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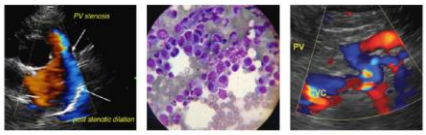
SVS Mobile Imaging CT 262 - 366 - 5970
fredgromalak@gmail.com



SonoPath
Clinical Sonography & Telecytology
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PATIENT

Riley Gibbs 37395A

SPECIES

Canine

BREED

Labrador Retriever

SEX

Male Neutered

AGE

8.5 Years

WEIGHT

34.1kg

INTERPRETED BY

Sebastian Jawinski, German Board Certified Vet Specialist in Diagnostic Imaging

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison Veterinary Specialists-Dr. Custead

INVOICE

50209

DATE

2-9-22

PRESENTING CLINICAL SIGNS

Riley was presented to the MVS Oncology Service on Aug 03, 2021 for further evaluation of an adrenal gland tumor. Riley presented to ER at MVS on 9/11/20 for ataxia, trembling, and facial paralysis. He was diagnosed with vestibular Dz and had an MRI performed that was wnl. After these episodes began, his hind end never returned to normal, but no full recurrent neurologic episodes were observed by owner. Riley was then seen by pcDVM on 7/1/21 for a slab Fx on 208, and upon PE at that time, marked weight loss was noted (~17lbs. over the past 9 months) and a large cranial abdominal mass was palpated. A distended abdomen and dull coat quality were also noted at this time. Riley had been PU/PD for roughly a year at this point. CBC/Chem/UA/UPC were performed, revealing elevated Na (157), GGT (14), Cholesterol (550), and ALP (163) as well as elevated HCT (57.3%) and PLT (461). UA w/ UPC revealed an elevated UPC of 5.7. Due to distended abdomen and PU/PD, ACTH Stim. (came back wnl) and LDDST were performed. LDDST results stated an elevated pre-Dex. level of 6.1 (4hr. post: 4.4, 8hr. post: 3.2); blood pressure was also elevated at this time (average of 170). An AUS and 2vCHR were then performed, revealing a 42mmx60mm L adrenal mass that is intimately associated with the caudal vena cava. Left adrenalectomy performed on 9/1/21 with narrow excision. Subsequent recheck ultrasounds revealed "a 3.6 mm, roughly ovoid, mildly hypoechoic region." Recurrence of the adrenal mass could not be ruled out. Riley has been doing well at home! He is eating/drinking/voiding normally. No v/d/c/s.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary system

The urinary bladder, trigone and pelvic urethra present normal findings without evidence of uroliths or sediment. Wall layering is intact on all views without overt focal or diffuse thickening. Ureters are not visualized and considered to be normal. No evidence of an inflammatory or neoplastic process is noted.

Both kidneys present marked capsular and cortical calcifications. Left kidney measures 6.71 cm length, right kidney 6.49 cm. There is still a clear corticomedullary definition. Renal pelvises and exits to the ureters are unremarkable.

Reproductive tract

The prostate is small, homogeneous and appears smoothly marginated.

Adrenal glands

In the region of the former left adrenal gland a ovoid to fusiform lesion is recognized with diameters of 1.39 x 0.54 cm, indicating a adrenal-like texture and corticomedullary definition. Color doppler does reveal significant perfusion.

The right adrenal gland measures 2.43 (estimated) x 0.52 cm and is inconspicuous.

Spleen

The spleen shows diameters of 1.86 cm. Splenic margins are mildly rounded. Splenic echogenic texture is inhomogeneous without protrusions of the capsule showing multiple small hypoechoic, partially nodule-like areas with diameters of 0.51 – 0.69 cm. Splenic vasculature presents normal course of vessels and unremarkable perfusion of the splenic veins.

Liver/Gallbladder

There is a questionable, hypoechoic nodule in the left liver noted (may be artificial, 1.47 cm). Liver images are inconspicuous apart from that. Echotexture, size and vasculature appear regular. Evidence of nodular

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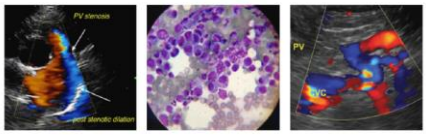

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or focal changes is not visible. The gallbladder is mildly filled without signs of relevant sludge, a florid process or cholestasis.

Gastrointestinal

The stomach, the small intestine and colon present intact wall layers being normal in width and echogenicity. Adjacent mesentery and fat tissue are of normal appearance. There is no overt evidence of an ileus, a florid-inflammatory or even neoplastic process. The mesenteric, epigastric and portal lymph nodes are considered to be normal.

Pancreas

All pancreatic parts displayed show isoechoic echogenicity to the surrounding omental fat. Signs of inflammatory changes or focal lesions are missing.

Free Abdomen

There is no evidence of peritoneal or retroperitoneal effusion noted. The para-aortal and medial iliac lymph nodes are considered to be normal. The abdominal fat and great vessels show no pathological findings.

ULTRASONOGRAPHIC FINDINGS

Primary

- Small hypoechoic, ovoid to fusiform structure in the area of the former left adrenal gland
- Mild unspecific splenomegaly and inhomogeneous splenic echotexture
- Signs of a moderate and chronic, bilateral nephropathy
- Questionable nodular lesion left liver

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasonographic findings of the hypoechoic structure in the region of the former left adrenal gland appear progressive compared to the last sonographic recheck. Diameters now range up to 1.39 x 0.54 cm (last ultrasound 0.36 cm). Relevant perfusion is not recognized. This however is not specific. Currently recurrence of neoplasia seems to be more likely than scar tissue due to former surgery. An aggressive pattern and erosion of the adjacent vessels is not noted (follow-up in 6 weeks recommended, including liver).

Splenomegaly is unspecific. The patchy appearance and the nodular-like areas are commonly seen with extramedullary hematopoiesis and/or benign lymphoid hyperplasia. Neoplastic infiltration and splenitis are further differentials. Final assessment is a matter of the temporary course (follow-up in 6 weeks) and/or ultrasound guided FNA.

Changes of the kidneys are bilateral. I suggest they are chronic and degenerative findings consistent with nephrosis that may represent residuals of former infection/inflammation. Chronic hypertension and hyperadrenocorticism may have been triggering factors.

The liver lesion is noted in just one loop and may be artificial. Liver should again be included in the next recheck examination.

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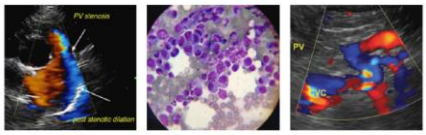

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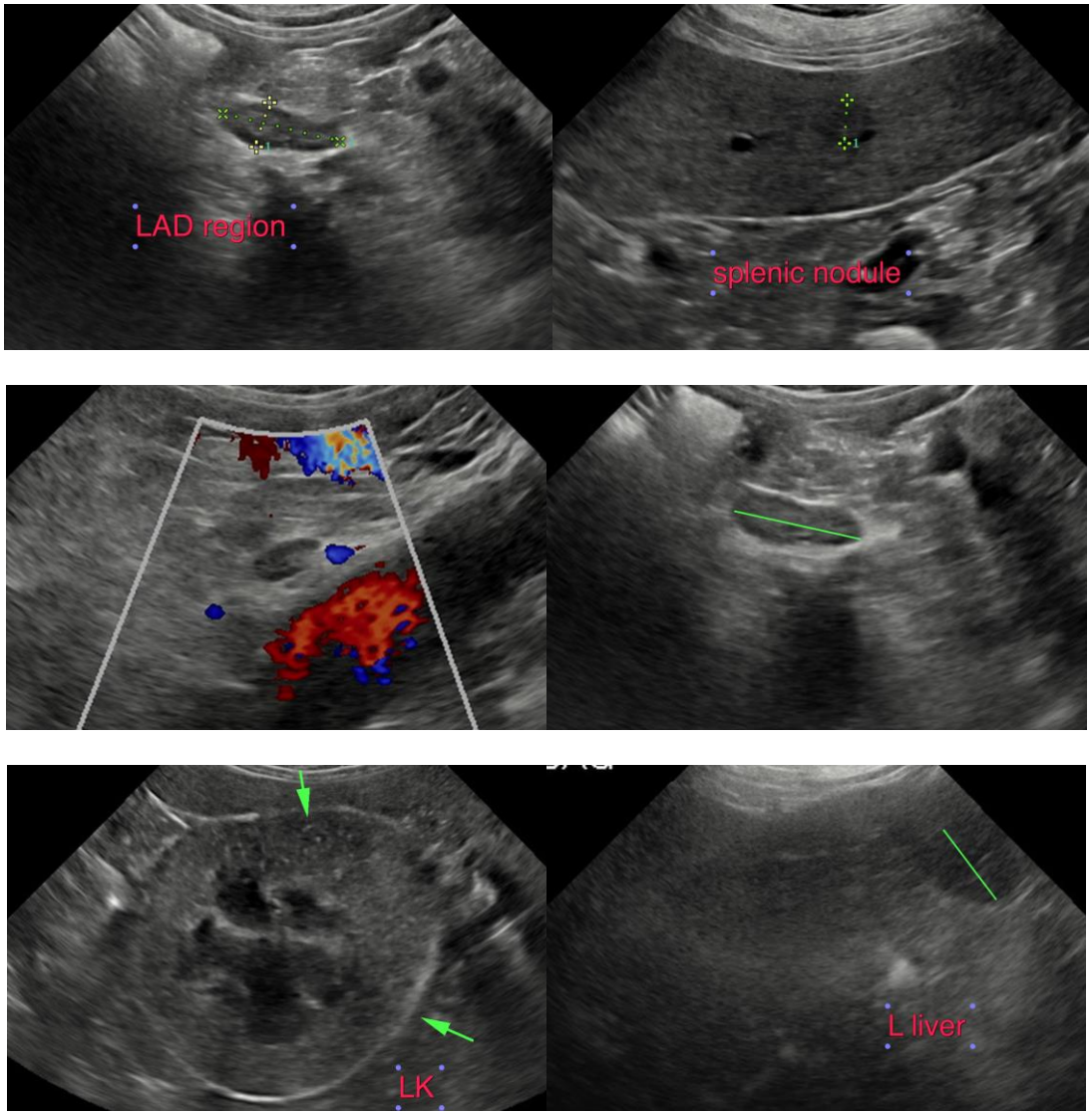

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Sebastian Jawinski, German Board Certified Vet Specialist in Diagnostic Imaging

Sebastian.Jawinski@sonopath.com