



PATIENT

Presley Lynott

SPECIES

Canine

BREED

Pit Bull X

SEX

Spayed Female

AGE

11 Years

WEIGHT

47

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

JK

HOSPITAL NAME

Hamburg Vet Clinic

REFERRING VET

Dr. Martens

INVOICE

46053

DATE

3/21/23

PRESENTING CLINICAL SIGNS

Weight loss, vomiting, elevated kidney values
Abnormal PE/Chem/CBC/UA Results: BUN 120, CREAT 7.7, PHOS 14, WBC 23.6

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 (6.66 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.

The right kidney has a normal shape and size (6.5 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 measuring 1.74 cm at the cranial pole, 1.01 cm at the caudal pole, and 3.52 cm in length. It is observed in its normal position cranial to the left renal artery. It is somewhat abnormal in appearance in that the cranial pole is enlarged and there is concern for possible soft tissue density in the adjacent vessel, possibly consistent with early vascular invasion.

The right adrenal gland is large measuring 0.94 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. The spleen echotexture is heterogenous and mildly mottled, 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 subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. 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.

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.



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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

- Bilateral adrenomegaly – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.
- Irregular, large left adrenal gland with possible vascular invasion – Adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.
- Mildly mottled spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Decreased corticomedullary distinction in both kidneys – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is decreased corticomedullary distinction in both kidneys, most consistent with chronic progressive age related renal disease. Recommend a urinalysis, culture, and blood pressure. Additionally, if acute renal failure is suspected, consider screening for Leptospirosis and diuresis. No mass lesions or stones are visualized, and there is no evidence of any obstructive process.

The left adrenal gland appears somewhat irregular and large, and there is questionable soft tissue density in the adjacent vasculature. If the renal disease can be stabilized, you could consider additional workup for possible adrenal mass lesion, including a contrast CT scan for possible surgical removal, and measuring catecholamine levels if there is significant hypertension present. Additionally, you could consider a recheck ultrasound in approximately 8 weeks to reevaluate the adrenal gland and the possible vascular invasion.



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The spleen appears slightly prominent and mildly mottled. This could be within normal limits for this individual, but if there is concern for underlying round cell neoplasia, then consider a fine needle aspirate.

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

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