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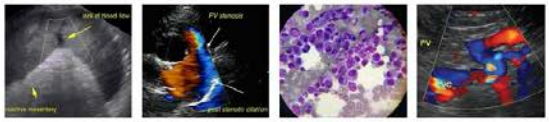

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Shasta Crandell

SPECIES

Canine

BREED

Retriever X

SEX

Spayed Female

AGE

13 Yers

WEIGHT

65 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Lux Pet Vet

REFERRING VET

Dr. Kristin Kee

INVOICE

39922

DATE

7/27/22

PRESENTING CLINICAL SIGNS

Chief Concern/Provisional Diagnosis: - Excessive panting - Decreased appetite & activity - History of sensitive stomach History/Physical Findings: Chronic history of panting (all the time, including in the middle of the night) that has progressively worsened over the past month. Previous veterinarian prescribed gabapentin and carprofen and per owner didn't seem to help with panting. Upon initial exam, patient is overweight and tachypneic with moderate periodontal disease and suspected osteoarthritis, especially of the hind end. At that time, owner was instructed to increase gabapentin dosing to every 8 hours and was advised to start omega-3 FA and Flexadin Advanced with UCII for life. Upon exam today for abdominal ultrasound, patient was not tachypneic and no other changes were noted. MEDS: Gabapentin Carprofen Cosequin Omega-3 FA Flexadin Advanced with UCII
Abnormal PE/Chem/CBC/UA Results: Summary of Laboratory Abnormalities: - Performed with previous vet: - 5/2/22: Only an abbreviated liver panel was performed - elevated GGT 17 IU/L (1-12) - 3/15/22: - CBC WNL - Elevated GGT 18 IU/L (1-12) - Hypertriglyceridemia 506 mg/dL (29-291) RADS: Gabapentin Carprofen Cosequin Omega-3 FA Flexadin Advanced with UCII

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 (5.98 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (5.4 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 in size measuring 1.11 cm at the cranial pole, 1.5 cm at the caudal pole, and 3.38 cm in length. It is observed in its normal position cranial to the left renal artery. It is somewhat abnormal in appearance in that it is enlarged. The parenchyma is severely heterogeneous with some cystic regions. There is questionable tissue extension just into the phrenicoabdominal vein.

The right adrenal gland is normal in size. 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.

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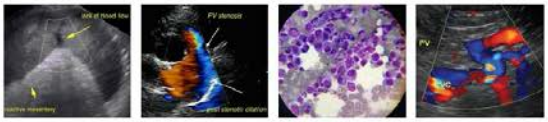

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Spleen

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 an ill-defined hypoechoic lesion visualized within the parenchyma, measuring 1.03 cm x 1.19 cm.

Liver

The liver is subjectively normal in size, and 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 are numerous ill-defined, irregular nodules visualized throughout the hepatic parenchyma. Examples of these are a hyperechoic nodule measuring 1.52 cm on the left side, and another measuring 0.66 cm. There is a larger mass effect measuring 4.25 cm x 4.9 cm visualized on the left side of the liver, which is slightly hyperechoic and heterogeneous.

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

Gastrointestinal

The stomach is moderately 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. 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. There are large mesenteric lymph nodes, one measures 1.18 cm in diameter. The omentum is generally of normal echogenicity.

Other

A brief view of the heart was submitted. No significant pericardial effusion was seen.

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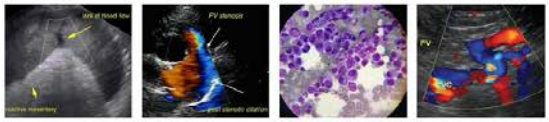

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PRIMARY FINDINGS

- Enlarged, heterogeneous, somewhat cystic left adrenal gland with questionable vascular invasion – Left adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.
- Ill-defined hypoechoic lesion visualized within the splenic parenchyma – 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.
- Heterogeneous liver with a large, focal mass effect and numerous small, ill-defined nodules – The larger mass effect is most consistent with a primary hepatic mass, although other possibilities exist. The smaller lesions trend towards more of a benign appearance, but a metastatic lesion cannot be ruled out.
- Large, hypoechoic mesenteric lymph nodes – The moderate mesenteric lymphadenopathy could be consistent with a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease(tick born disease-such as bartonella, fungal infections, FIP (cats)) etc. A fine needle aspirate with cytology is recommended for further evaluation.

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.
- Moderate gastric ingesta - This patient was not fasted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a left-sided adrenal mass lesion visualized. It is relatively normal in shape with only very mild possible vascular invasion. This could be a source for panting, particularly if it is a pheochromocytoma causing intermittent hypertension, etc. These are my recommendations for an evaluation of an adrenal mass. These lesions can be benign or malignant and can secrete hormones or be non-active.

- 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

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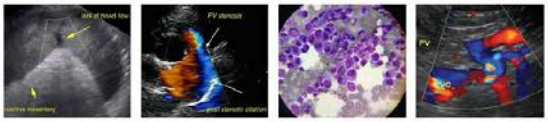

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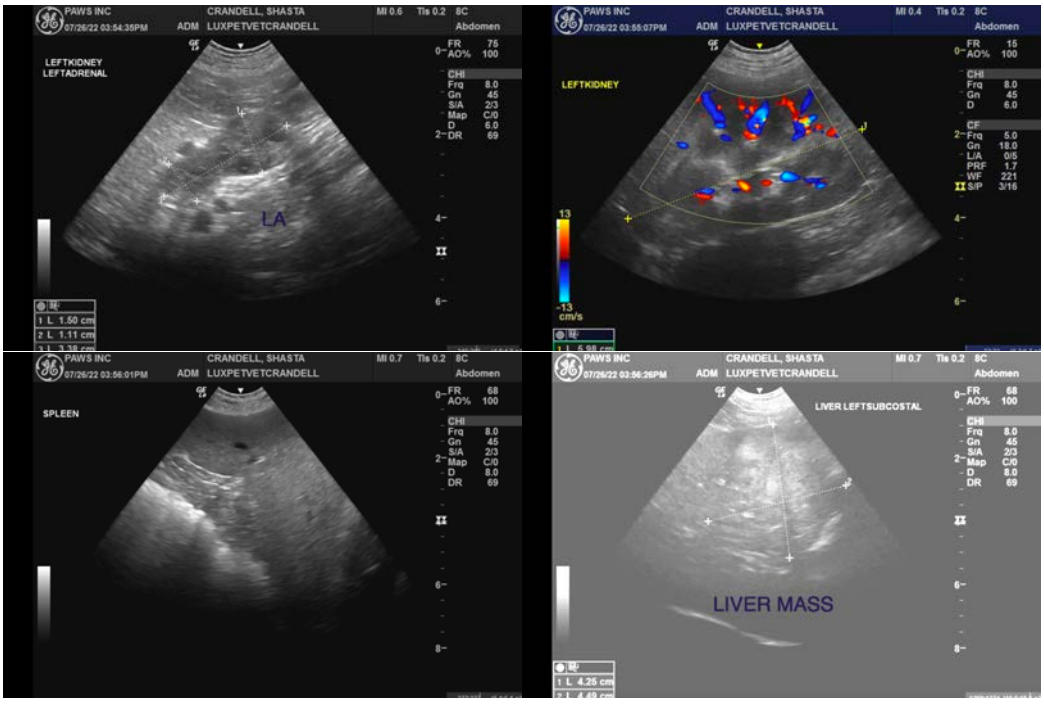
- Recommend blood pressure evaluation-if hypertensive consider testing catecholamine levels for a possible pheochromocytoma
- Due to the invasive nature of these masses a CT scan is recommended to evaluate for metastasis and vascular invasion.
- If no symptoms of cushings are present, consider either 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.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

Additionally, there is a hyperechoic liver mass visualized. If this is a primary hepatic mass, these lesions can behave relatively benignly, and be slow growing. Prognosis with surgical removal can be very good, but given the adrenal mass lesion, metastatic nodules are always possible. If possible, consider a fine needle aspirate of the liver mass (if reachable). If not, general liver could be helpful.

Additionally, there are enlarged mesenteric lymph nodes. Consider a fine needle aspirate to try and rule out the possibility of metastatic disease in this location.



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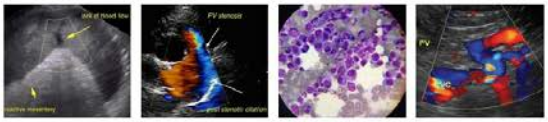

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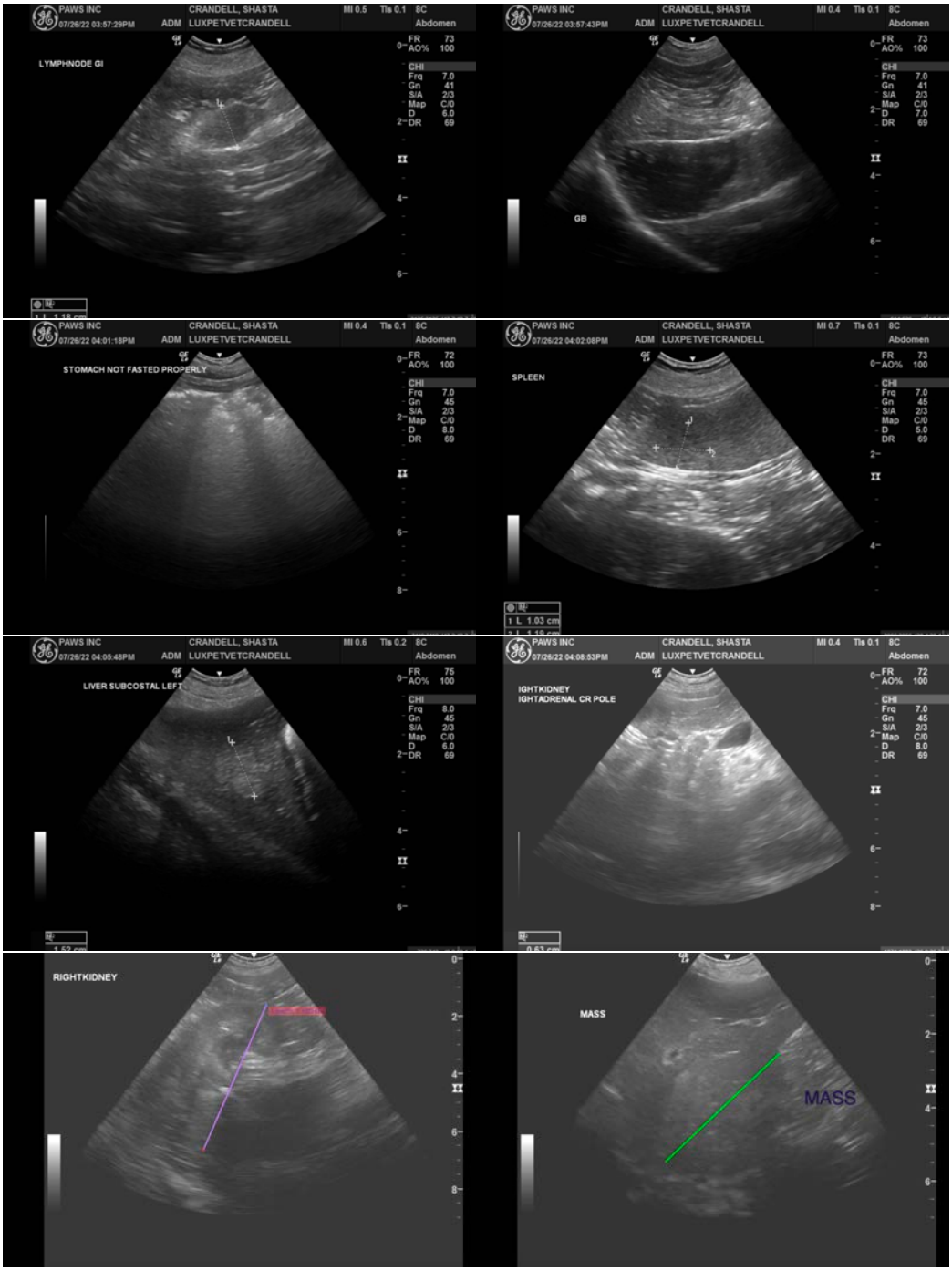

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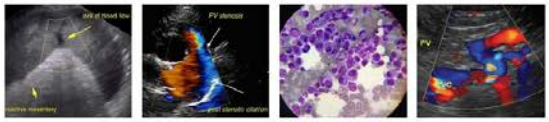

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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