



<b>PATIENT</b>	<b>PRESENTING CLINICAL SIGNS</b>
Abby Brown	<p>Assessed by AHP ER June 13th + 19th for diarrhea. Patient has history of presenting to AHP ER several times in 2019-2021 for suspected acute gastroenteritis and pancreatitis. Was also assessed by AHP IM Service in March 2021- elevated folate at this time with unremarkable GI panel otherwise; probiotic and metamucil were recommended at this time BW performed by family vet end of May showed elevated liver enzymes (ALP 1,373, ALT 232) AUS performed early June showed R adrenal mass, small L adrenal, enlarged and hypoechoic liver w few nodules, gall bladder debris. On June 13th visit was dispensed metronidazole which helped but diarrhea reoccured when stopped. O also notes previous probiotic trial similar response with reoccurring diarrhea when discontinued When assessed June 19th had cortisol + folate/B12/TLI performed. Elected not to proceed with abdo US given how recently one had been performed. Discussed following up with CT scan instead and following up with LDDST with ref vet. Dispensed tylosin in interim. Over the years has had episodes of vomiting/diarrhea- O previously suspected dietary indiscretion. Most times will take meds and resolves. About 5 weeks ago started having diarrhea- was soft to liquid-y, not formed. Will have some blood, some mucus too. Was having increased frequency when having diarrhea. Did probiotic trial initially with family vet - helped a bit, but not much. Reoccured right after discontinued. Started a separate fortiflora with prebiotic too - no help. Brought ate AHP- started metronidazole x 5 days- when finished diarrhea was back. Returned and got tylosin- still on this (few pills left). Doing fine while on the tylosin (O stopped using the probiotic while giving tylosin). Also has liver enzyme elevation + adrenal gland nodule that monitoring.</p> <p>Abnormal PE/Chem/CBC/UA Results: PREVIOUS DIAGNOSTICS: March 2021: -abdo US: Diffuse non-specific hepatopathy without parenchymal disruption. Benign hepatopathies are considered primarily since there is no disruption of the parenchymal architecture. This could be related to an endocrinopathy or drug administration. A cause for vomiting is not identified. Therefore, gastroenteritis would be considered most likely. May 30, 2022 (Leslieville AH) -CBC: platelets 472 H (448), rest WNL (HCT 0.45) -biochemistry: creatinine 42 L (44), ALT 232 H (121), ALP 1373 H (160), rest WNL -4dx: negative June 9, 2022 (Hound ultarsound- interpreted by RadTerra) -abdo US: Enlarged and diffusely hypoechoic liver Few small hypoechoic hepatic nodules Moderate amt gall bladder debris R adrenal mass with no evidence of vascular invasion Mildly small L adrenal gland (up to 17.6mm thick by 24mm in length) Mild L renal diverticular mineralization June 19th, 2022 (AHP) -QUAT: PCV 46, TS 8 H (7.5), K 4.8 H (4.7), Cl 106 L (111), lactate 4.3 H (2) -baseline cortisol: 157 -GI panel: TLI &gt;50 H (35), B12 &gt;1,475 H (617), folate WNL</p>
<b>SPECIES</b>	
Canine	
<b>BREED</b>	
Shih Tzu	
<b>SEX</b>	
FS	
<b>AGE</b>	
11 Years	
<b>INTERPRETED BY</b>	
Sebastian Jawinski, German Board Certified Vet Specialist in Diagnostic Imaging	
<b>HOSPITAL NAME</b>	
Animal Health Partners	
<b>REFERRING VET</b>	
Westgarth	
<b>INVOICE</b>	<b>COMPUTED TOMOGRAPHY OF THE THORAX &amp; ABDOMEN</b>
52618	Pre/post contrast studies provided for review.
<b>DATE</b>	<b>COMPUTED TOMOGRAPHIC FINDINGS</b>
6-28-22	<p>Chest:</p> <p>The lungs are regularly ventilated with close contact to the inner thoracic wall on all sides. There is no evidence of pleural thickening, fluid accumulation or free pleural gas. Pulmonary density is within normal limits, there is no evidence of focal or nodular pulmonary lesions.</p>



**PATIENT**

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The mediastinum is regular in width and density. The cranial mediastinal lymph nodes appear mildly enlarged but are inconspicuous in shape and contrast behavior. The thoracic trachea and esophagus present as expected.

**SPECIES**

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The diaphragm appears normal.

**BREED**

Shih Tzu

Abdomen:

The liver presents rounded margins but normal findings in terms of surface, texture and contrast behavior. Liver margins to the right adrenal gland (s. below) are not clearly defined.

**SEX**

FS

The gallbladder is inconspicuous without evidence of cholestasis. The common bile duct is considered to be normal.

The pancreas presents normal size and shape with a smooth surface. The peripancreatic fat tissue and omentum are inconspicuous.

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The spleen shows normal findings in terms of size, surface, shape and contrast behavior.

Unremarkable presentation of the bilaterally symmetrical kidneys.

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The left adrenal gland is small and inconspicuous. The right adrenal gland shows a mass of 1.94 cm, appears rounded and highly heterogeneous. Margins to the caudal liver are indistinct. In addition to that the caudal vena cava at least gets markedly impressed by the lesion. The right renal vein is normal.

As far as can be assessed, the stomach and all parts of intestine are regularly presented without any indication of a wall thickening or a mass. There are no signs of an obstructive or functional ileus.

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Ureters, urinary bladder, trigonum and urethra are presented as expected. There is no evidence of cystic calculi.

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Abdominal lymph nodes and abdominal vessels have no particular findings. Signs of peritoneal/retroperitoneal effusion or free gas are not recognized.

**COMPUTED TOMOGRAPHIC DIAGNOSIS**

**INVOICE**

52618

- Right adrenal mass with suspected invasion of the caudal vena cava and the caudal margin of the right liver
- Unspecific hepatomegaly
- Mild mediastinal lymph adenomegaly

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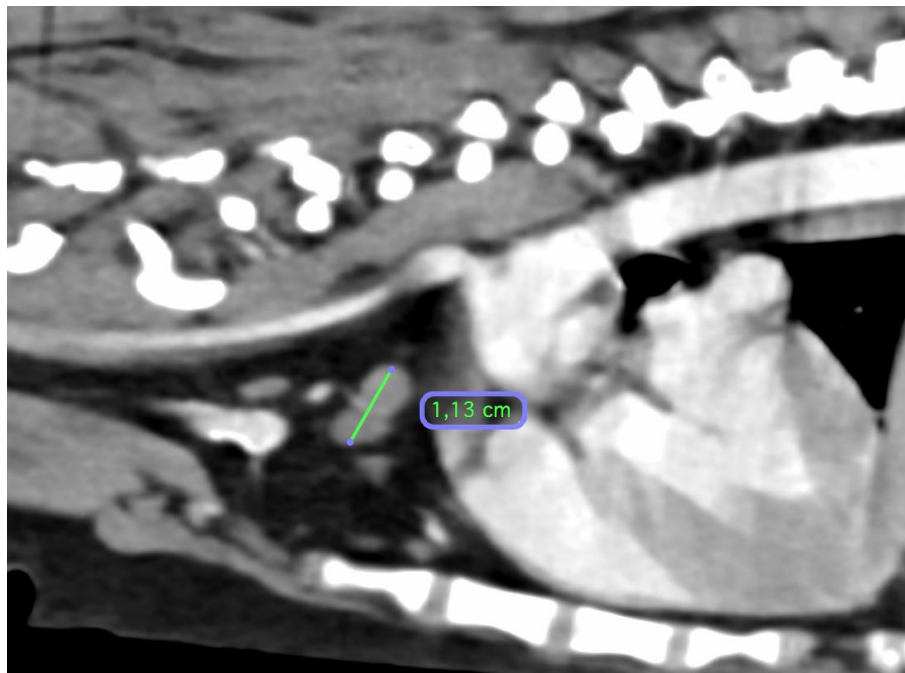
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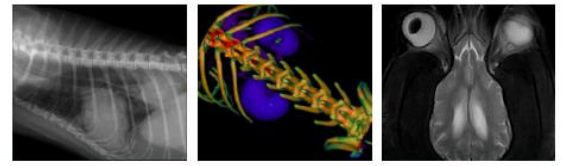
**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The CT findings most likely represent an aggressive/malignant adrenal neoplasia with suspected inclusion of the liver margins and the CVC. Final assessment of the adrenal lesion (benign, malignant; functional, non-functional) is not possible with CT and a matter of the clinical presentation, the temporal evolution and urine/blood tests. I currently favor a malignant lesion (adenocarcinoma, pheochromocytoma). The unilateral appearance and CT-morphology would go along with that assumption. Possible further functional tests include LDDS, HDDS, ACTH stimulation, urine cortisol-creatinine ratio, blood pressure for hypertension and urine analysis (USG). A sonographic recheck is recommended to evaluate the right caudal liver and the CVC.

Hepatomegaly is an unspecific finding and commonly seen with chronic liver disease (lipidosis, chronic hepatitis). Nodular/focal changes are not detected except for the suspected invasion of the adrenal mass.

The changes of the mediastinal lymph nodes described above are still consistent with reactive-inflammatory lymphadenitis and are not typical for a distant metastatic spread.





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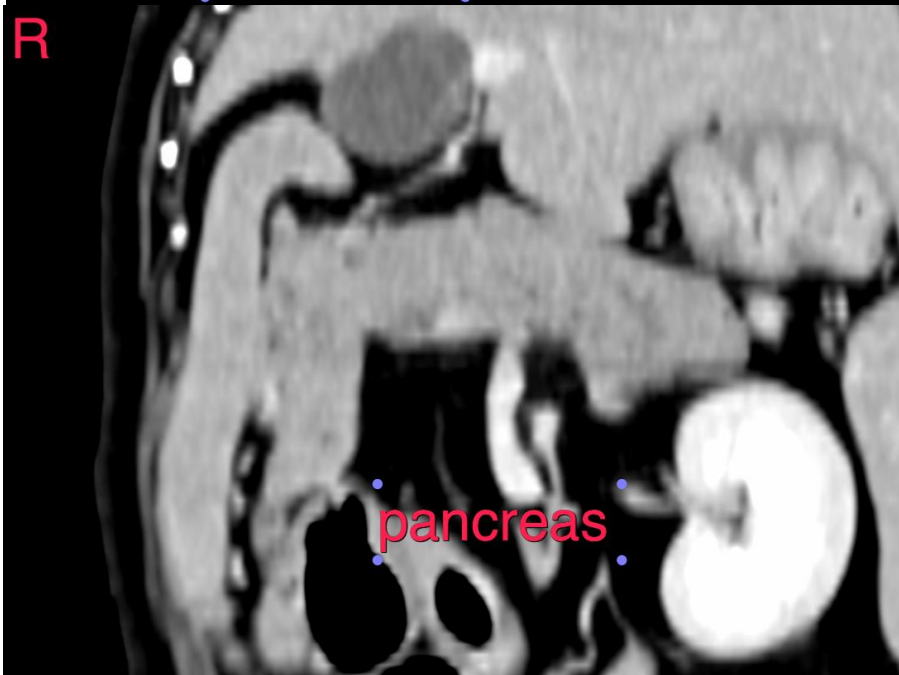
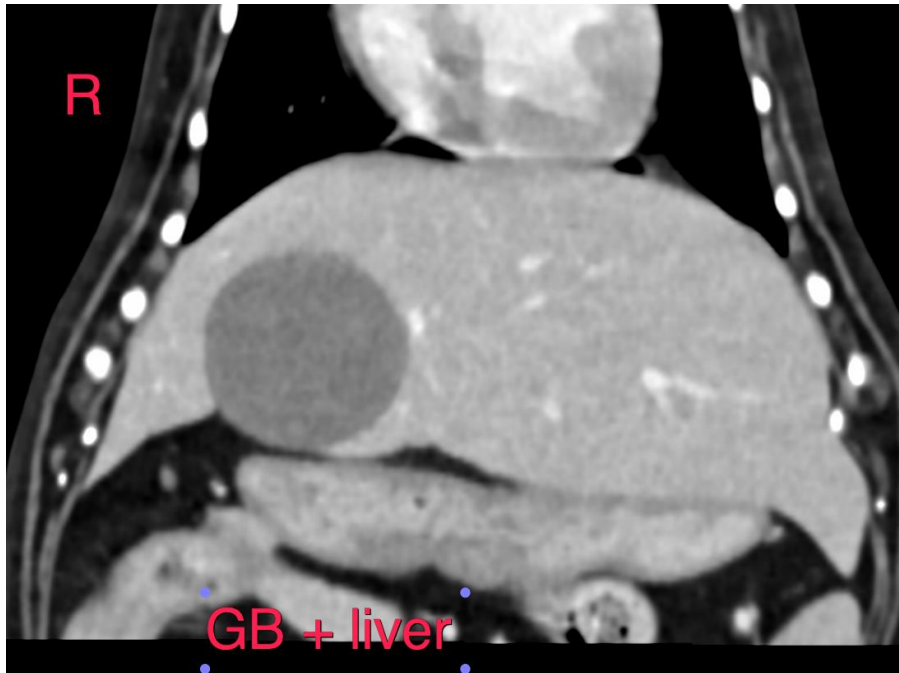
Westgarth

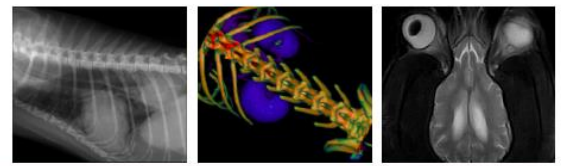
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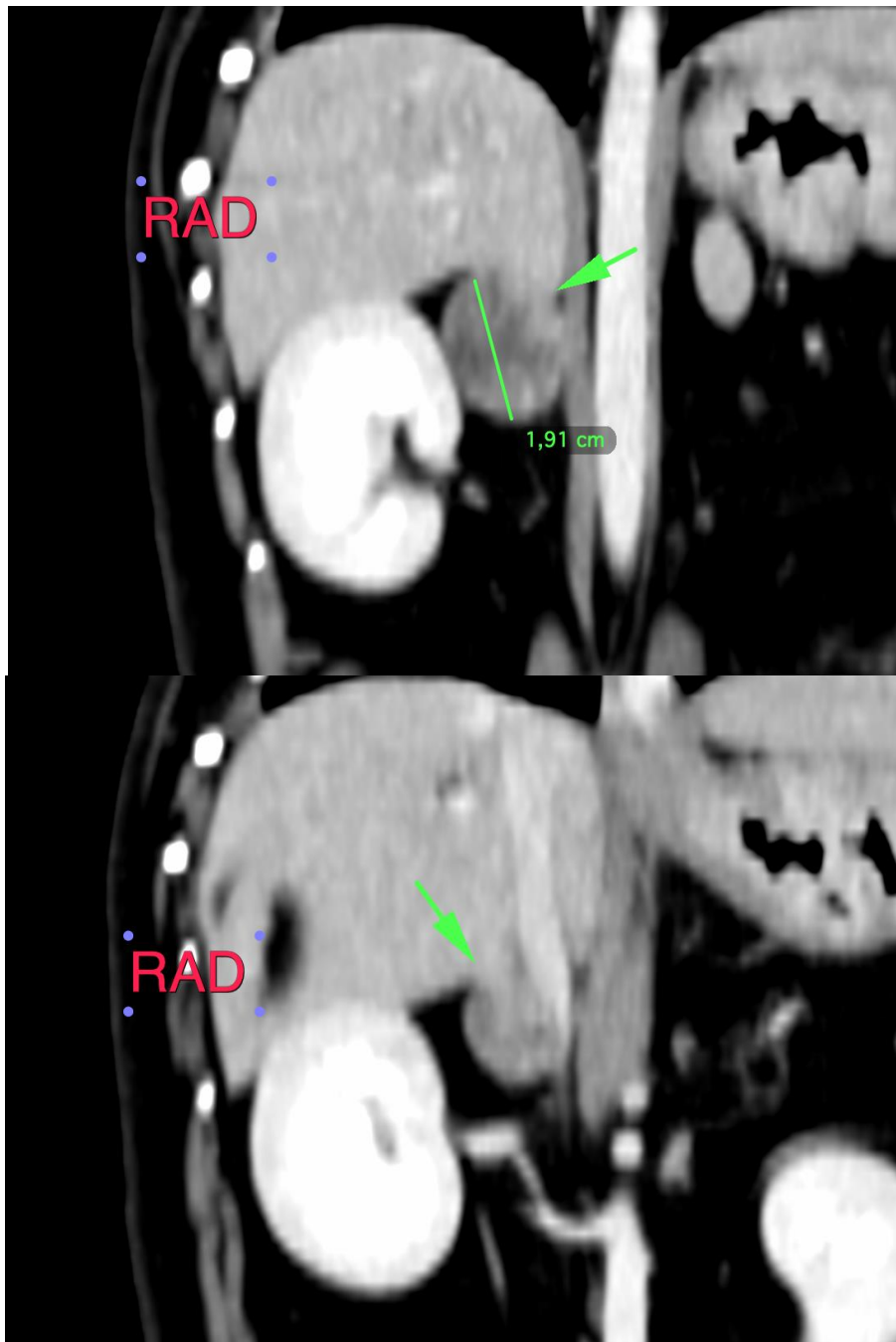
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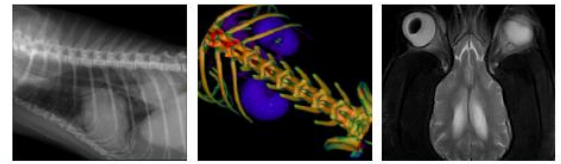
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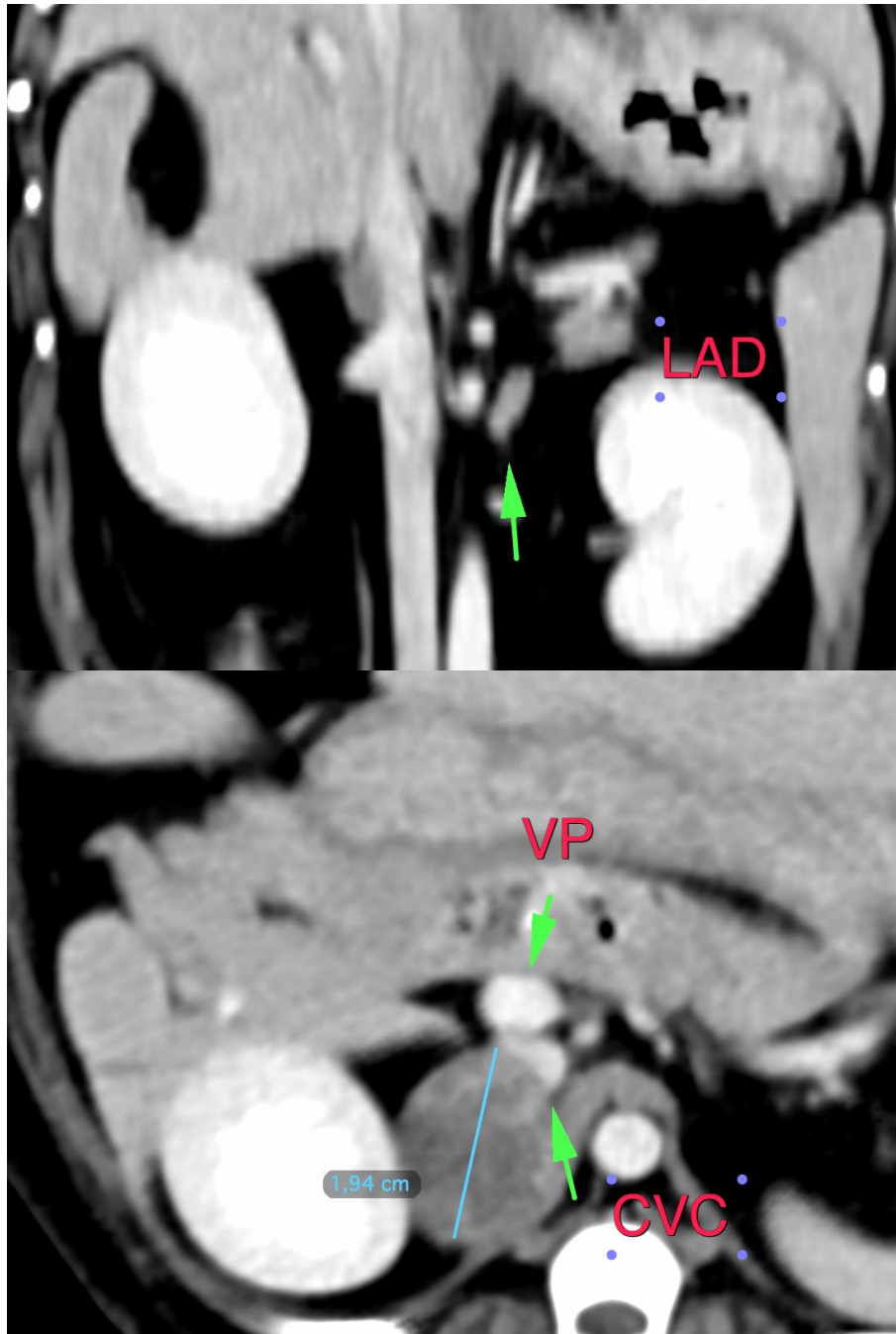
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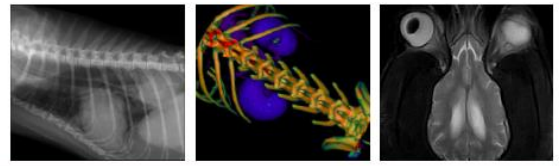
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

**SPECIES**

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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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