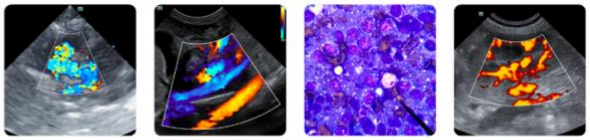




**PATIENT**

Katana Lopez

**SPECIES**

Canine

**BREED**

American Akita

**SEX**

Spayed Female

**AGE**

14 Years 1 Month 3 Weeks

**WEIGHT**

27.2 kg

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Dr. Jill Rankin

**HOSPITAL NAME**

Fen Vet Beltline

**REFERRING VET**

Dr. Creelman

**INVOICE**

35814

**DATE**

12/8/25

## PRESENTING CLINICAL SIGNS

History: 1) Chronic Diarrhea – DDx: Inflammatory bowel disease, dietary intolerance, infectious enteritis (bacterial, parasitic), neoplasia. Systemic causes like liver or kidney disease are also possible. 2) Oliguria/Dysuria – Assessed to be likely secondary to pain and discomfort associated with the hind limb lameness, causing reluctance to posture to urinate. 3) Progressive Muscle Wasting and Weight Loss – Chronic, multifactorial problem likely related to a combination of age, chronic pain, and potential underlying systemic or gastrointestinal disease.

Abnormal PE/Chem/CBC/UA Results: low dose dex test was WNL - June 2025 ACTH stim testing - Pre-cortisol 51 and post cortisol 571 - April BW April - low hematocrit (35) Hemoglobin low 107 MCH and MCHC low Retic hemoglobin low 22.3 WBC low- Lymphopenia Low platelets (clotting suspected) Hyperkalemia (7.1) - breed associated? 21 Na:k ratio Mild ALP elevation USG 1.023 Low T4 FreeT4 and TSH WNL (low normal).

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (6.8 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (6.3 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

### *Adrenal Glands*

**See Free Abdomen section.

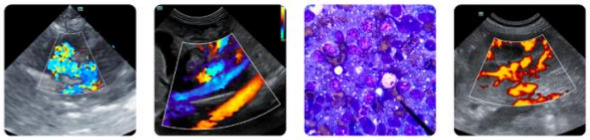
### *Spleen*

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

### *Liver*

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. Some mineral/sand debris is noted, with no visible evidence of obstruction. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.



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### *Gastrointestinal*

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

### *Pancreas*

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

### *Free Abdomen*

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

In the area of the left adrenal gland is an approximately 2.4 cm wide x 4.7 cm long heterogenous expansive cavitated lesion. In the area of the right adrenal gland is a similar appearing heterogenous cavitated lesion, measuring approximately 3.3 cm x 3.6 cm in size. At the end of this study, there is an abdomen labeled similar appearing lesion, measuring approximately 3.0 cm in diameter. I believe there are at least two separate lesions, but I'm not certain that all three are separate lesions, with the mid abdominal lesion potentially being attached to the left lesion.

Additionally, in the right cranial abdomen, within the vena cava, is an approximately 1.6 cm thick x 5.0 cm long, echogenic density.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- Possible/suspect bilateral adrenal masses with suspect vascular invasion- concerning for infiltrative neoplasia, such as adenocarcinoma, pheochromocytoma, versus other. Having said that, a thrombus within the vena cava versus tumor invasion can't be ruled out. Similarly, given the possibility of a third mid abdominal lesion, unrelated to the adrenal glands, while thought less likely, could indicate that the changes are cystic enlarged lymph nodes with the ability to see normal adrenal glands masked by the presence of the lesions.

### Secondary Findings

- Mildly heterogenous liver- These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly

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chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

- Moderate gallbladder debris- Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

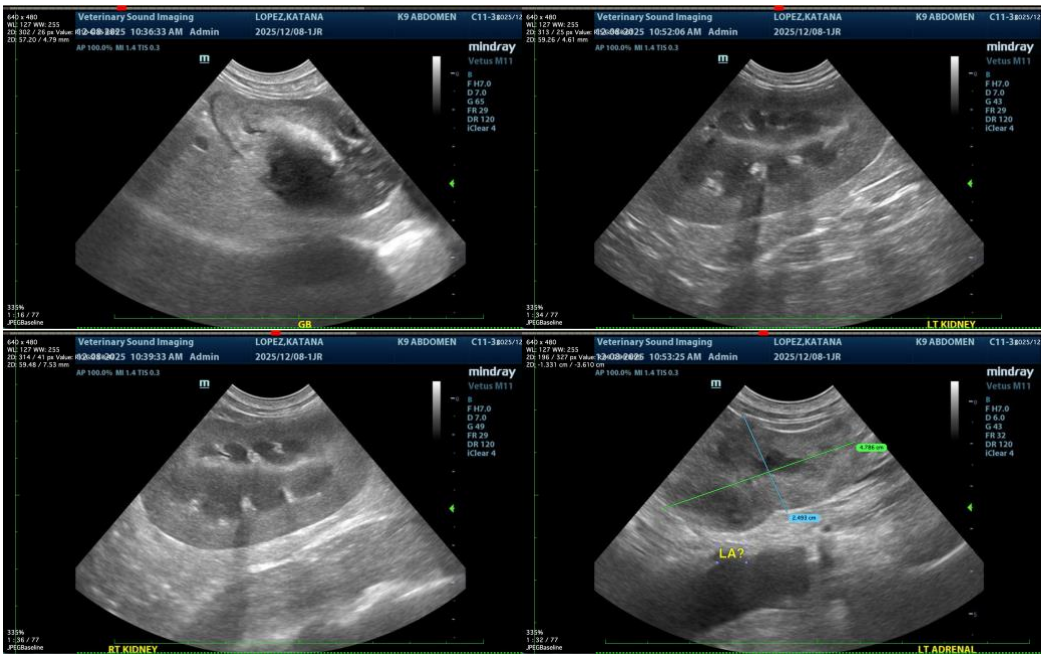
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The provided history mentions blood work with dates of April and June, which indicates the recommendation, if that's the most recent blood work, a recheck full general metabolic health screen, to include CBC, chemistry panel, electrolytes, and urinalysis, and if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Additionally, if not recently evaluated, a low dose dexamethasone suppression test could be rechecked. The lab work attachment, unfortunately, was unable to be opened.

A blood pressure is also recommended if not recently evaluated.

Ultimately, however, advanced imaging, such as an abdominal contrast CT scan, is recommended for further investigation/clarification of the lesion, the vascular invasion, etc., which may help guide, stage, etc., surgical intervention or other tissue sampling methods, if indicated.



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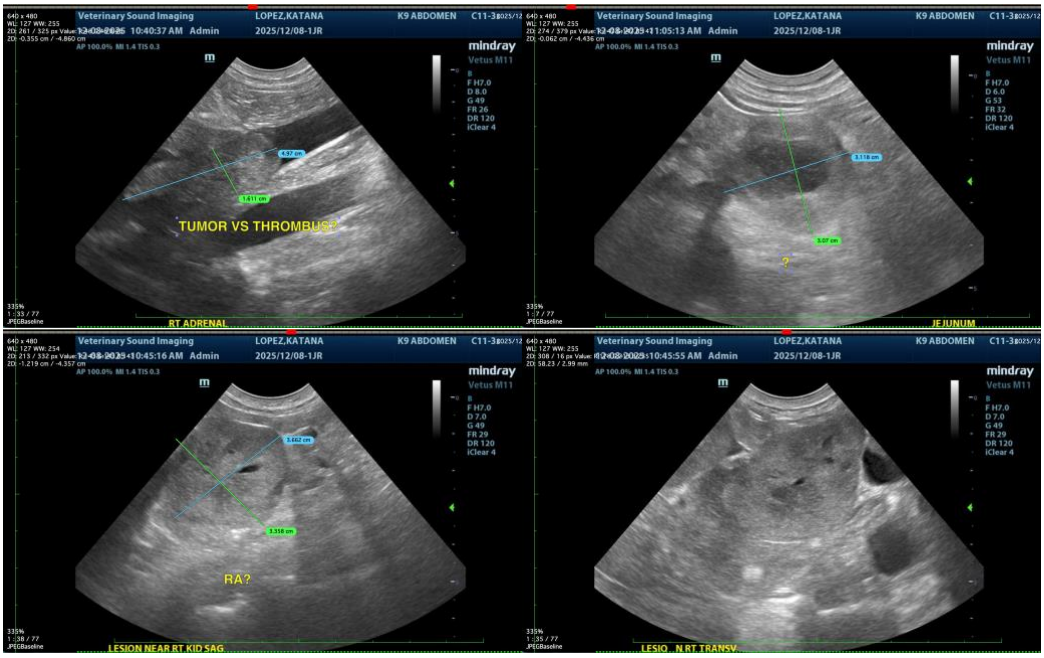


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**Beth Johnson, DVM DACVIM**

info@sonopath.com