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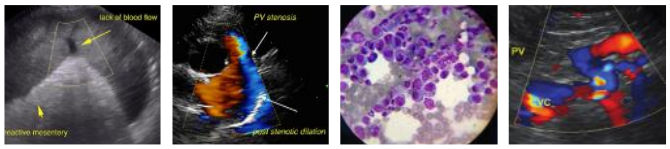
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
JD Finkbiner

SPECIES
Canine

BREED
Dachshund Mix

SEX
MN

AGE
13yr

WEIGHT
17.6lb

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

IMAGING PERFORMED BY
A. Rodriguez

HOSPITAL NAME
Foxfield Veterinary Services

REFERRING VET
A. Rodriguez

INVOICE
14486ag

DATE
08/07/2023

PRESENTING CLINICAL SIGNS

Anorexia and dark thick feces since 8/4/23

Abnormal PE/Chem/CBC/UA Results: 8/4/23: BUN 34, CA 12.8, Tbili 1.1, RBC: 9.2, HCT: 54

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with 2-3 small dependent calculi. An example of calculus measured 0.83 cm in diameter. Concurrent mild non-dependent particulate sediment was present. The sediment may indicate cellular debris / protein, crystalline debris, lipid, or mucus. The ureteral papillae were normal. The ureters were not visible which is normal.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Bilateral areas of minor medullary mineral was present with mild bilateral pyelectasia and cortical cysts. The left kidney measured 5.6 cm in length. The right kidney measured 5.4 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the residual prostate appeared normal and free of pathology.

Adrenal Glands

A primary spherical non-homogenous mass was present in the area of the left adrenal gland measuring 2.8 cm x 2.2 cm. The right adrenal gland was overtly normal in size, position and shape. The right adrenal gland measured 0.49 cm width at the caudal pole and 1.8 cm length.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Small non-disruptive well-defined, symmetrical, hyperechoic nodules were present throughout the cranial to caudal 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 or neoplastic changes were not noted. The hyperechoic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver/Gallbladder

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content and moderate congealed non-organized sediment. The cystic and common bile ducts were normal.

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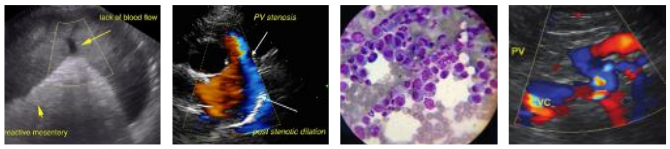

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Gastrointestinal

The stomach presented overtly normal fundus and gastric body wall. The potential for mildly thickened ventral pylorus wall measuring potentially 1.0 cm in width was present. The lumen of the stomach was empty with mild luminal gas and no signs of ileus, obstruction or foreign material.

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.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder lumen calculi.
- Moderate chronic renal changes with medullary mineral, bilateral pyelectasia and cortical cysts.
- Mass in the area of the left adrenal gland.
- Normal volume liver with mild parenchymal remodeling.
- Moderate gallbladder sediment (non-mucocele).
- Empty stomach exhibiting potential for mildly thickened pylorus wall, sonographically unremarkable small bowel.

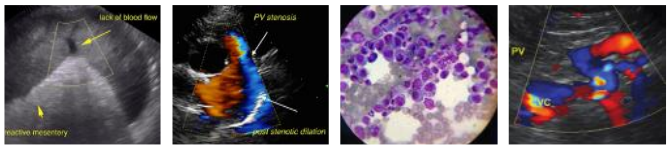
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S is recommended.

The mass in the area of the left adrenal gland is most suggestive of adrenal origin and likely neoplastic criteria with considerations including carcinoma, pheochromocytoma, adenomatous change, hyperplasia or other. A screening BP is advised to assess for evidence of hypertension which may allude to emerging adrenal neoplastic criteria i.e., pheochromocytoma. A urine catecholamine level if clinical concern for pheochromocytoma could be considered.

The potential mildly thickened pylorus wall is non-specific with considerations including regional pyloric gastritis, infectious gastropathy i.e., helicobacter or non-obvious ulcer given elevated BUN and reported dark colored feces. Although thought less likely, potential for emerging pyloric mural neoplasia cannot be excluded.

Gastric protectant protocol i.e., Omeprazole 1 mg/kg PO SID over the next 3 weeks, dietary therapy +/- empirical therapy for helicobacter with sonographic monitoring of the stomach and mass in the area of the left adrenal gland for evidence of progression would be reasonable. Alternatively,



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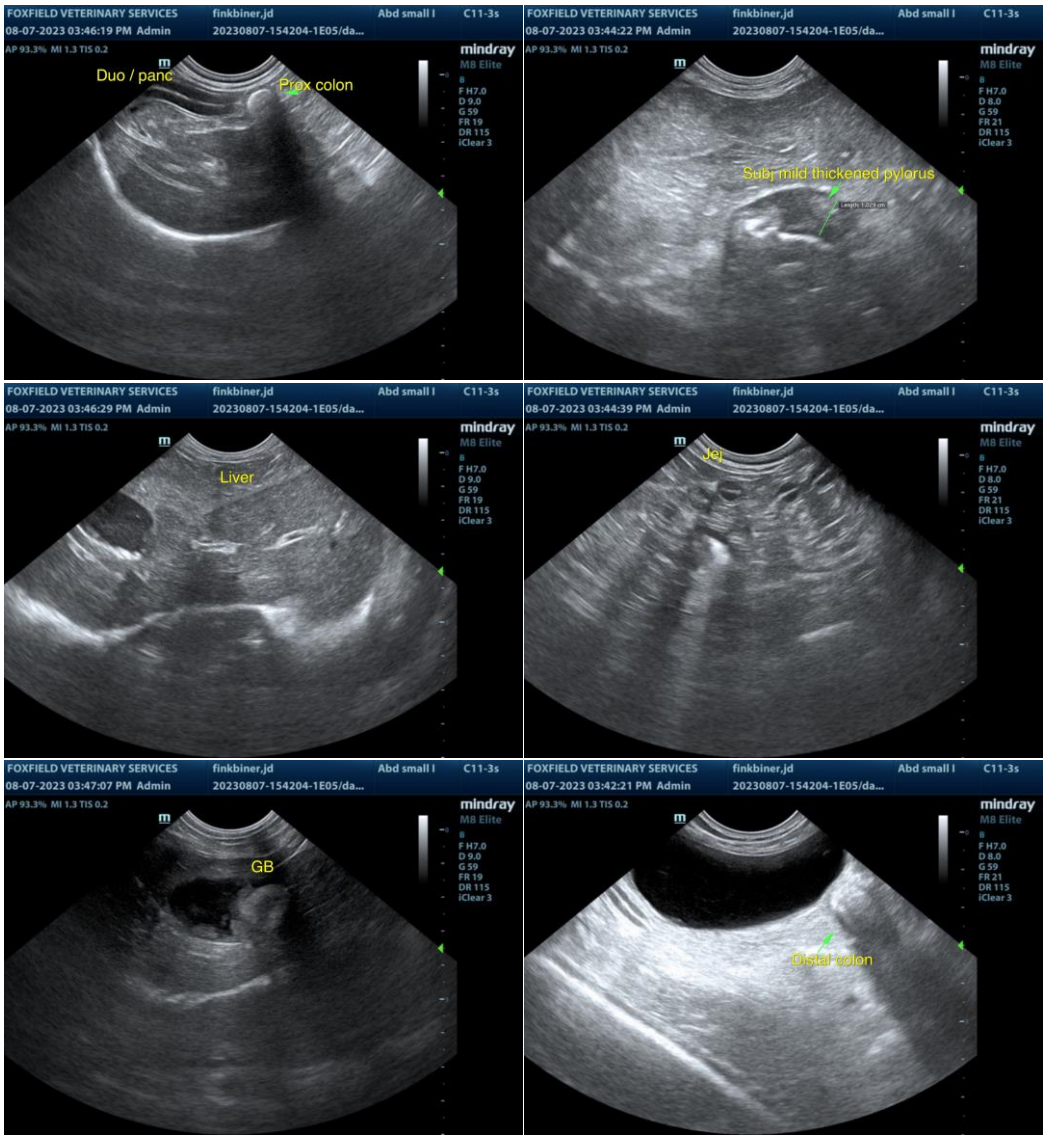
abdominal CT for further clarification specifically of the left adrenal mass as the possibility of vascular invasion could be present would be ideal.



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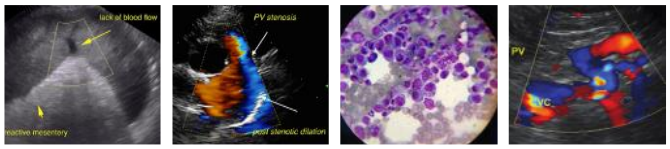

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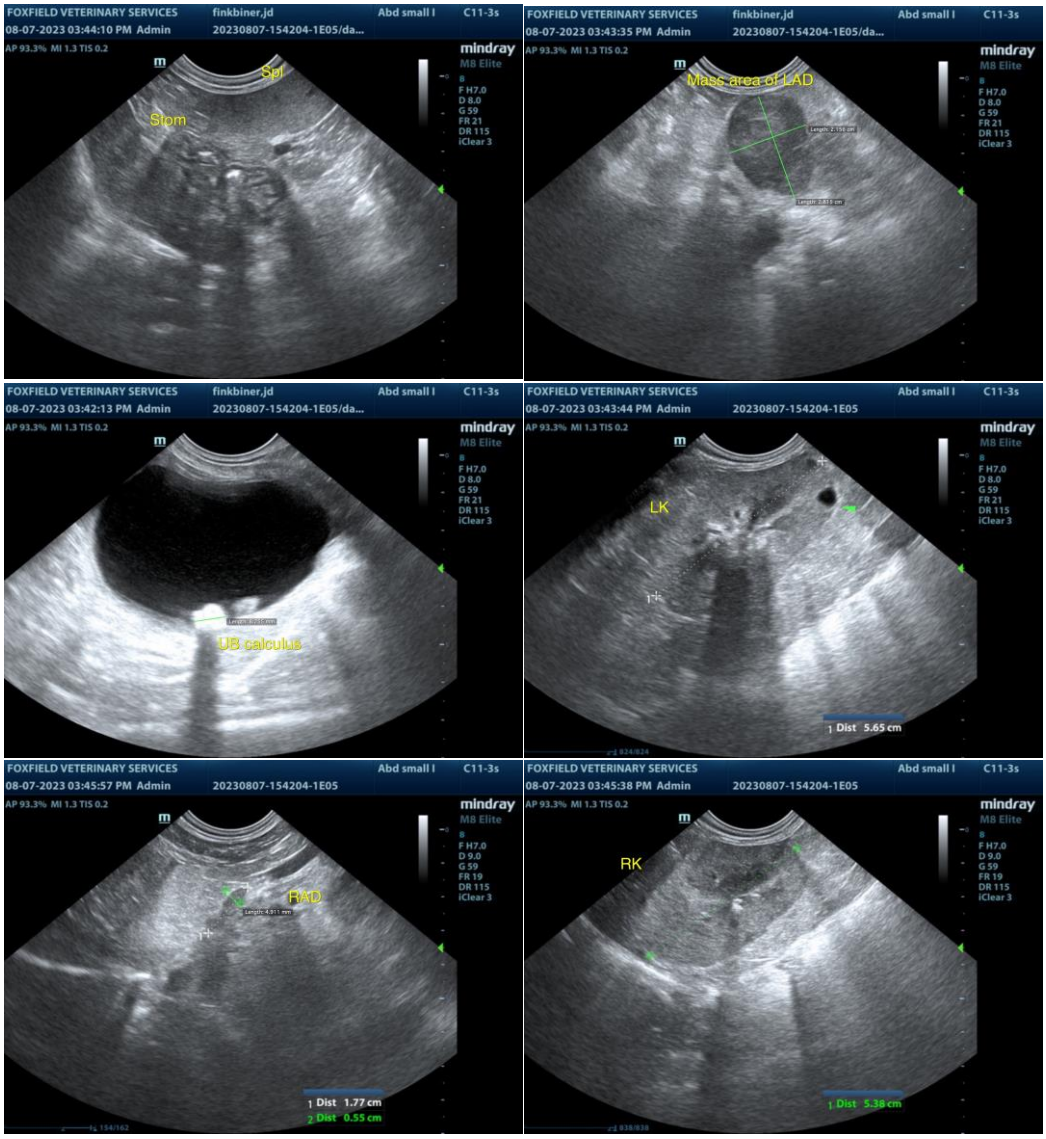

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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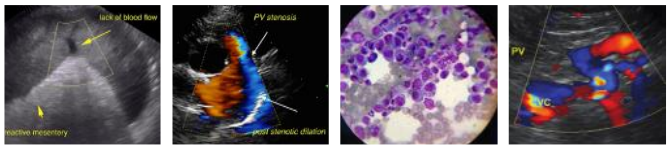

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