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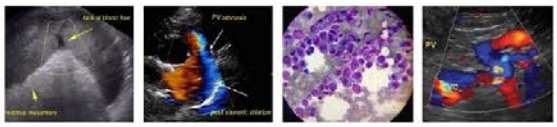


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Sadie Callen

SPECIES

Canine

BREED

Mini Dachsund

SEX

Spayed Female

AGE

9 Years

WEIGHT

12.1 Pounds

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

The Maples AH

REFERRING VET

Dr. Kazienko

INVOICE

26106

DATE

10/6/21

PRESENTING CLINICAL SIGNS

Fever, anorexia, not drinking much. Was given Convenia, Dexamethasone, Cerenia and Tramadol. Has been Cytopoint for allergies.
Abnormal PE/Chem/CBC/UA Results: ALP 1270, ALT 645, AST 106, GGT 17, TBili 12.9, Sodium/Potassium ratio 40, unremarkable CBC.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. No evidence of pyelectasia or overt pyelonephritis. The left kidney measured 4.7 cm. The right kidney measured 4.5 cm.

No overt pathology in the area of the uterine stump or aortic trifurcation.

Adrenal Glands

A focal, well defined, hyperechoic nodule was present in the cranial pole of the left adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 1.2 cm x 0.86 cm. The left adrenal overall measured 0.98 cm at the cranial pole and 0.64 cm at the caudal pole. This is likely suggestive of a benign process such as adenoma, granuloma or myelolipoma if no clinical signs of adrenal disease are currently present. Potential emerging aggressive neoplasia cannot be ruled out. Therefore, recheck ultrasound every 3-6 months is suggested to monitor for changes in size or appearance. A screening blood pressure is suggested.

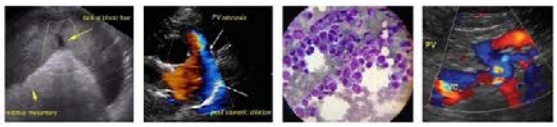
A focal, well defined, hyperechoic nodule was present in the cranial pole of the right adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 0.62 cm x 0.54 cm. The right adrenal overall measured 0.90 cm at the cranial pole and 0.55 cm at the caudal pole. This is likely suggestive of a benign process such as adenoma, granuloma or myelolipoma if no clinical signs of adrenal disease are currently present. Potential emerging aggressive neoplasia cannot be ruled out. Therefore, recheck ultrasound every 3-6 months is suggested to monitor for changes in size or appearance. A screening blood pressure is suggested.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver presented normal in size. The hepatic parenchyma revealed diffuse reduced echogenicity compared to the spleen and renal cortical parenchyma with a mild coarse echotexture. Increased portal vein prominence was evident. The capsule of the liver was normal in margination. Distinct masses or nodules were not evident. The hepatic and portal vasculature were normal in appearance. The gallbladder was normal in size. The gallbladder wall was uniformly mildly thickened and echogenic in



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appearance. Mild luminal debris was present. This is suggestive of chronic gallbladder wall inflammation and possible fibrosis. Primarily anechoic luminal content was present. No evidence of peripheral inflammation. The common bile duct was normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. Stomach wall measured 0.42 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. Duodenum wall measured 0.30 cm.

Normal visible colon wall layers were present with generalized semiformed to soft feces present.

Pancreas

The parenchyma of the pancreas was hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

Free Abdomen

No evidence of omental masses, abscess, lymphadenopathy, or peritoneal effusion.

ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenal nodules – suspect adenoma
- Hepatopathy
- Mild chronic cholecystitis pattern with mild luminal debris
- Chronic pancreatitis, potential for pancreatic fibrosis
- Possible mild gastroenteritis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential for left, right or bilateral emerging adrenal neoplasia possible, yet considered less likely at this time. Screening blood pressure advised. Sonographic monitoring of the adrenal nodules is recommended with initial recheck in 4-6 weeks to assess for evidence of progression. Potential considerations for the liver may include acute or acute on chronic non-specific hepatitis (immune mediated, infectious, or other), vacuolar hepatopathy and non-obstructive cholestasis, metabolic/reactive hepatopathy, or occult infiltrative neoplasia (less likely), or other hepatopathy.

Further assessment may include Leptospirosis titers/PCR and hepatic FNA (Assuming normal clotting status) for screening cytology. No evidence of post-hepatic obstruction. Hospitalization with antibiotics therapy (given the fever) along with hepatosupportive and gastrointestinal support is recommended. Recheck sonogram suggested if persistent or increasing hepatic enzymes, or if evidence of cholestasis is noted despite conservative therapy.

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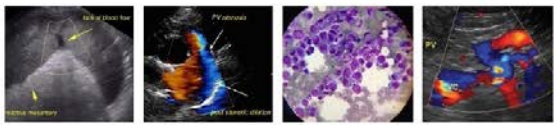

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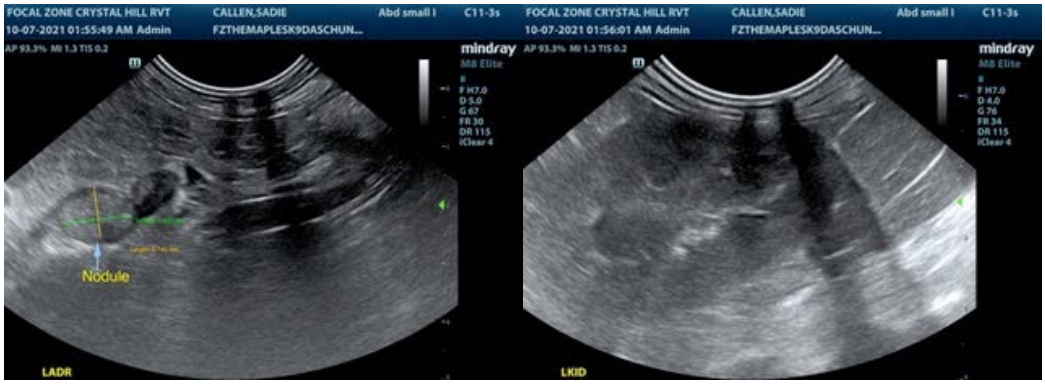

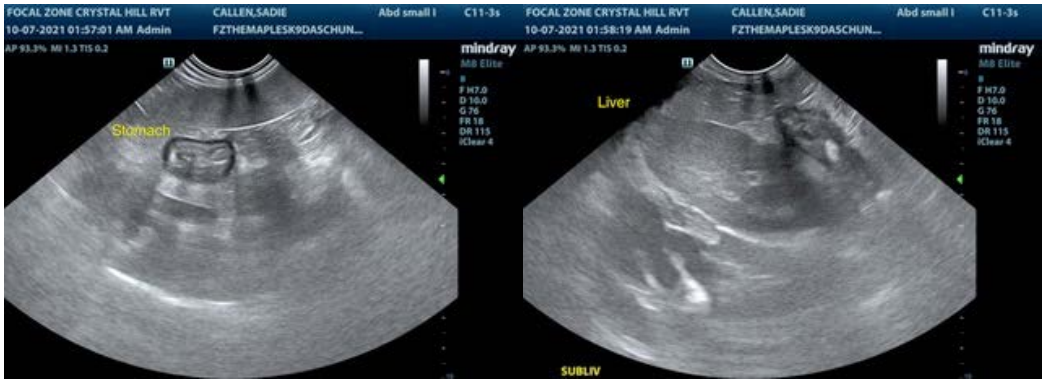

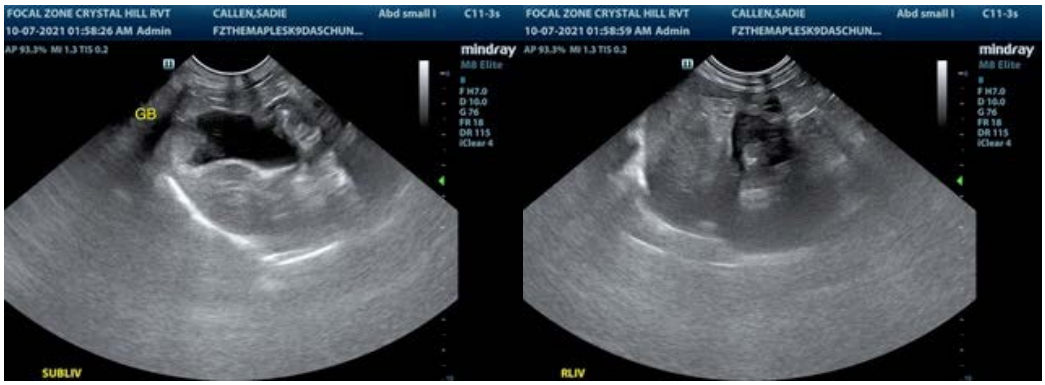

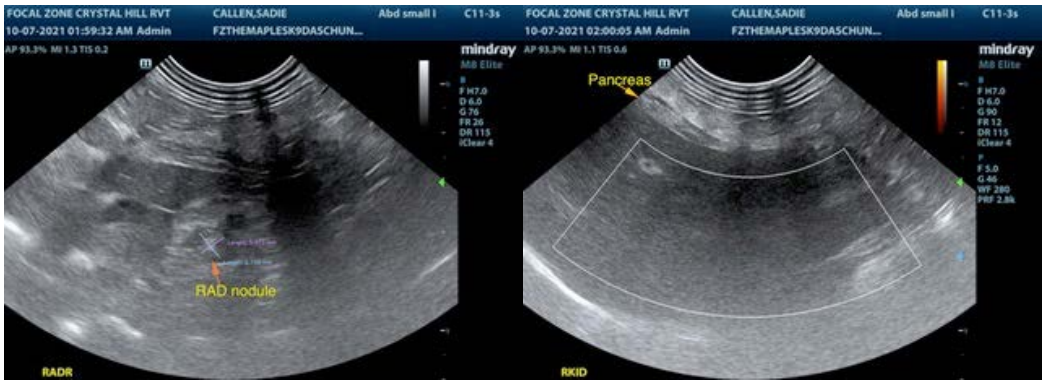

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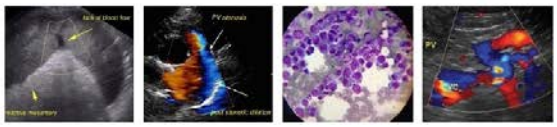

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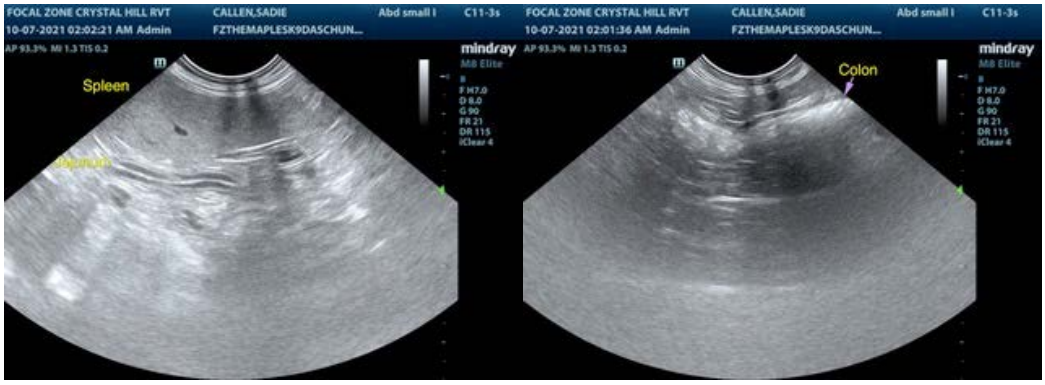

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
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