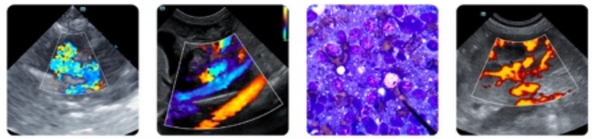


PATIENT
Lucy Strike

SPECIES
Canine

BREED
Dandie Dinmont terrier

SEX
Spayed female

AGE
14 years

WEIGHT
15.2 lbs

INTERPRETED BY
Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY
Dr. Julia Wiederholt

HOSPITAL NAME
Dreaming Summit AH

REFERRING VET
Dr. Wiederholt

INVOICE
75508

DATE
5/13/26

PRESENTING CLINICAL SIGNS

History: Intermittent diarrhea for 2+ months with minimal response to probiotic, metronidazole, and prescription Hill's GI Biome. Tense on abdominal palpation but PE otherwise unremarkable. Abdominal radiograph report noted two left caudodorsal abdominal masses of retroperitoneal origin suspected to be left renal +/- splenic as well as moderate hepatomegaly.
Abnormal PE/Chem/CBC/UA Results: Fecal sample 3/27/2026 negative. Labwork run 4/26/2026 showed mild regenerative anemia (rbc 5.4, hematocrit 39.8, hemoglobin 12.4, reticulocytes 189) and moderately elevated ALP (739 - historical). Remainder of CBC/chem, lytes, CPL, cobalamin, folate, UA, T4 wnl.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. The bladder neck, trigone region, and proximal urethra are unremarkable. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 4.99×2.59 cm, and the thickness of the cortex is 0.49 cm in the sagittal plane. The right kidney is normal in shape and size: 5.41×2.71 cm, and the thickness of the cortex is 0.47 cm in the sagittal plane. Both kidneys demonstrate cortical echogenicity similar to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.40 cm at the cranial pole and 0.57 cm at the caudal pole. The right adrenal gland measures 0.54 cm at the cranial pole and 0.53 cm at the caudal pole.

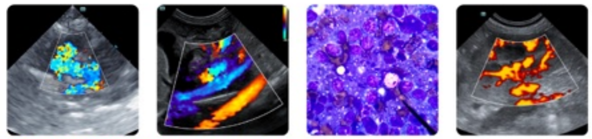
Spleen

Splenic thickness is 1.14 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal Tract

The stomach is empty and folded, with preserved wall layering and normal mural thickness (2.50 mm). The pylorus measures 4.33 mm. The duodenum measures 3.45 mm, and the jejunum measures 3.17 mm, both with preserved wall layering. The ileum could not be confidently characterized. The ileocecocolic junction was not visualized. No ultrasonographic evidence of focal gastrointestinal inflammation, mechanical ileus, or foreign material is identified. The colon measures 1.20 mm in thickness, with formed feces present within the descending colon.

Pancreas

The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No abdominal effusion or peritonitis is observed.

A complex multilobulated mass measuring approximately 4.55×2.78 cm is present within the mid abdomen, closely associated with the aorta, caudal vena cava, and cranial mesenteric artery region. The lesion demonstrates mixed soft tissue and fluid echogenicity, including regions of hypoechoic to anechoic material with internal echogenic components that may represent hemorrhagic fluid and/or clot material.

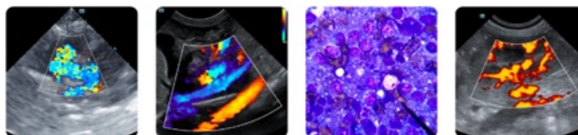
PRIMARY FINDINGS

- Largest mass measuring approximately 4.55×2.78 cm adjacent to the aorta, caudal vena cava, and cranial mesenteric artery.
- Poorly defined diffuse infiltrative/peritoneal soft tissue extension with loss of normal tissue planes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Hypoechoic soft tissue mass is present throughout the central mesenteric region, associated with a larger complex multilobulated cavitary mass located within the mid abdomen adjacent to the aorta, caudal vena cava, and cranial mesenteric artery. The lesion demonstrates mixed soft tissue and fluid echogenicity, including echogenic intralesional material compatible with hemorrhagic fluid and/or abscess or clot formation.

Based on the submitted images, the lesions appear most likely centered within the mesenteric root and/or associated intestinal mesentery rather than arising from the spleen. Although definitive determination of the organ of origin is limited by the available acoustic windows and infiltrative nature of the process, no convincing direct splenic attachment or focal splenic mass is identified ultrasonographically.



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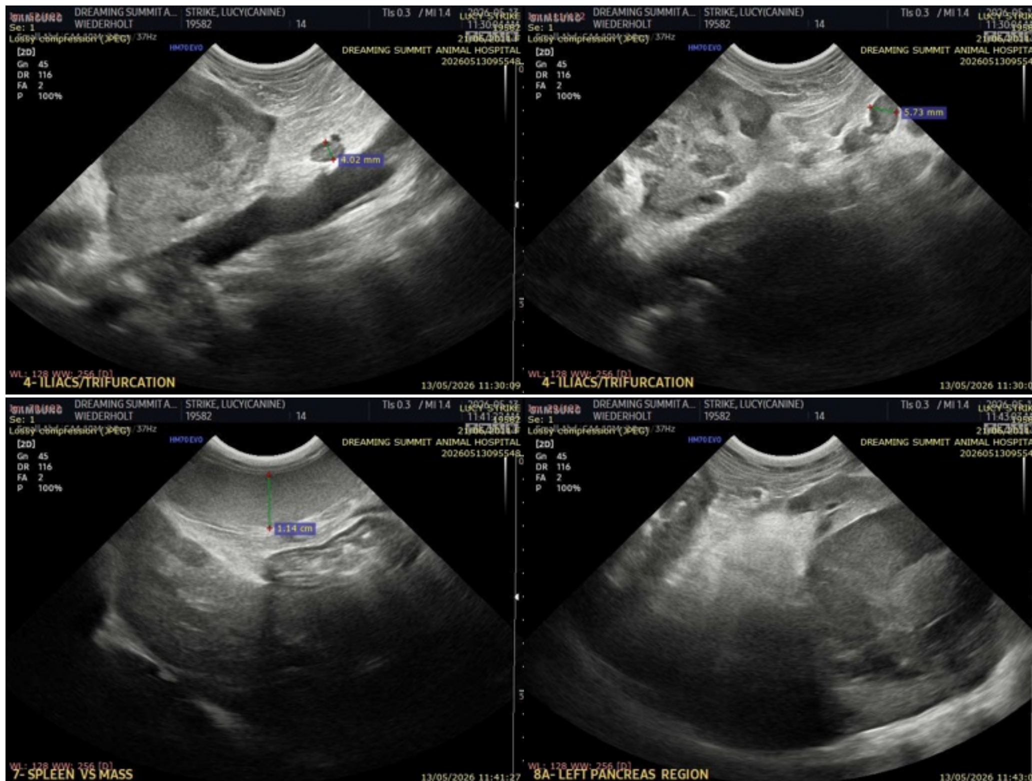
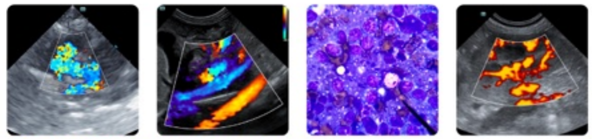
The overall appearance is most concerning for an infiltrative/neoplastic mesenteric-intestinal process with associated cavitary/necrotic or hemorrhagic change. Differential considerations include intestinal neoplasia with metastatic mesenteric involvement, lymphoma, metastatic carcinoma, sarcoma, or other infiltrative malignant round cell neoplasia.

No ultrasonographic evidence of generalized hemoabdomen or diffuse septic peritonitis is identified at this time.

Recommendations

- Ultrasound-guided fine needle aspiration of the mesenteric masses and/or the complex cavitary lesion is strongly recommended as the next diagnostic step, provided a safely accessible region can be identified. Sampling of the more solid components should be prioritized over cavitary/hemorrhagic areas when possible.
- Cytology should ideally be submitted with preparation for possible flow cytometry and/or PARR if lymphoma is suspected.
- Thoracic imaging is recommended for staging purposes.
- Abdominal CT may be beneficial for better characterization of the primary site of origin, extent of mesenteric involvement, vascular relationships, and surgical resectability if clinically pursued.





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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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com