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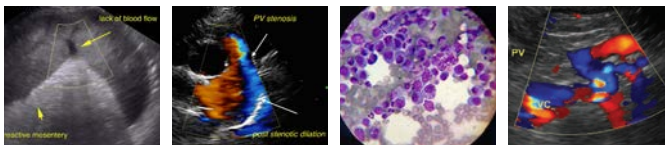


PATIENT

Pixie Danner

SPECIES

Canine

BREED

Lab X

SEX

Spayed Female

AGE

14 Years

WEIGHT

64.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Schanche

HOSPITAL NAME

TotalBond VH

REFERRING VET

Dr. Schanche

INVOICE

46075

DATE

3/22/23

PRESENTING CLINICAL SIGNS

Reason for Referral: increasing ALP, PU/PD (USG 1.013 range), skin/conformation changes and LDDST did not suppress at 4 & 8 hour consistent w/ CCD; however baseline cort not elevated. AUS to confirm CCD and characterize PD vs. AD. Almost 10 lb weight loss since last year. 3/13/23 - AST 14, ALP 491, USG 1013 3/16/23 - LDDS - pre 2.9, 4hr 3.8, 8 hr 3.0, Urine cortisol to creatine 36 (>26)

Abnormal PE/Chem/CBC/UA Results: 3/13/23 - AST 14, ALP 491, USG 1013 3/16/23 - LDDS - pre 2.9, 4hr 3.8, 8 hr 3.0, Urine cortisol to creatine 36 (>26)

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 (7.0 cm). Overall echogenicity is normal with adequate 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 (7.38 cm). Overall echogenicity is normal with adequate 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 normal in size measuring 0.71 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

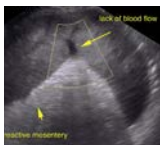
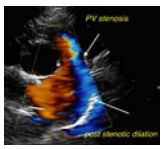
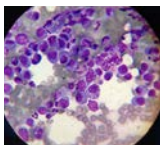
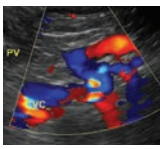
The right adrenal gland is large, measuring 3.16 cm at the cranial pole, 1.07 at the caudal pole, and 4.67 cm in length. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is abnormal in appearance in that the cranial pole is enlarged and has created a mass effect. No evidence of vascular invasion is 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. There is a hypoechoic nodule visualized at 1.01 cm in the mid body of the spleen. Additionally, caudal to the spleen there is a somewhat irregular hypoechoic focal mass effect measuring 2.36 cm x 2.24 cm. A direct attachment to the spleen cannot be 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. There is an irregular hyperechoic mass lesion measuring 3.15 cm x 2.95 cm seen in the cranial aspect of the liver.

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.36 cm 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. Duodenum wall measures 0.46 cm. Jejunum wall measures 0.39 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 area of 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

- Hypoechoic nodule in the spleen – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

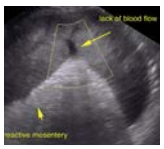
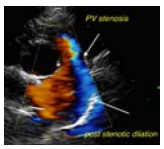
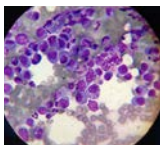
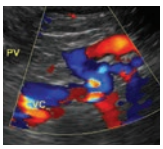
- Hypoechoic irregular mass effect visualized caudal to the spleen – This mass effect could be splenic, omental, less likely a left ovary. Consider a fine needle aspirate.

- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

- Enlarged cranial pole of the right adrenal – Adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The right adrenal is large, creating somewhat of a mass effect. There is no overt evidence of vascular invasion, but this cannot be definitively ruled out. This could represent a benign or a neoplastic lesion and could be actively secreting hormones or be non-secretory. Adrenal function testing would be difficult to interpret in this patient, as cortisol levels could be mildly elevated due to non-adrenal illness. Recommend a blood pressure evaluation. If hypertension is present, consider measuring catecholamine

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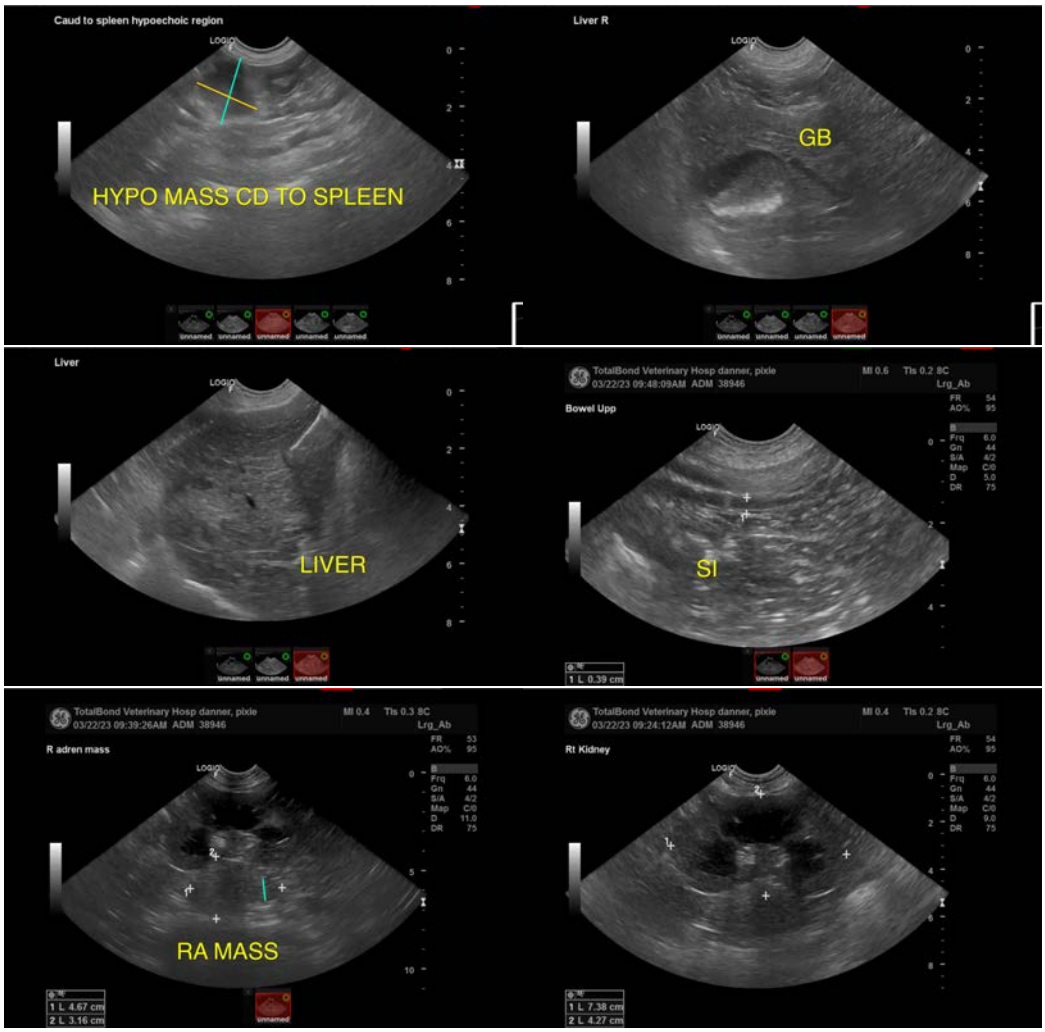
levels, looking for a pheochromocytoma. Additionally, if surgical removal would be considered, I would strongly recommend a contrast CT scan, looking for evidence of metastasis and vascular invasion.

There is a small hypoechoic nodule visualized within the splenic parenchyma. This could be a benign lesion or an early neoplastic lesion. Additionally, there is an irregular hypoechoic lesion caudal to the spleen. A direct connection to the spleen cannot be visualized, so the nature of this mass effect is unknown. Consider a fine needle aspirate (I believe this has already been done). The aforementioned CT scan could be helpful in further evaluating this lesion. Additionally, a fine needle aspirate of the splenic nodule could be considered, particularly if adrenalectomy is to be considered.

The liver is large and heterogeneous with an irregular hyperechoic mass effect. The general appearance of this lesion is somewhat benign, but an underlying neoplastic lesion cannot be definitively ruled out. The location of this lesion would be challenging for non-invasive sampling. At this time, I would likely recommend continued monitoring with ultrasound.

Given the multiple concurrent issues going on and the weight loss described, I would be hesitant to medically treat this patient for Cushing's. Options moving forward largely involve imaging for possible surgical intervention or continued monitoring with supportive care.

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



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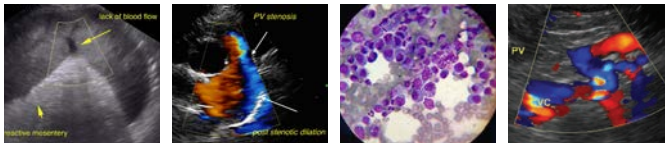

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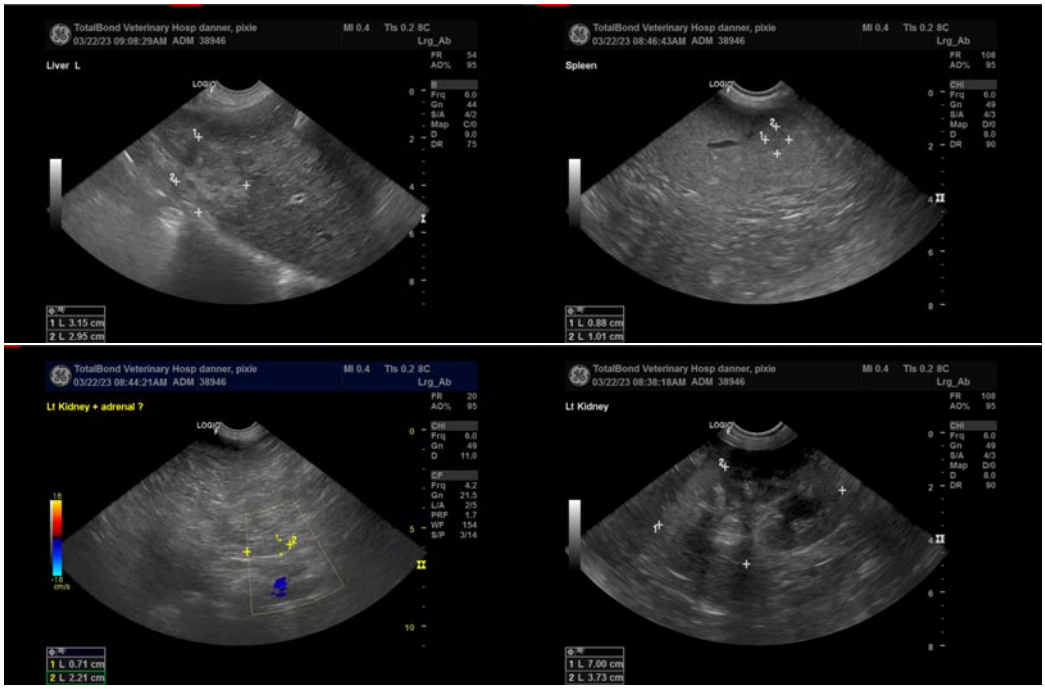

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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