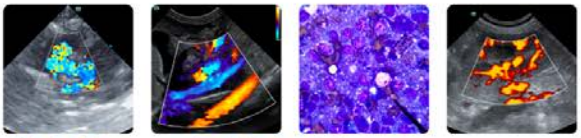


PATIENT

Rocky Caputo

SPECIES

Canine

BREED

Cairn Terrier

SEX

Neutered Male

AGE

7 Years

WEIGHT

21 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Animal Hospital of Sussex County

REFERRING VET

Dr. Scairpon

INVOICE

72955

DATE

2/13/26

PRESENTING CLINICAL SIGNS

BCS 6/9, V/D. Lymphadenopathy (enlarged-all). Vertical nystagmus. No current meds.

Abnormal PE/Chem/CBC/UA Results: Elevated WBC and ALP

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen.

The prostate is normal and measures 6.4 mm in width. It is symmetrical and has uniform echogenicity.

The right kidney presents normal size (4.9 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

The left kidney presents normal size (4.8 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adrenal Glands

The cranial pole of the right adrenal gland has a mass present that measures 1.4 cm in diameter. The caudal pole is normal and measures 0.58 cm in diameter. The mass at the cranial pole of the right adrenal gland may be functional.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 3.4 mm and the caudal pole measures 4.7 mm.

Spleen

The spleen is normal in size, shape, margination and echogenicity. No masses are seen. Normal blood flow is noted.

Liver

The liver is diffusely enlarged with irregular mottled echotexture. Echogenicity is hypoechoic. The liver has a diffusely lobulated shape.

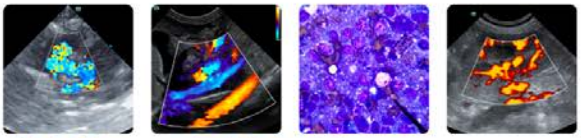
The gallbladder presents normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention or obstruction.

Gastrointestinal

The stomach and intestines have normal wall layering and thickness. Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.



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Free Abdomen

Enlarged iliac lymph nodes are noted. Two representative left iliac lymph nodes measure 1.9 cm x 1.73 cm and 0.80 cm x 1.4 cm. No free abdominal fluid is seen.

Diffusely, the patient has mesenteric lymphadenopathy. A representative mesenteric lymph node measures 1.0 cm x 1.6 cm.

All of the abdominal lymph nodes described are hypoechoic and rounded with the surrounding fat being hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Diffuse moderately to markedly enlarged abdominal lymph nodes including mesenteric and iliac lymph nodes – Mostly likely infiltrative neoplasia such as lymphoblastic lymphoma, mast cell disease versus histiocytic sarcoma. A benign reactive etiology is unlikely.
- Diffusely enlarged, hypoechoic, lobulated liver – Concern for infiltrative neoplasia similar to what is causing the diffuse lymph node enlargement, including lymphoma, mast cell disease, histiocytic sarcoma.
- Right adrenal mass at the cranial pole.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the history suggesting the at the patient has peripheral lymphadenopathy, recommend aspirating peripheral lymph nodes and submitting for cytology to determine if lymphoma is the cause of the patient's diffusely enlarged peripheral and abdominal lymph node enlargement.

If the peripheral lymph nodes are not enlarged enough to aspirate for cytology, then the next step would be to sedate the patient and aspirate enlarged abdominal lymph nodes for cytology to obtain a diagnosis.

If clinically warranted, given that the patient does have a reported elevated ALP, I would recommend screening the patient for Cushing's disease via a low-dose Dexamethasone suppression test. I would also recommend obtaining a systemic blood pressure for the patient. If the patient is found to be hypertensive, recommend ruling out that the right-sided adrenal mass is due to a pheochromocytoma. If the patient is found to be hypertensive, recommend submitting a urine metanephrine to rule out the possibility of a pheochromocytoma.

At this time, the priority would be to diagnose the cause of the patient's peripheral and abdominal lymphadenopathy. Once there is a diagnosis and treatment plan has been determined, recommend returning 2-3 months to perform a recheck abdominal ultrasound, focusing on the right adrenal gland. If the mass seen in the right adrenal gland is stable in size at that time, it is unlikely that any further action will be required. Regarding the right-sided adrenal mass, if the mass appears to be progressively enlarging over time, then at that time I would recommend referring the patient to a surgery specialist to discuss right-sided adrenalectomy, but the initial step would be to determine if the right-sided adrenal gland is functional at this time, concurrently with determining the cause of the patient's diffuse lymphadenopathy.

Recommend fine needle aspirate of the patient's liver and submission for cytology to rule out round cell neoplasia as a cause of the patient's liver presentation.

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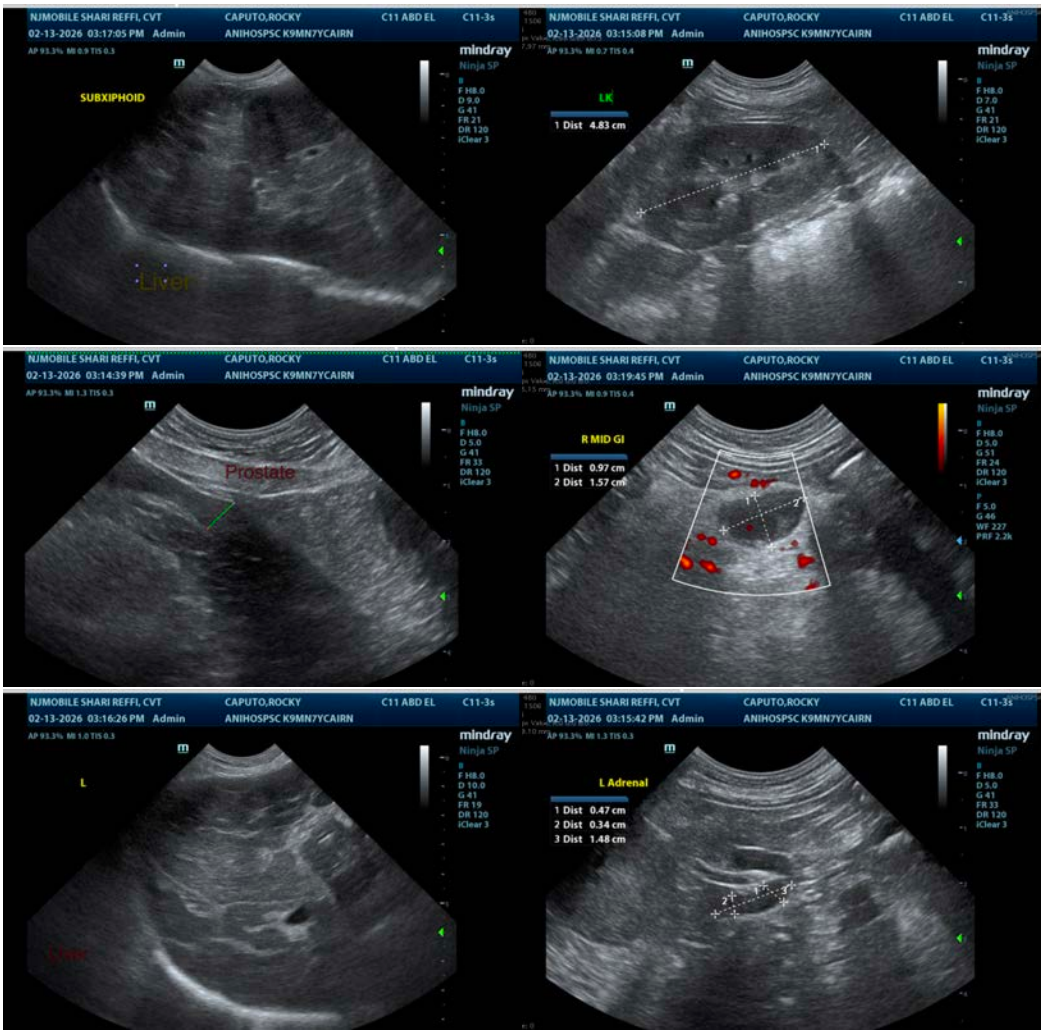
Patient's prognosis is guarded at this time pending the ultimate diagnosis as to the cause of the patient's enlarged, lobulated appearing liver and the presence of the diffuse enlarged abdominal lymph nodes.



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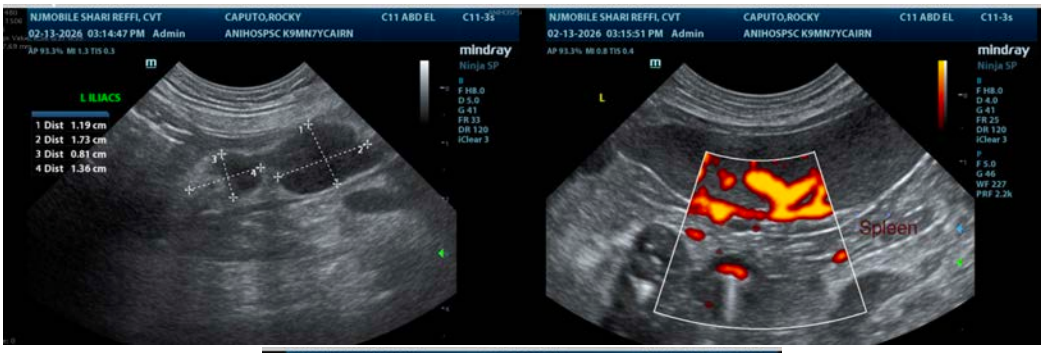

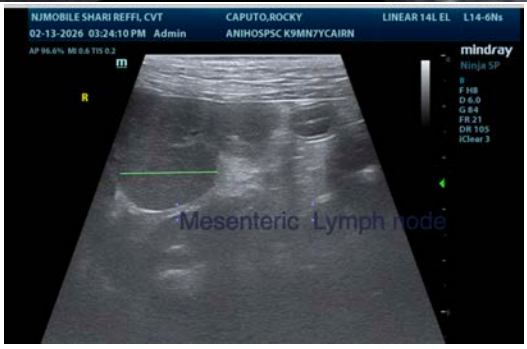

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com