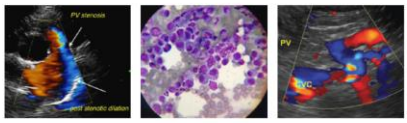


PATIENT

Mia Bell

SPECIES

Canine

BREED

Malamute

SEX

SG

AGE

12 years

WEIGHT

70 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Casey Youngren, DVM

INVOICE

14210

DATE

7/6/22

PRESENTING CLINICAL SIGNS

Presented Friday for weakness and difficulty getting up. New client/patient. Records are from 2 clinics the past few years. History of Lyme disease in 2018. History of sensitive stomach (on science diet sensitive stomach OTC (use to be on i/d years ago)). No V or D at time of exam (O reported this am she did vomit monday twice). Has been on Previcoxx for years O reports and Deramaxx prior. Has been on Denamarin 425mg SID for over a year (unsure of when prescribed-limited records). Has been on Bravecto and Milbeguard. O also reports she was told to give Famotidine 10mg as needed. Previous records show it was on and off Metronidazole for years. On a joint supplement (o thinks Dasaquin). O reports it received Adequan injections at the previous Vet's office in May 2022. O thinks it did not help. Was fasted 13 hours before scan
Abnormal PE/Chem/CBC/UA Results: Pale Mucous Membranes, moderate crepitus and decreased ROM in rear stifles (suspect old CCL tears), BCS 4/9, weight loss (minimal previous records). CBC: mild nonregen. or pre-regen. anemia, mild neutrophilia (smear unremarkable) Chem: ALT and ALP moderately elevated (has been increasing based on previous labwork done at other clinics, even with being on Denamarin). Rest WNL 4DX: neg for all 4 UA: SpGr 1.019

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 was noted.

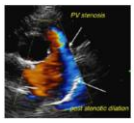
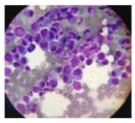
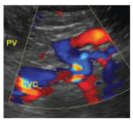
The area of the aortic trifurcation was without pathology including no evidence of medial iliac or sublumbar lymphadenopathy / masses.

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. The left kidney measured 6.4 cm in length. The right kidney measured 7.2 cm in length.

Adrenal Glands

Mild asymmetrical nonhomogeneous left adrenal mass was present measuring 4.3 cm length x 3.0 cm width at the caudal pole. No overt evidence of left adrenal parenchymal mineralization was noted. Concurrent soft tissue echo was noted within the lumen of the caudal vena cava consistent with probable vascular invasion associated with the left adrenal mass. The soft tissue echo measured approximately 2.6 cm in diameter. Caudal vena cava thrombus Is considered a less likely differential diagnosis.

The right adrenal gland was overtly normal in size, position, and shape exhibiting subtle nonhomogeneous yet nonmineralized parenchyma, and measuring 3.2 cm length x 0.76 cm width at the caudal pole.

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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. No evidence of splenic nodules, masses, or neoplastic criteria.

Liver/ Gallbladder

The liver exhibited mild to possible moderate generalized enlargement with normal structure and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without overt evidence of hepatic vascular congestion. No overt hepatic masses or nodules were noted. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate, variably echogenic ingesta with concurrent mild luminal fluid. No evidence of mechanical pyloric outflow obstruction was noted. The ventral gastric body wall width measured 0.50 cm.

The small intestine exhibited generalized intact yet subjectively prominent wall layering owing to propensity for mildly prominent mucosa and mildly prominent muscularis layer. The duodenum wall measured 0.59 cm width. The jejunum wall measured 0.50cm width. No evidence of intestinal masses or loss of intestinal wall layering was noted.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Mild volume subjective anechoic peritoneal free fluid was present. Focal to intermittent mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example lymph node measured 3.5 cm x 1.0 cm.

ULTRASONOGRAPHIC FINDINGS

- Left adrenal mass with evidence of vascular invasion
- Hepatopathy - progressive chronic vs. acute on chronic criteria, vacuolar hepatopathy, inflammatory / immune-mediated disease, hematopoiesis, indistinct nodular hyperplasia, or other hepatopathy possible, potential of occult neoplasia cannot be excluded
- Mild nonspecific chronic renal changes

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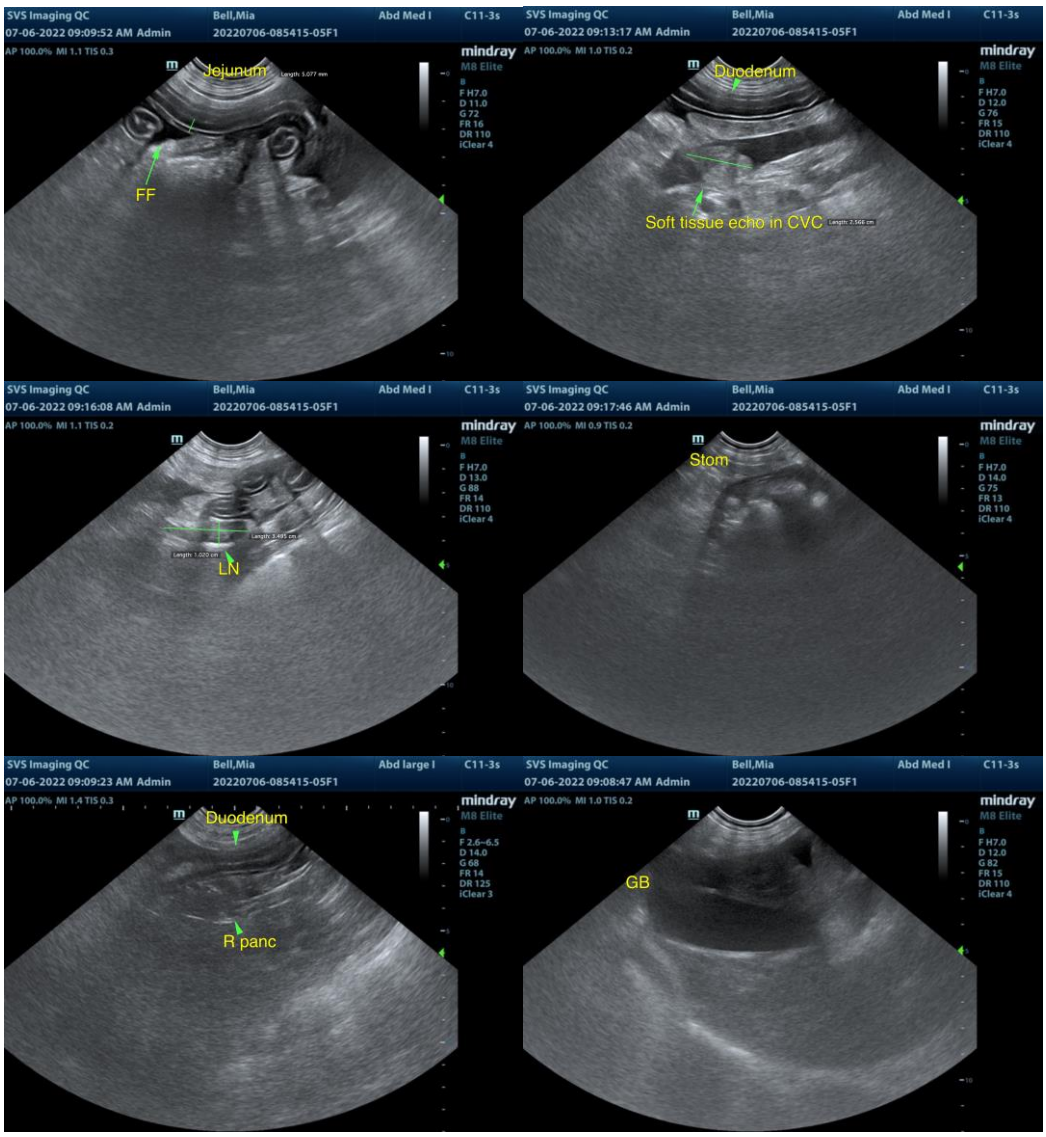
- Suspect chronic inflammatory enteropathy with associated subjectively benign / reactive mild mesenteric lymphadenopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left adrenal mass is consistent with neoplastic criteria given the evidence of vascular invasion. Adenocarcinoma, pheochromocytoma, or others are possible. Screening blood pressure is recommended to assess for evidence of hypertension which may allude to a pheochromocytoma, given the patient's reported weakness.

Assuming normal clotting status, screening hepatic FNA for cytology, as well as abdominal effusion analysis cytology +/- C/S if clinically indicated could be considered. Abdominal CT could be considered if possible for further assessment of the left adrenal mass. However, surgical options regarding the left adrenal mass may be precluded given evidence of vascular invasion. Three view chest radiographs are suggested to rule out concurrent thoracic pathology and assess cardiopulmonary status.



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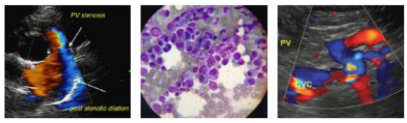

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Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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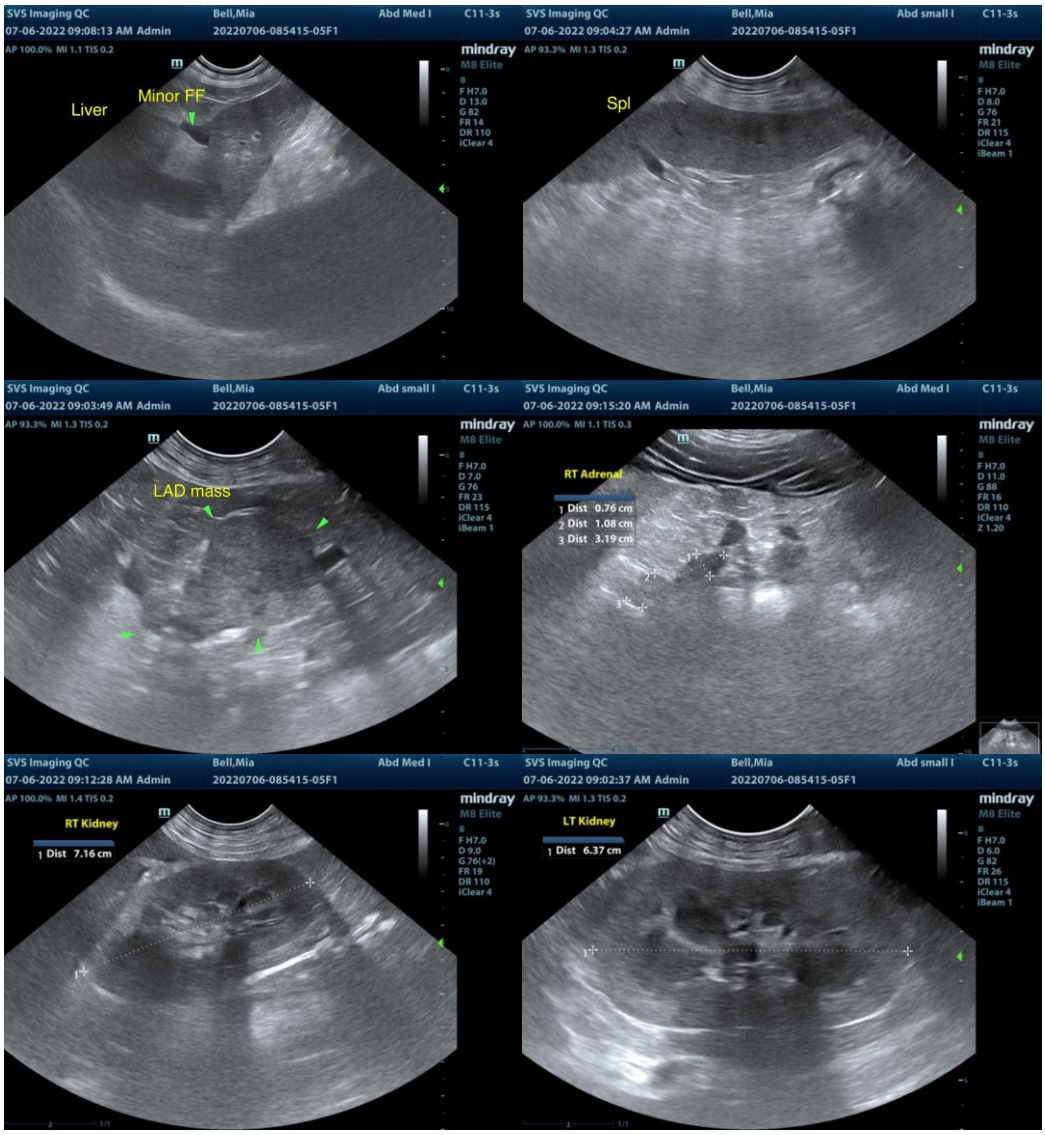

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com