PATIENT

Mr Kolby Kall

SPECIES

Canine

BREED

Dachshund

SEX

Neutered Male

AGE

18 Years

WEIGHT

9.5 Pounds

INTERPRETED BY

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS

IMAGING PERFORMED BY

Meghan Morse, LVT, CVT

HOSPITAL NAME

Orchard Grove AH

REFERRING VET

Dr. Cassano

INVOICE

36177

DATE

3/10/26

PRESENTING CLINICAL SIGNS

Possible abd mass on rads- recommended AUS by Dr in Florida

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction. The residual prostate was unremarkable.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some mild age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex, and no evidence of pelvic dilation was present. The left kidney measured 4.2 cm. The right kidney measured 4.13 cm.

Adrenal Glands

The **right adrenal gland** was visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 1.73 cm x 0.83 cm at the cranial pole and 0.58 cm at the caudal pole.

The **left adrenal gland** was enlarged, irregular and hypoechoic, measuring 1.9 cm x 1.16 cm at the caudal pole and 0.54 cm at the cranial pole. Capsular expansion was noted without capsular escape.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted. Caudal folding of the spleen was noted.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

Gastrointestinal

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The **stomach** was normal in structure. Minor fluid filled gastric lumen was noted. There was no evidence of obstructive pattern. Areas of hyperperistalsis were noted. This is consistent with response to irritation. A mineralizing jejunal mass was noted in this patient, measuring 2.2 cm x 3.5 cm. Some reactive mesentery was noted around the jejunal mass. Soft stool was noted in the colon.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some moderate parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation, then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

- Jejunal mass with regional inflammation – carcinoma versus leiomyosarcoma. Leiomyoma is possible. Round cell neoplasia is unlikely. The jejunal mass appears resectable with resection of approximately 6.0 cm of small intestine recommended.
- Hyperactive gastrointestinal tract, consistent with GI upset
- Soft stool in the colon
- Irregular enlarged left adrenal gland – adenoma, adenocarcinoma, pheochromocytoma all possible. This appears resectable.
- Caudal splenic folding
- Geriatric abdomen otherwise

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Chest radiographs and serial blood pressure are indicated. Intestinal resection, anastomosis, and left adrenalectomy are recommended.

Note that 30% of Addisonian dogs are atypical and have normal sodium potassium ratios. Screening can be performed with a urine cortisol to creatinine ratio (UCCR) of less than 2.0 ug/dl is indicated as a screening for Addison's. This has near a 100% negative predictive value. UCCR less than 1.4 ug/dl is 100% sensitive and 97 % specific for Addison's. If the UCCR is greater than 2.0 ug/dl and Addisonian signs are present, then disease induced adrenal burnout may be the case. UCCR measures a 12-hour cortisol whereas baseline cortisol is a moment in time and fluctuates. Therefore, a UCCR is more sensitive and specific than baseline cortisol. Otherwise, baseline cortisol could be utilized if > 2.0 then this is negative also for Addison's, yet less sensitive and specific. Therefore, baseline UCCR is considered the best screening test. Therefore, if UCCR is less than 2.0 then full ACTH stimulation would be recommended for the diagnosis of Addison's. This is based on Del Baldo, et.al JVIM 2022

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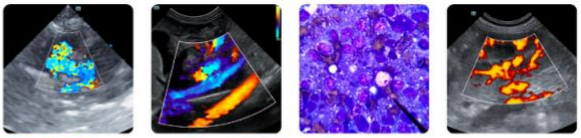

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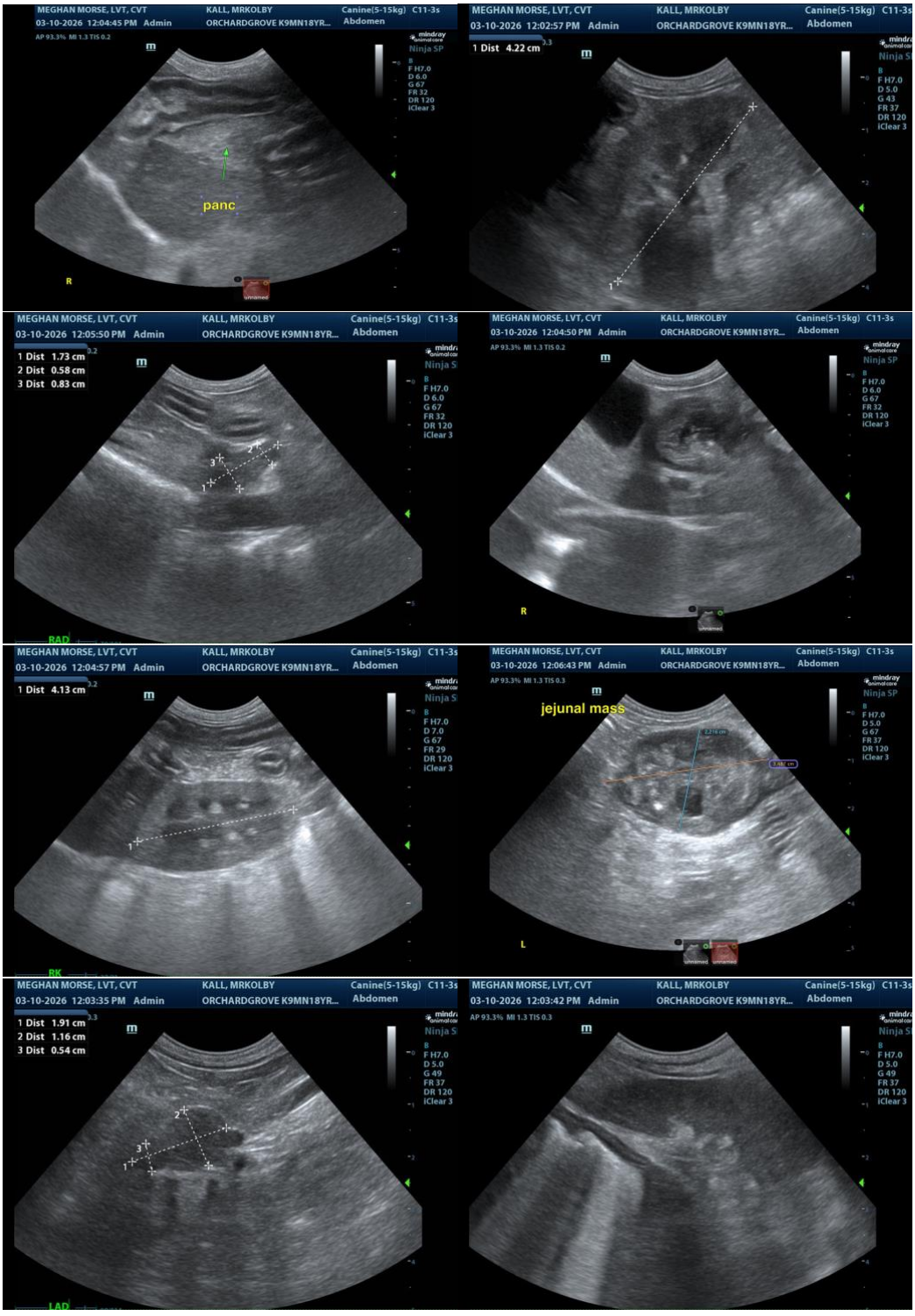
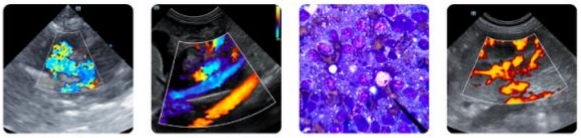


The information and recommendations provided are based on the images presented by the referring



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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.

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS,
CEO, Owner, Founder -- SonoPath.com
info@SonoPath.com