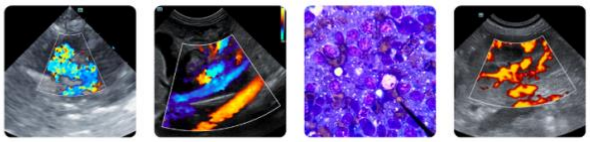


PATIENT

Reese Black

SPECIES

Canine

BREED

Australian Mix

SEX

Female Spayed

AGE

14

WEIGHT

10.5 kg

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Laura Bennett, DVM

HOSPITAL NAME

Wilvet South

REFERRING VET

Laura Bennett, DVM

INVOICE

22303

DATE

12-21-25

PRESENTING CLINICAL SIGNS

History: Pt started acting off 2 days ago per O, pt was V and acting off per O. The following morning pt continued puking and refused to eat. Pt did not do much for the majority of the day besides lay down, pt started puking again later on in the evening (random and mainly bile), Per O V would mainly happen after pt would Dr. Pt continued to V overnight and this morning lethargy is severe per O. Took pt into rDVM today and rDVM transferred (12/20)

Abnormal PE/Chem/CBC/UA Results: ALT: 258 (10-125) PCV 58% TS 9.8 g/dl Chem: Glu 216 (H), Crea 2.5 (H), Phos >16.1 (H), TP 8.6 (H), Glob 5.0 (H), Alb 3.6, ALT 218 (H), ALKP 326 (H). rest WNL. Lytes: Cl 108 (L), K 4.9 (N) SNAP cPL: Normal BC: Hct 48.8%, WBC 28.22k (H), Neut 23.36k (H), suspect bands, Mono 2.13k (H), rest NSF. UA (cysto): dark yellow, opaque. USG 1.012, pH 8.0, Pro 500, Sediment: WBC >50/HPF, RBC >50/HPF, rods present, non-hyaline casts >1/LPF. Urine culture submitted to Idexx PT: 27 sec (H) - difficult blood draw, suspect artifact PT (fresh sample): 14 sec (N)ransfer from rDVM 12/20 for vomiting, anorexia, & lethargy. P severely dehydrated and azotemic on presentation. Increasingly dyspneic. Abd US showed mass (liver vs. adrenal). Supraventricular tachycardia developed. P remains O2 dependent.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary is moderately distended. The wall is variably thickened (up to 0.42 cm). Severaly polypoid-like lesions are arising from the mucosal surface. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.65 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present (0.1 cm in the longitudinal plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.10 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present (0.13 cm in the longitudinal plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Left Adrenal Gland

The majority of the left adrenal gland is visualized and is enlarged (0.99cm at caudal pole) with swollen peripheral contours. The parenchyma is hypoechoic-to-heterogenous in appearance, with loss of glandular detail. Surrounding vasculature appears normal.

Left Adrenal Gland

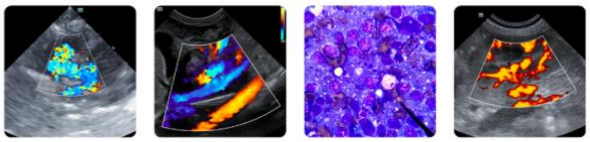
(See ***"Other"*** category).

Spleen

The spleen is normal in size (1.21 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few, small, myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size prominent-in-size, with irregular peripheral contours. The parenchyma is hypoechoic relative to the spleen, and relatively homogenous in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.



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The gallbladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic-to-mineralized, mostly gravity-dependent, sludge/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The lumen is minimally fluid-distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

Pancreas
(See ***"Other"*** category).

Lymph Nodes
The abdominal lymph nodes are normal/not visible.

Free Abdomen
The mesentery in the cranial- to mid-abdomen is hyperechoic. Trace free fluid is observed.

Other
In the right cranial quadrant, in the region of the right adrenal gland, a 3.9 x 3.2 cm heterogenous mass is visualized. Adjacent to the mass, a 2.6 x 2.0 cm ill-defined, hypoechoic-to-heterogenous structure/lesion is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mass in the right cranial abdomen, the origin of which is unclear. It is suspected to be arising from the right adrenal gland. However, other origins (i.e., pancreas, mesentery, liver, lymph node) cannot be excluded. Neoplasia (i.e., adenocarcinoma, sarcoma, round cell tumor) is suspected, with a lower possibility of an inflammatory or other benign lesion. The ill-defined structure adjacent to the mass may represent a thrombus, area of pancreatitis. other.

Secondary Findings

- Bilateral nonspecific age-related renal changes with dystrophic mineralization and trace pyelectasia
- Left adrenomegaly
- Gall bladder sludge/sand, non-mucocele
- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof.
- The urinary bladder changes are suggestive of polypoid cystitis, with a lower possibility of emerging neoplasia.

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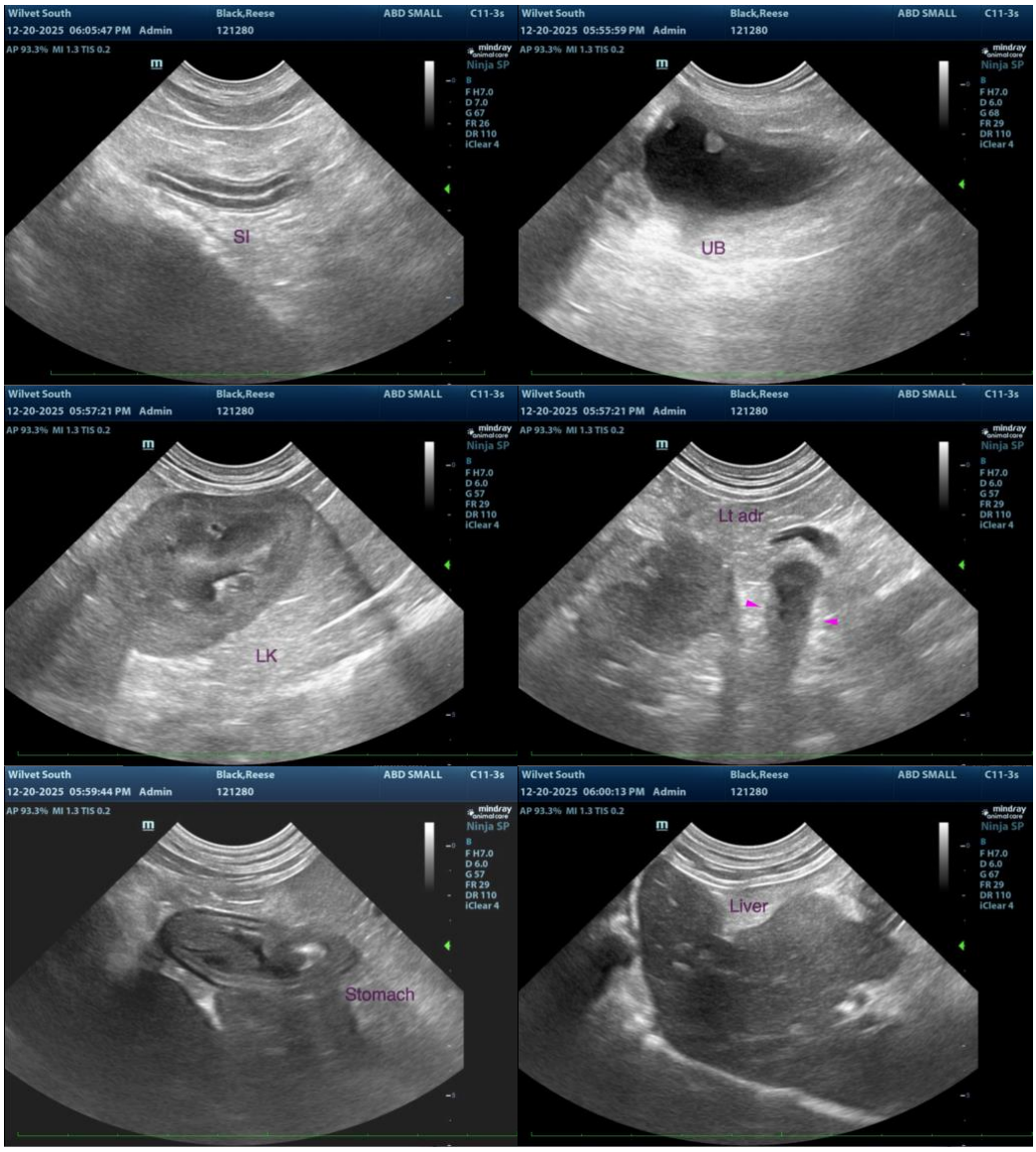
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three-view thoracic radiographs are recommended to assess for pulmonary metastases. If there is no evidence of pulmonary metastatic disease and an aggressive approach is desired, consider an abdominal CT scan for further evaluation of the abdominal mass. Consultation with a board-certified surgeon should also be considered. If further diagnostics are not pursued, palliative care is recommended.



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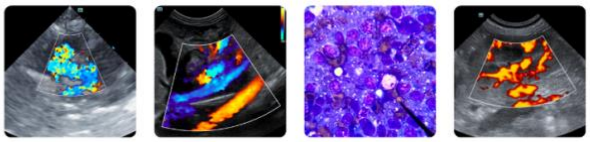

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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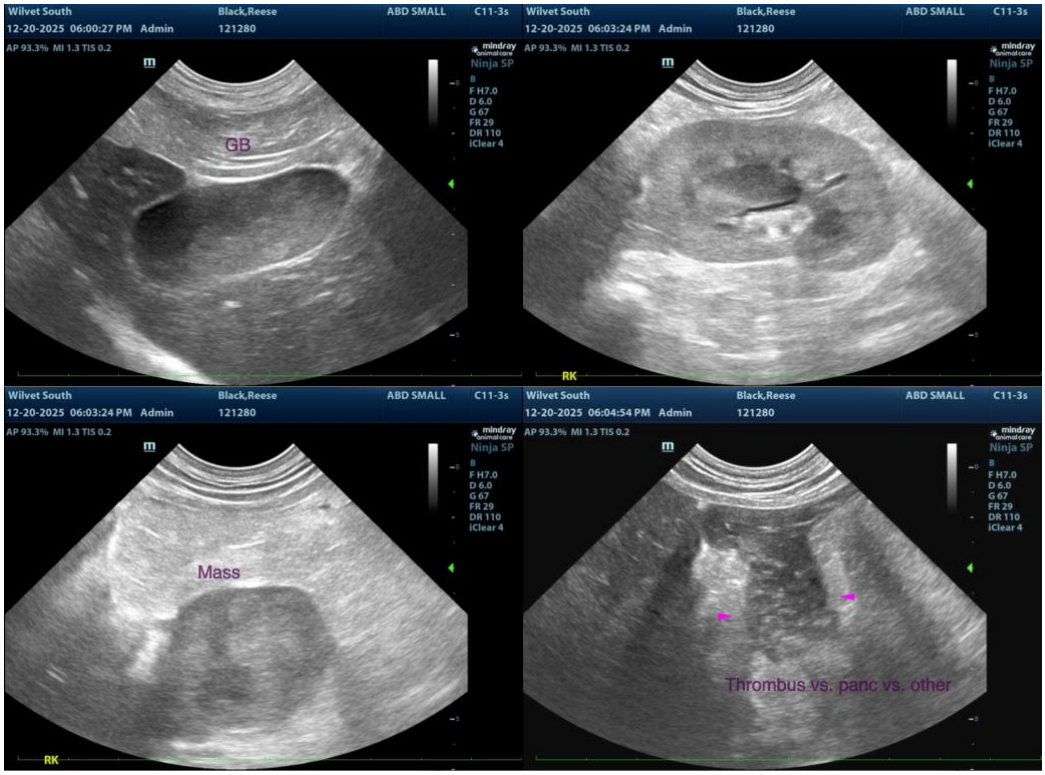

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com