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Clinical Sonography & Telecytology
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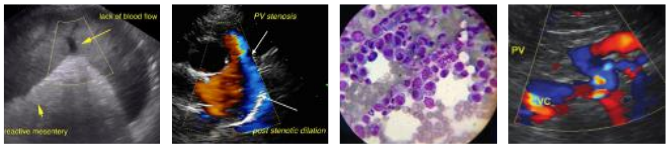


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Sugar Wimbush

SPECIES

Canine

BREED

Westie Mix

SEX

Spayed Female

AGE

10 Years 5 Months

WEIGHT

41.5 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Cassells-Conway

HOSPITAL NAME

Central Broward AH

REFERRING VET

Dr. Janeen Lezcano

INVOICE

12561

DATE

8/17/21

PRESENTING CLINICAL SIGNS

History: P has been PU/PD since 9/2020. An AUS was performed and showed a R adrenal mass. The LDDS confirmed HAC, but suggestive of PDH?. BP at the time was borderline. O was referred to an internist but never pursued. P now has very large intramuscular mass in R thigh (lipoma?) which is hindering mobility and comfort. O wanting to pursue sx for limb, adv work up for adrenal mass necessary prior and likely more serious.

Abnormal PE/Chem/CBC/UA Results: 6/21: CBC: monocytosis, Chem: ALP: 970H, creat: 0.5, T4: 1.3, UA: SG: 1.018, bacteruria, quiet sediment (free-catch) 10/21: LDDS: pre: 6.4H, 4hrs: 1.4, 8hr: 3.1 10/8/2020: AUS w SonoPath, PLZ REVIREW 10/20: UPC: 0.5, 9/20: CBCL: WNL, Chem: ALT: 155H, ALP: 632H, choles: 361H, trilgyc: 1102, NON FASTED; C/S of urine: NEG

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 or masses. There are rare small hyperechoic shadowing structures consistent with very small calculi observed to measured at 0.31 cm and 0.33 cm.

The left kidney has a normal shape and size (3.98 cm). Overall echogenicity is mildly 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 (7.54 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.63 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.

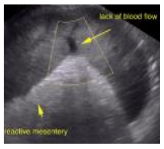
The right adrenal gland is large in size measuring 3.58 cm x 4.96 cm at the caudal pole where there is a hypoechoic discrete round mass effect. The caudal pole is 0.65 cm. The length of the adrenal in total is 5.46 cm. There is a large round mass effect at the cranial pole. Previous measurements (10/18/2020) were 3.1 cm x 3.3 cm, so it appears larger. There is no free fluid surrounding this mass and it appears to be impinging on the local vasculature, but there is no obvious evidence of invasion.

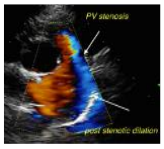
Spleen

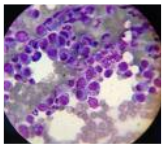
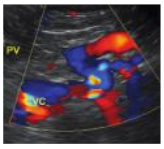
The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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





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normal. No focal nodules or cystic lesions are observed. The gallbladder 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 in the dependent portion of the gallbladder. There is no evidence of bile duct dilation or inflammation around the gall bladder.

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

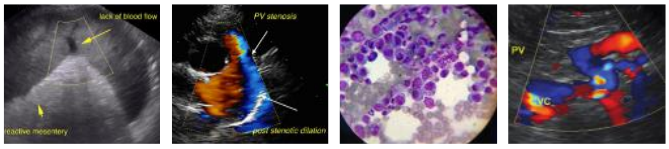
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegally. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Large right sided adrenal mass- Left/right adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other. Images suggestive of progressive disease
- Large hyperechoic liver- 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
- Small mineralizations in the urinary bladder- I recommend urinalysis and culture. Correlate with abdominal radiographs. These are likely small enough to pass at this time
- Large amount of gallbladder sludge- The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting. Consider starting ursodiol

Secondary Findings



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- Decreased corticomedullary distinction in both kidneys- Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis
- Prominent slightly 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

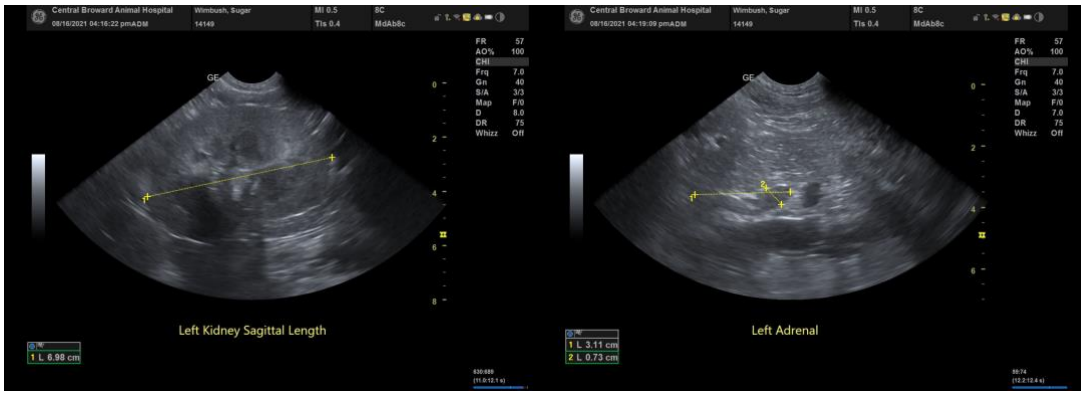
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The previously visualized right sided adrenal mass appears larger. There is no evidence of obvious invasion, but it is certainly possible. Options moving forward include:

- No direct therapy for Cushing's disease, but evaluation for comorbidities such as proteinuria and hypertension, which could be managed
- Adrenal testing with the intention to treat medically so differentiation is less important. Consider ACTH stimulation test or adrenal panel with ACTH stimulation test
- Evaluation for possible surgical adrenalectomy

I recommend blood pressure, urine protein to creatinine ratio, urine culture, 3 view thoracic radiographs and referral to a veterinary surgeon and veterinary internist for preoperative advanced imaging and to decide if the patient is a good surgical candidate.

If surgery is desired for the leg, due to quality-of-life issues, then it is likely that chest radiographs, blood pressure and UPC should ideally be done. There is also the risk for intraoperative hypertension if this could possibly be a pheochromocytoma. Risk for PTE would be moderately increased with surgery as well.



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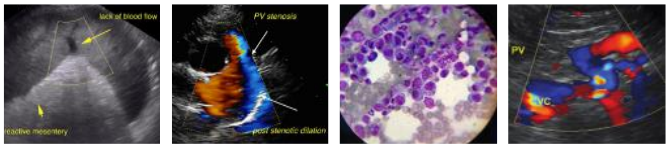

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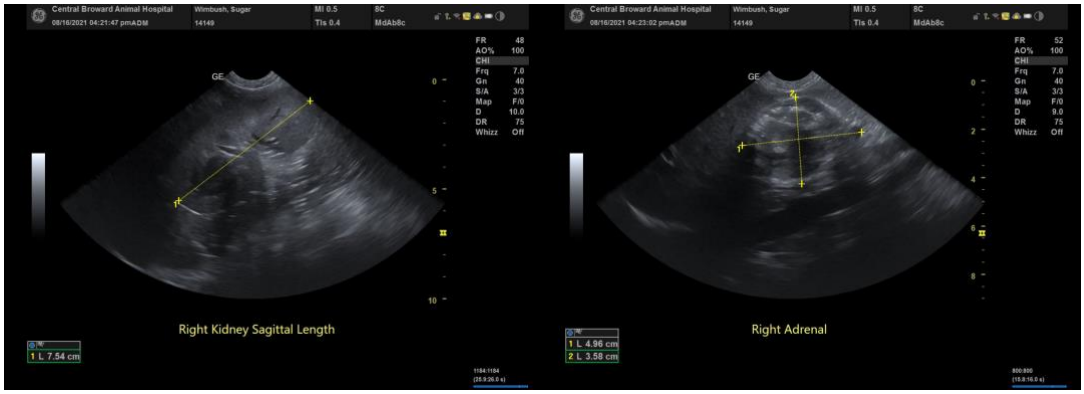

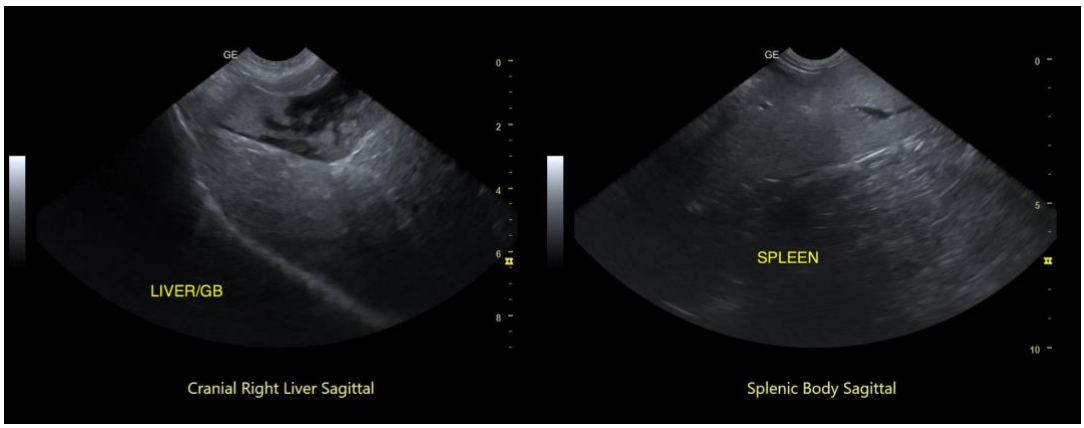

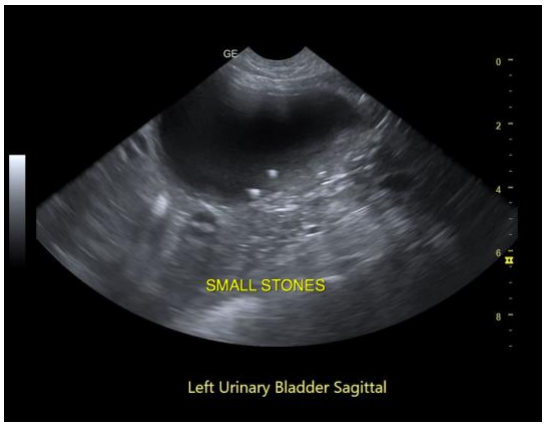

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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