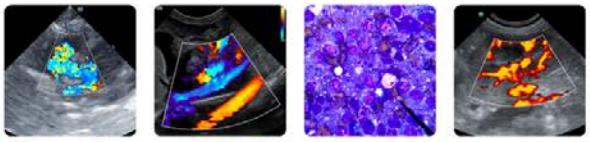




**PATIENT**

Bailey Kanterman

**SPECIES**

Canine

**BREED**

Labradoodle

**SEX**

Neutered Male

**AGE**

12 Years 1 Month

**WEIGHT**

12.2 kg

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Dr. Sookhoo

**HOSPITAL NAME**

Calusa Veterinary Center

**REFERRING VET**

Dr. Glotzer

**INVOICE**

75485

**DATE**

5/28/26

## PRESENTING CLINICAL SIGNS

Panting and uncomfortable, especially with left coxofemoral manipulation, at 8PM PE. Administered methadone following PE and patient seemed to settle and lay down. Seemed comfortable throughout rest of night. Re-evaluated at 12:30AM and patient was much more comfortable on left coxofemoral manipulation. Gait also seemed improved. No appetite. Persistent semi-formed/gelatinous hematochezia. No vomiting noted. PU/PD. No gall bladder or spleen - previously removed.

Abnormal PE/Chem/CBC/UA Results: Hyperglycemic, severe hypokalemia, Hypertensive, Elevated ALP, azotemic,

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The 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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal is size (5.4 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.

The left kidney is normal is size (4.9 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*

The left adrenal gland is unable to be visualized in these images.

*See “other” regarding the right adrenal gland.

### *Spleen*

The spleen has reportedly been previously removed.

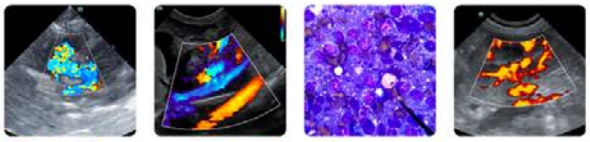
### *Liver*

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. In the mid liver there is an approximately 1.5 cm in diameter discrete homogeneous, hyperechoic nodule. Multifocal intrahepatic biliary mineral densities are noted. Visible vasculature and biliary tree appear normal without distension or congestion

The gallbladder has reportedly been previously removed.

### *Gastrointestinal*

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted,





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delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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 a scant/trace amount of anechoic free fluid in the cranial abdomen.

There is no apparent pathologic lymphadenopathy noted in these images.

In the right cranial abdomen is a coarse, homogeneous, hypoechoic mass measuring approximately 3.1 cm x 4.0 cm in size with a 1.2 cm in diameter caudal extension off the mass, that in some views is consistent with a right adrenal mass, but in others appears to potentially originate from the liver.

## ULTRASONOGRAPHIC FINDINGS

- Possible right adrenal mass could represent infiltrative neoplasia such as adrenal adenocarcinoma or pheochromocytoma, or adrenal adenoma, with hyperplasia being possible but considered less likely. As described above, however, this mass may not be adrenal gland in origin.
- Mildly heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Discrete mid liver nodule – Differentials for a discrete hyperechoic liver nodule include primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, myelolipomas, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.
- The spleen and gallbladder have reportedly been previously removed.

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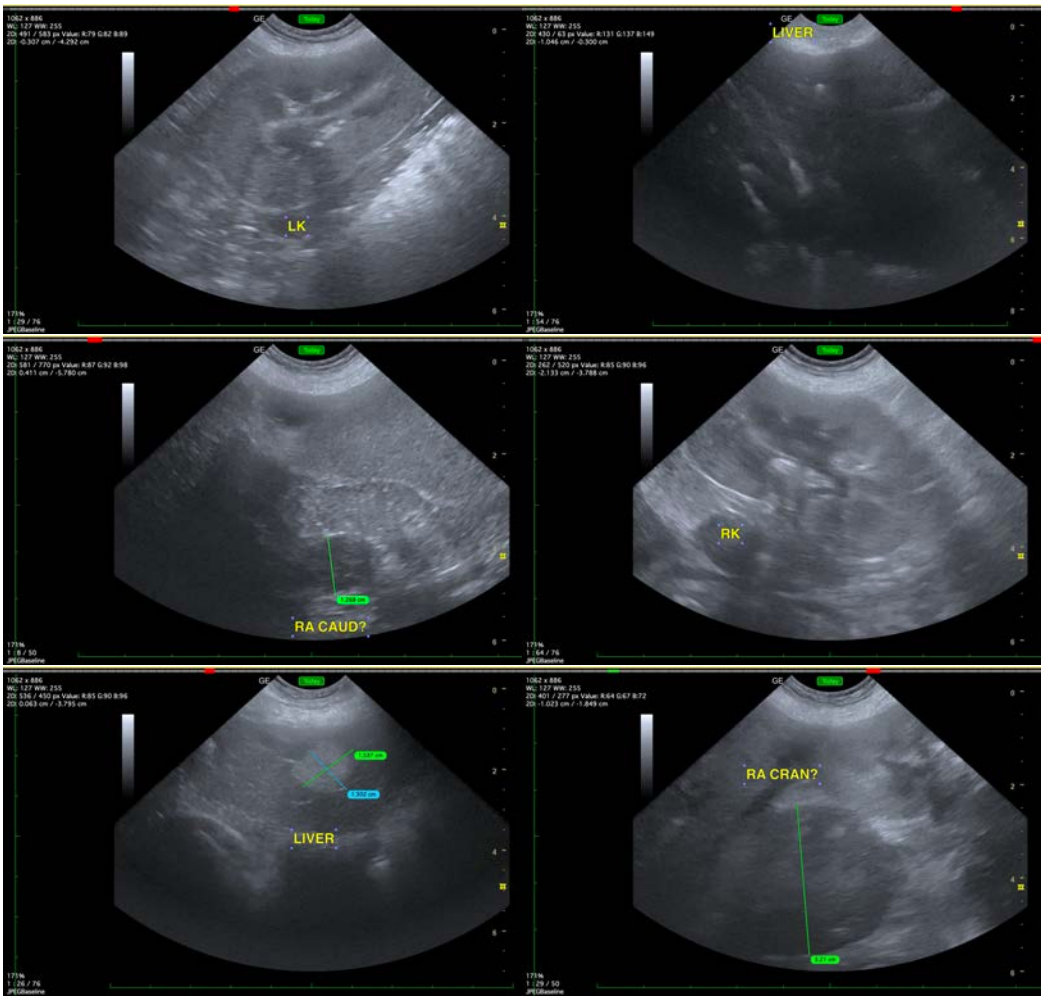
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a 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 ratio is recommended.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Given patient's reported hyperglycemia and hypertension, etc., adrenal origin for the mass makes sense. However, definitive origin, vascular invasion, etc. is difficult to determine. Therefore, advanced imaging such as an abdominal contrast CT scan is recommended. Additionally, and/or alternatively, fine needle aspirates of the mass could be considered if patient's coagulation status is appropriate.

Pending results, hormone testing such as a low-dose Dexamethasone suppression test could be considered or potentially urine catecholamine testing.



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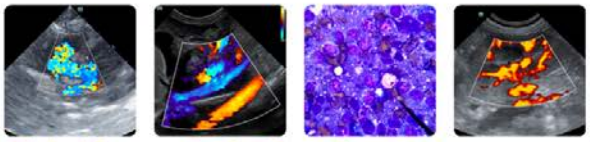

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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**Beth Johnson**, DVM, DACVIM
info@sonopath.com