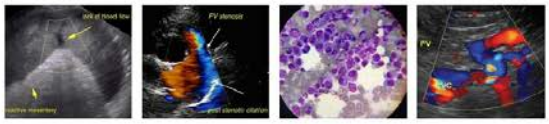

PATIENT

Gabby Johnson

SPECIES

Canine

BREED

Toy Poodle

SEX

Spayed Female

AGE

14 Years

WEIGHT

6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountRose AH

REFERRING VET

Dr. Katie Weldon

INVOICE

47152

DATE

5/4/23

PRESENTING CLINICAL SIGNS

P presented for a second opinion on dental disease and extractions. Also concerned about anesthesia. Checked labs to assess prior to dental. P sucks her back feet non-stop as well and O wants to address this. P had an elevated UPC of 8.2 (first time this has been checked). P also has low ALB that we want to assess the cause. Discussed feet sucking could be behavioral vs. secondary to GI upset/acid reflux. P has been on several allergy meds from previous vet with no relief of clinical signs. Working diagnosis PLN vs enteropathy BP 146mmHg avg systolic on oscillometric machine Medication -include dosage & frequency Gabapentin 50mg/ml liquid 0.6ml PO BID started 2 weeks agoNeeds dental/anesthesia

Abnormal PE/Chem/CBC/UA Results: CBC- Low HGB 13, MCH 21.5, MCHC 31, Retic HGB 23.6; elevated Monos 1330 Chem- Elevated SDMA 15, CK 231; low BG 58, ALB 1.9, Alb/Glob ratio 0.5, ALT 11 T4- WNL UA- 4+ protein, 2-5 RBCs, HGB USG- 1.023. BG rechecked on a fasted sample and was normal at 85. UPC 8.2,

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears of normal thickness with no significant mucosal irregularities, although there is a slight rounded thickening visualized at the cystourethral junction measuring 0.38 cm x 0.55 cm. This could represent imaging artifact or a true mucosal irregularity. Recommend continued monitoring.

The left kidney has a normal shape and size (3.25 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 (3.29 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 and irregular, measuring 0.41 cm at the cranial pole, 1.35 cm at the caudal pole, and 1.73 cm in length. It is observed in its normal position cranial to the left renal artery. It is abnormal in appearance in that there is a large heterogeneous mass effect in the caudal pole. No evidence of vascular invasion is visualized.

The right adrenal gland is normal in size measuring 0.50 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, 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.

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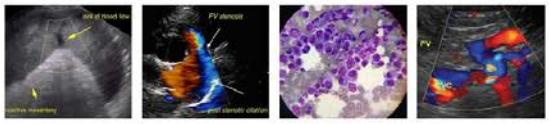

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Liver

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 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 <0.7cm 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. Duodenum wall measures 0.40 cm. Jejunum wall measures 0.28 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

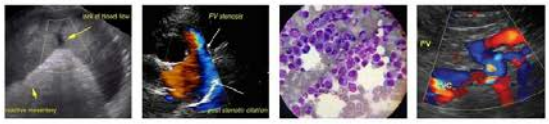
The right limb of the pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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

- Small irregularity/thickening at the cystourethral junction – recommend urinalysis and culture and reevaluation of this region in 6-8 weeks with a more distended urinary bladder.
- Heterogeneous mass effect in the caudal pole of the left adrenal gland – Adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.
- 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.



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- 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.

SECONDARY FINDINGS

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a heterogeneous mass effect in the caudal pole of the left adrenal gland. This could represent a benign or neoplastic lesion, and it could be secretory or non-active. These are my recommendations for further evaluation of an adrenal mass.

- 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 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 cushings 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.

If hypertension is present, this could be contributing to the elevation in urine protein to creatinine levels. Additionally, if this is secreting cortisol, that can also contribute to proteinuria. No focal lesions were visualized with the gastrointestinal tract to suggest a concurrent enteropathy. Based on the severity of the urine protein to creatinine ratio (provided it is repeatable and there is an inactive urine sediment), I suspect the proteinuria secondary to a protein losing nephropathy. Consider a liver function test and a GI panel to Texas A&M to further evaluate for hypoalbuminemia secondary to concurrent liver disease or looking for supportive evidence of a concurrent enteropathy.

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

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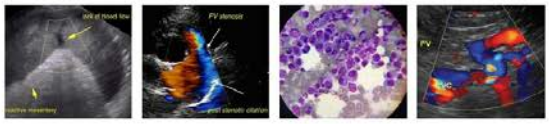

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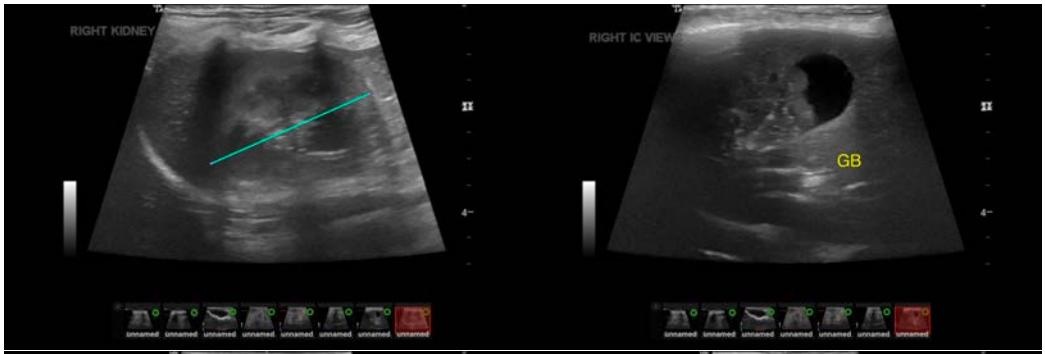

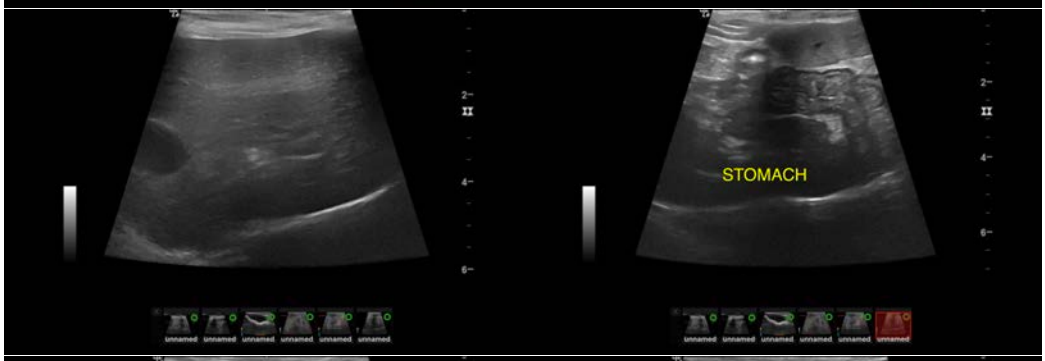

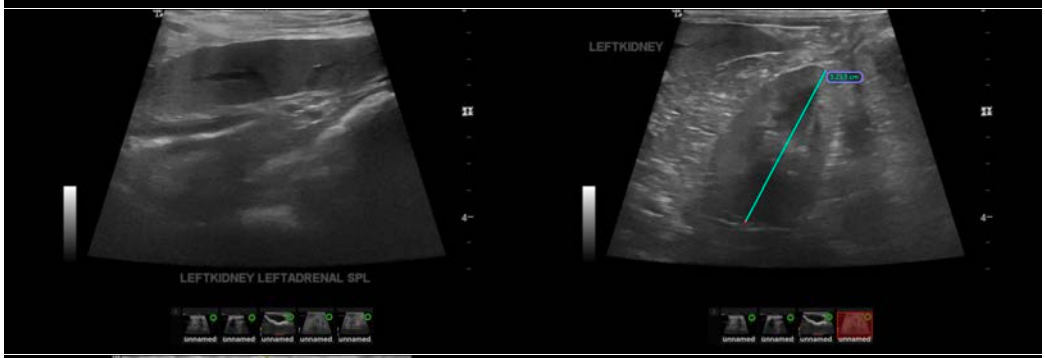

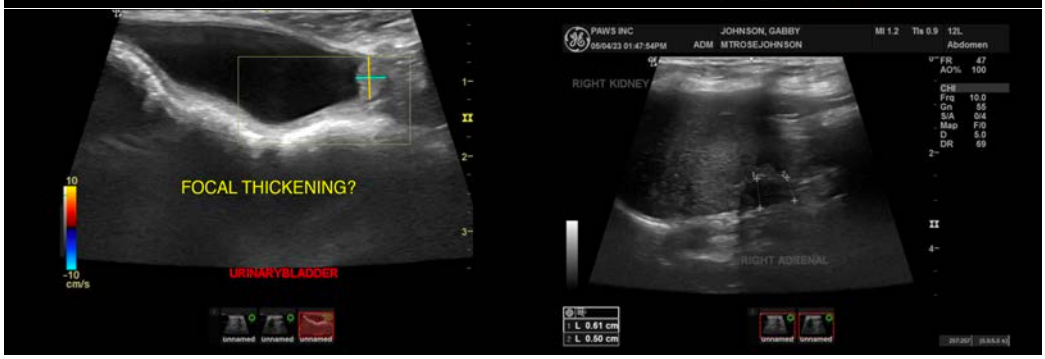

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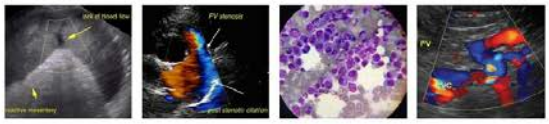

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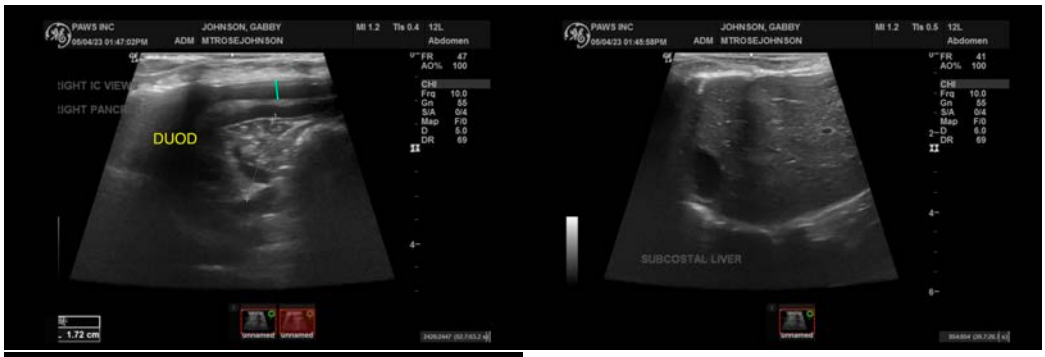

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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