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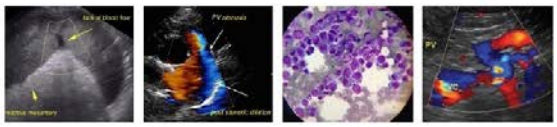


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Tinkerbell Orr

SPECIES

Canine

BREED

Basenji

SEX

Spayed Female

AGE

14 Years

WEIGHT

19.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Burford Vet Hospital

REFERRING VET

Dr. Clench

INVOICE

39335

DATE

7/8/22

PRESENTING CLINICAL SIGNS

P presented for assessment of suspected sudden blindness. O reports over past 3-4 weeks P has seemed to have trouble going downstairs and eye's seemed a little cloudy, this morning P did not want to move from bed and was bumping into things. Had to have food and water brought to her, ate a bit of food and drank a bit of water. 3-4 weeks ago had an episode of GI upset and was vomiting, O fed boiled chicken and rice and it got better. Has been a bit more lethargic past month and seems to startle more easily. T = 38.3 HR = 92 RR = panting BCS = 4/9 Bilateral cataracts, absent menace, absent PLR moderate azotemia, IRIS stage 2 kidney disease Has lost 1kg since March 2022 meds: Baytril 150mg SID for 10 days, Aventi Kidney one large scoop BID, K/D diet
Abnormal PE/Chem/CBC/UA Results: Creatinine - 168 BUN - 15.4

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with significantly echogenic 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.73 cm). Overall echogenicity is slightly hyperechoic with poor 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 (3.98 cm) with pinpoint non-obstructive nephroliths. Overall echogenicity is slightly hyperechoic with poor 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is large in size and irregular, measuring 0.97 cm at the cranial pole, 1.48 cm at the caudal pole and 3.63 cm in length. It is observed in its normal position cranial to the left renal artery. It is irregular in appearance in that the caudal pole is hyperechoic and irregular and has a mass effect with surrounding irregular tissue, which is suggestive of possible early vascular invasion.

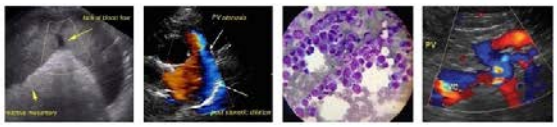
The right adrenal gland is normal in size measuring 0.74 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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. There is an ill-defined, hypoechoic small mass effect visualized in the cranial third of the spleen measuring 2.31 cm x 1.95 cm.

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.



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The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation. These changes can be consistent with an early gall bladder mucocele.

Gastrointestinal

The stomach is dilated with a large amount of 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 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

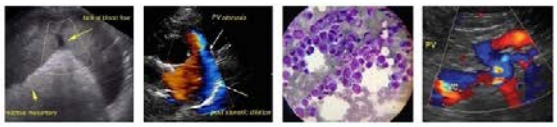
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

Other

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

PRIMARY FINDINGS

- Echogenic debris in the urinary bladder
- Hyperechoic mass effect in the caudal pole of the left adrenal gland – Left adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.
- Irregular, hypoechoic mass effect 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. This lesion is slightly more concerning, as it appears to deviate the splenic capsule somewhat.
- 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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- Large gallbladder debris – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.
- Large fluid/shadowing material within the gastric lumen – Correlate with feedings history and abdominal radiographs. If adequately fasted then consider such differentials as delayed gastric emptying or a partial outflow tract obstruction (none visualized).

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 large, irregular, hyperechoic mass effect on the caudal pole of the left adrenal gland. The tissue surrounding this area is abnormal, and there appears to be evidence of early vascular invasion. These are my recommendations for evaluation of an adrenal mass. These masses can be benign or malignant and can secrete hormones or be non-active. Based on the irregular appearance of this mass, a cancerous process is considered more likely. Options moving forward include:

- 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.

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

Additionally, there is a hypoechoic small mass lesion within the spleen. This could represent a benign or neoplastic lesion, but based on the mild deviation of the splenic capsule, a more aggressive lesion is considered. Options moving forward include a fine needle aspirate or splenectomy to further evaluate.

The liver is large and heterogeneous. This could be secondary to a cortisol excess from the left adrenal mass. Recommend continued monitoring and a liver function test/fine needle aspirate if there is concern for liver enzymes progressing.

As expected, there are bilateral renal changes, most consistent with chronic progressive renal disease. If not already done, recommend a urinalysis, culture and blood pressure evaluation.

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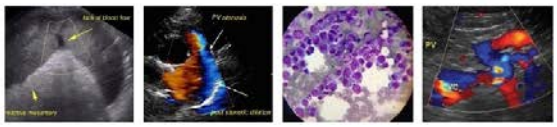

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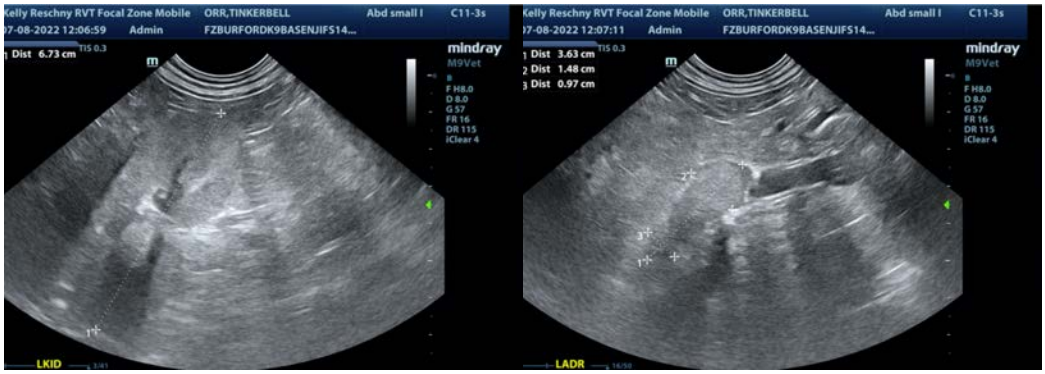

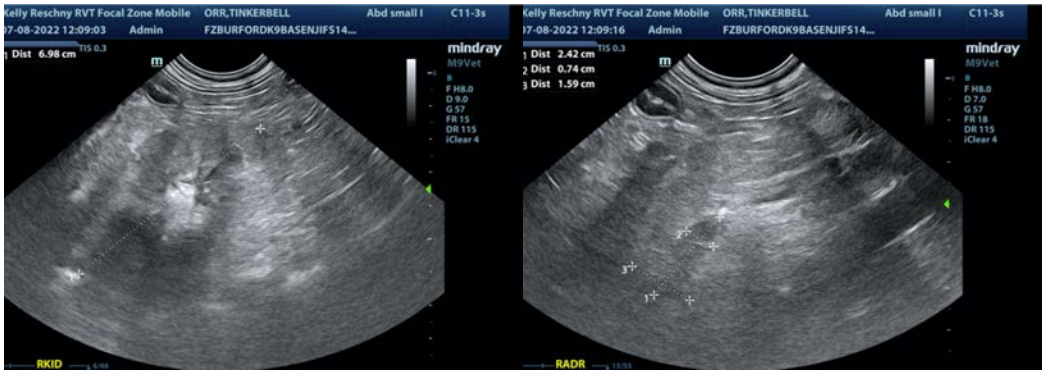

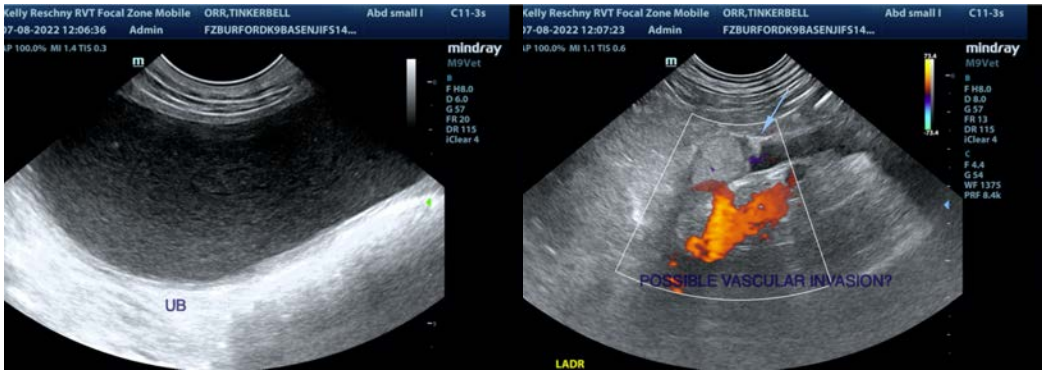

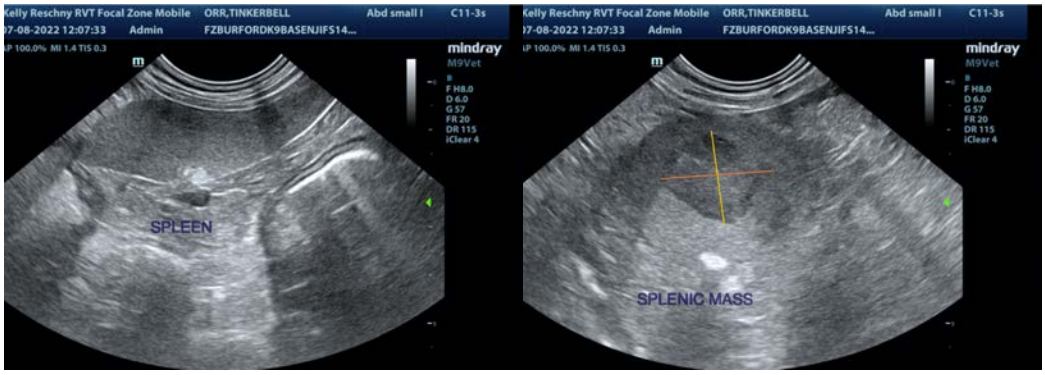

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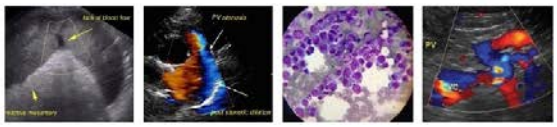

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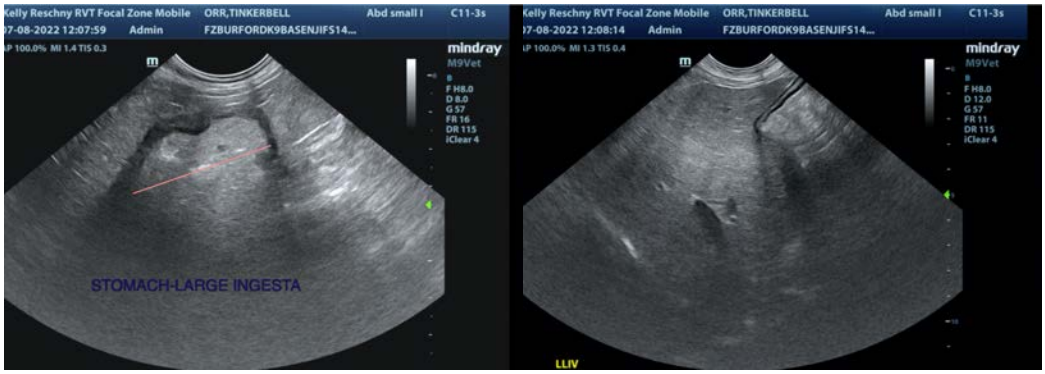

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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