



## PATIENT

Wesson Balzac

## SPECIES

Canine

## BREED

American Pitbull  
Terrier

## SEX

Neutered Male

## AGE

11 years

## WEIGHT

64 lbs

## INTERPRETED BY

Dr Brittany Sinclair,  
BVSc(hons),  
DACVECC

## IMAGING PERFORMED BY

Dr Gabriel Ferrer

## HOSPITAL NAME

Pulse Pet Ultrasound  
Services

## REFERRING VET

Dr. Jonathan De Jesus

## INVOICE

10732

## DATE

11/13/2025

## PRESENTING CLINICAL SIGNS

Presented for combined echocardiogram and abdominal ultrasound to evaluate anorexia, vomiting and cardiac arrhythmia. Pt has a 3 days history of slowing down and not eating much. Presented to rDVM and diagnostics showed possible abdominal mass and arrhythmia.

Abnormal PE/Chem/CBC/UA Results: PE: arrhythmia ECG attached for evaluation Radiograph and BW attached as supporting documents.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The prostate is mildly enlarged. It contains multiple coalescing anechoic fluid filled structures, most consistent with prostatic cysts or abscesses. There are multiple small, hyperechoic opacities within the prostate, most consistent with mineralization.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Cortical mineralization noted in these images. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. Left kidney measures 6.82 cm in length, and the right kidney measures 6.7 cm in length.

### Adrenal Glands

The left adrenal gland was visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. The left adrenal measures 2.77 cm in length, 0.75 cm at the caudal pole and 0.82 cm at the cranial pole.

The right adrenal gland is significantly enlarged and effaced with heterogenous, irregular, mass tissue. Visible phrenic vasculature is unremarkable. The right adrenal measures 2.48 cm in length, 1.05 cm at the caudal pole and 1.19 cm at the cranial pole.

### Spleen

The spleen contains a large, complex, partially cavitated mass measuring at least 7.81 cm x 4.56 cm.

### Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing gravity dependent debris present. There is no surrounding free fluid or signs of active inflammation.

### Gastrointestinal



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The stomach contains a small amount of gas shadowing, partially obstructing contents but is not overtly distended. Towards the pylorus the gastric wall becomes thickened with loss of wall layering. Remainder of gastric wall appears to be of normal thickness with normal wall layering.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

### **Pancreas**

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

### **Lymph Nodes**

No clinically significant lymphadenopathy or abnormalities noted.

### **Free Abdomen**

No masses or free fluid were noted.

## **ULTRASONOGRAPHIC FINDINGS**

- Complex, partially cavitated splenic mass.
- Right adrenal mass.
- Pyloric thickening with loss of wall layering – Most consistent with developing gastric mass. Rule out gastritis.
- Cystic prostatitis with mineralization – Possible neoplasia.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Splenic changes are most consistent with a splenic mass. This is considered a likely reason for the ventricular tachycardia. Correlate with findings from echocardiogram. If rate and rhythm can be controlled, splenectomy should be considered.

Right adrenal gland enlargement is most consistent with adrenal mass which may be malignant or benign. It appears subjectively resectable with capsular expansion without obvious capsular escape or vascular invasion. Cardiac rate and rhythm control should be prioritized over surgical removal of the adrenal gland. A pheochromocytoma may be contributing to cardiac arrhythmia, however, it is more likely that this adrenal mass is incidental and less critical compared to the arrhythmia and splenic mass. If adrenalectomy is being considered, re-surgical abdominal CT for surgical planning and thoracic CT for metastasis screen is recommended. Differentials owing to sonographic architecture and clinical history include carcinoma, pheochromocytoma, adenoma, hyperplasia, cortisol secreting tumor, myelolipoma less likely. I recommend urine catecholamine screen for pheochromocytoma detection if surgical removal is pursued as pre-surgical treatment of pheochromocytoma is essential. It is possible



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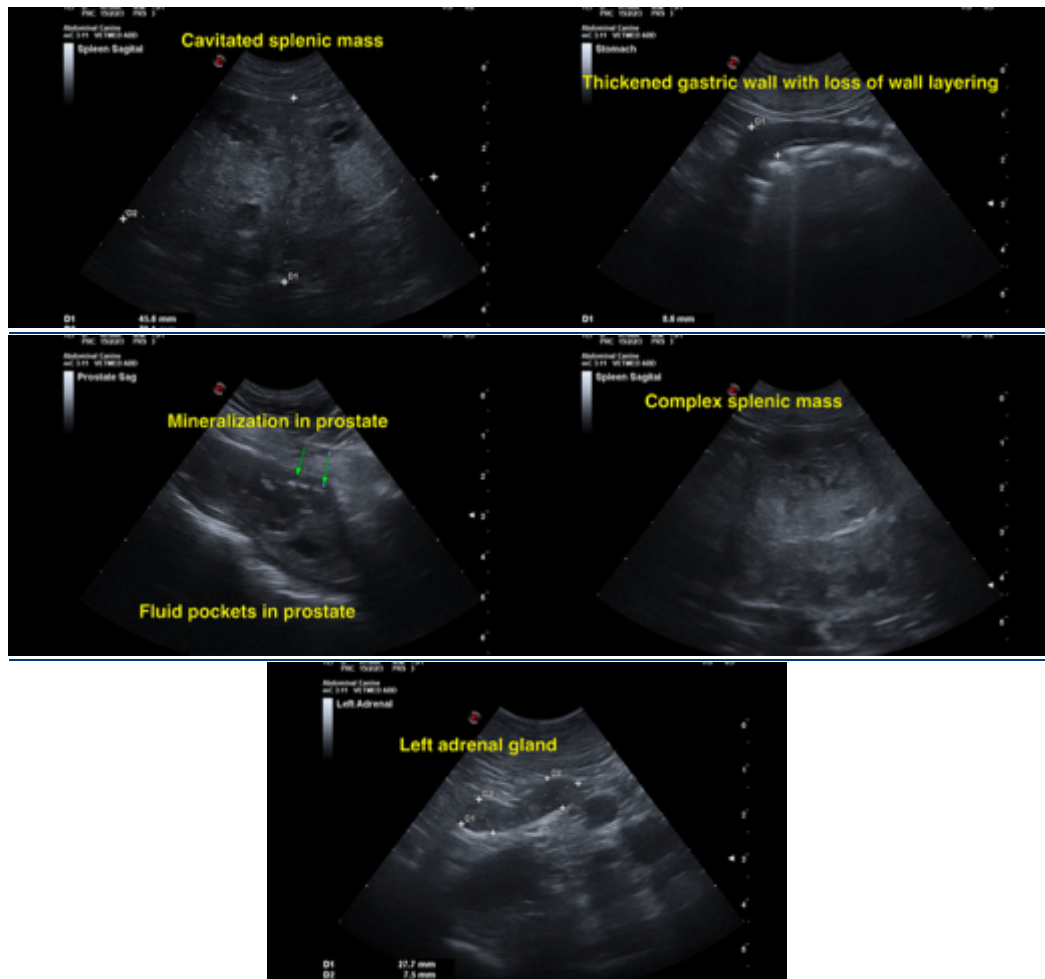
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to have both cortisol and catecholamine secretion from the same adrenal tumor so presence of hypercortisolemia does not obviate the need for presurgical urine metanephrine screening.

The clinical significance of pyloric thickening with loss of wall layering is uncertain. If there are chronic GI issues, this may represent pyloric hypertrophy or other non-neoplastic cause. However, the loss of wall layering is concerning for a neoplastic invasion. If possible, FNA of the stomach wall could be considered. Many gastric masses do not exfoliate well, and biopsy may be required for a more definitive diagnosis. This is not a likely cause of arrhythmia.

Most significant findings is cystic prostatitis which is most concerning for prostatic carcinoma, but could be bacterial in origin. Prostatic aspirate for cytology and culture is recommended to assess for neoplasia and infection. Urine culture and/or prostatic wash with cytology and culture could be considered. CADET BRAF testing can pick up prostatic neoplasia if transitional cell in origin. Empiric therapy with antibiotics with good prostatic penetration (enrofloxacin, TMS, clindamycin, etc) for a minimum of 4 weeks and recheck imaging to monitor for resolution could also be considered.





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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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

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