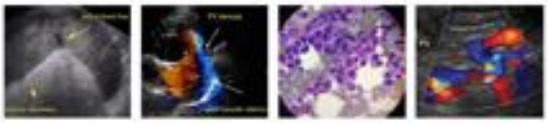


PATIENT

Molly Stanley

SPECIES

Canine

BREED

Maltese Mix

SEX

Spayed Female

AGE

06/09/2013

WEIGHT

9.6kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Mount Rose Animal Hospital

REFERRING VET

Dr. Lori Burnham

INVOICE

10096

DATE

3/7/2023

PRESENTING CLINICAL SIGNS

Sedation-none, very tense abdomen- History of ALP elevations. Noted to be 753 on 09/2021, 1104 on 06/22, and finally, 1649 in Feb 2023. 3+ protein on dipstick in Feb 2023, spec. grav. 1.047, 2+ Ca Ox crystalluria. The remainder of the bloodwork is fairly normal. Patient appears somewhat heavy in the abdomen ("doughy" on palpation).

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 measuring 5.04 cm with numerous small cortical cysts and pyelectasia at 0.41 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size measuring 5.20 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.62 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.

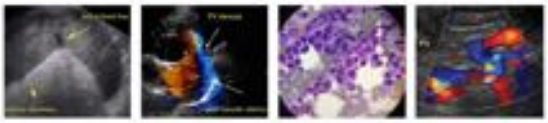
The right adrenal gland is large in size measuring 2.72 cm at the cranial pole, 0.43 cm at the caudal pole, and measures 2.41 cm in length. It's visualized in its normal position between the right kidney and the caudal vena cava. It's abnormal in appearance in that the cranial pole is heterogenous and significantly enlarged creating a mass effect measuring 2.7 cm x 2.25 cm. 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 subjectively large 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. There is a very small ill-defined hyperechoic nodule visualized in the parenchyma measuring 0.82 cm x 1.01 cm.



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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.

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 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

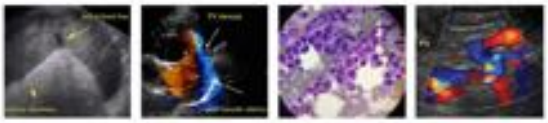
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Decreased corticomedullary distinction in both kidneys with cortical cysts and left sided pyelectasia. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- Large heterogenous liver with small hyperechoic nodule. 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. The nature of the hyperechoic nodule trends towards a benign lesion, recommend continued monitoring.

- Large mixed echogenicity right adrenal mass. Adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.



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SECONDARY FINDINGS

- Prominent mottled pancreas. The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis, or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large mixed echogenicity mass effect associated with the right adrenal, based on the history provided I would be suspicious that this could be a cortisol secreting tumor. These lesions can be benign or cancerous and can be secreting hormone or be non-active. These are my recommendations for further evaluation:

- If signs of Cushing's 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 Cushing's is suspected and supported by adrenal function testing, consider medical therapy with lysodren or trilostane and/or consider surgical removal (recommend referral to a board-certified veterinary surgeon and possible pre op CT)-This can be a challenging surgery with significant risk for complication
- Recommend blood pressure evaluation-if hypertensive consider testing catecholamine levels for a possible pheochromocytoma
- Due to the invasive nature of these masses a CT scan is recommended to evaluate for metastasis and vascular invasion.
- If no symptoms of Cushing's are present, consider either referral for surgery or if surgery is not an option consultation with a veterinary oncologist regarding chemotherapeutic options and continued monitoring with ultrasound (in 4-6 weeks) can be considered.
- Some aggressive adrenal tumors can grow quickly and there is risk for acute hemorrhage from vascular invasion.

Based on an ultrasonographic evaluation of this lesion, it could be a good candidate for surgical removal.

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

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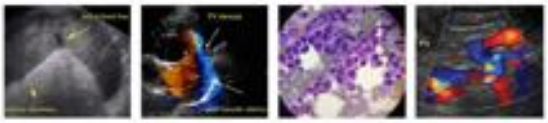

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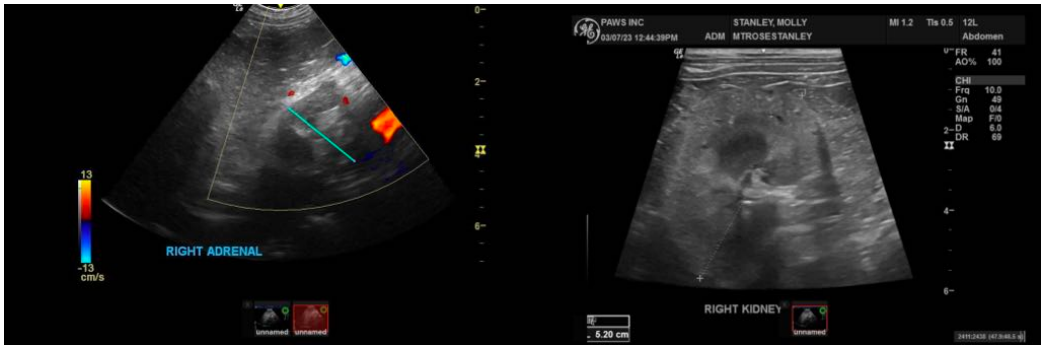

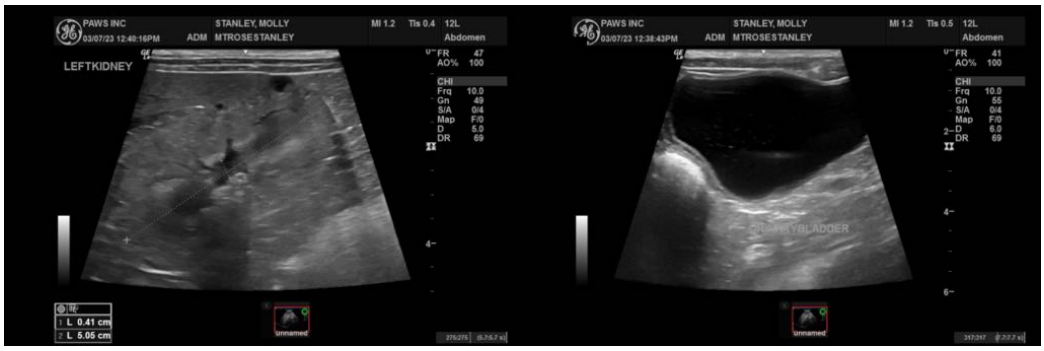

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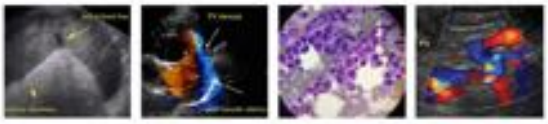

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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