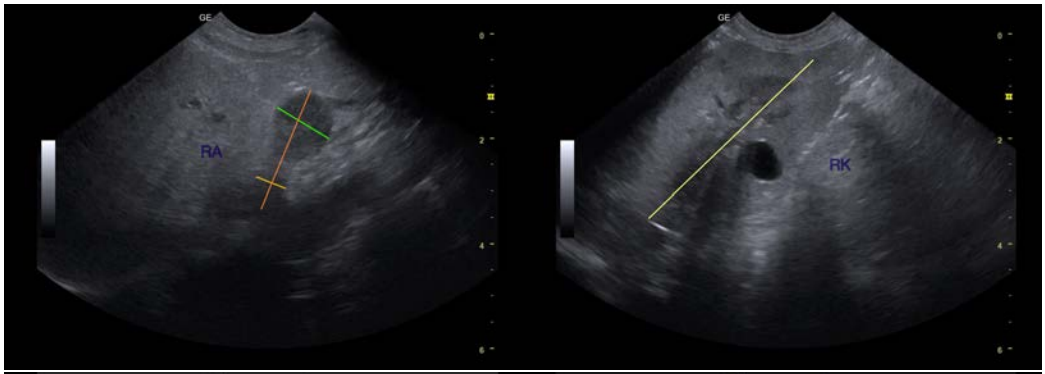

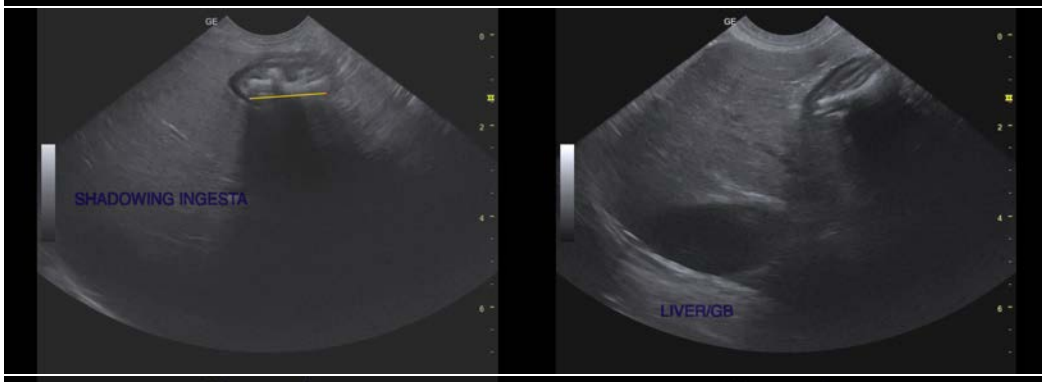

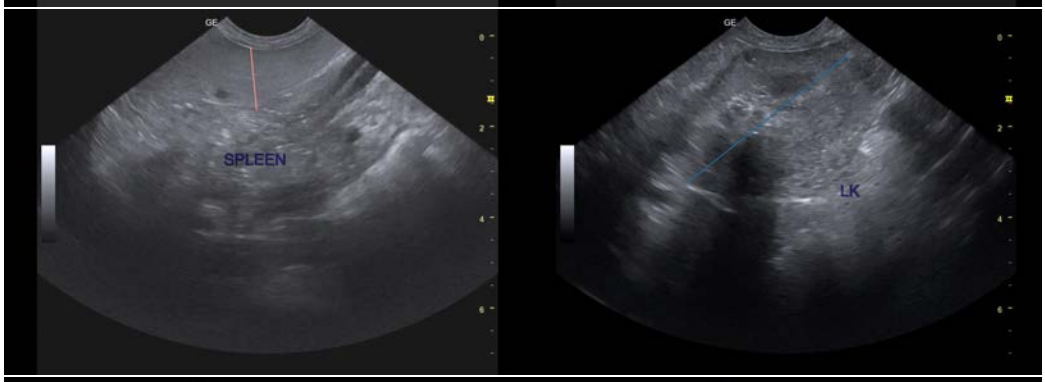

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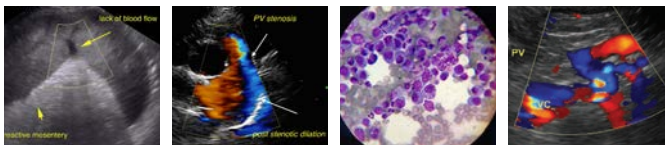

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com