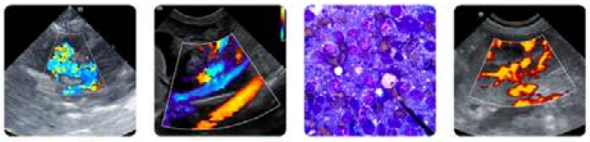


PATIENT

Penny Rusinak

SPECIES

Canine

BREED

Corgi

SEX

Female

AGE

12 Years

WEIGHT

24.3 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Cristy Fisher

HOSPITAL NAME

Pine Creek Veterinary Hospital

REFERRING VET

Dr. Sophia Jakymiw

INVOICE

73350

DATE

3/3/26

PRESENTING CLINICAL SIGNS

1 month ago develop right sided periocular swelling. Resolved with NSAID therapy for 5 days. 3 weeks ago developed difficulty prehending food. Has severe / extreme dental disease. Improved again on NSAID therapy. 1 day ago is unable to open mouth and is vomiting and having diarrhea.

During exam this morning, patient is unable to open her mouth at all and she has extensive masseter and temporalis muscle atrophy.

Abnormal PE/Chem/CBC/UA Results: Hypocalcemia 7.5 (7.9 - 12) Hypoalbuminemia 1.9 (2.2 - 3.9) Hyperglobulinemia 5.1 (2.5-4.5) Amylase and Lipase elevation 2432 and 5043 2 M antibody titer pending

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 right kidney presents normal size (5.6 cm) with normal shape and architecture. Moderate loss of corticomedullary distinction. In the cranial pole of the right kidney there is a 2.8 cm cortical cyst present that appears benign. No mass lesion associated with this cyst. There is a mild amount of hyperechoic flocculent debris within the cystic fluid. There are numerous pinpoint hyperechoic foci in the renal pelvis, consistent with benign renal nephrocalcinosis. No pyelectasia or ureteral dilation.

The left kidney presents normal size (4.9 cm) with normal shape and architecture. Mild loss of corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 5.6 mm and the caudal pole measures 6.7 mm.

The left adrenal gland has a mass at the cranial pole. The cranial pole of the left adrenal gland is enlarged and hyperechoic, measuring 1.5 cm x 1.0 cm. The caudal pole measures 4.2 mm and appears normal.

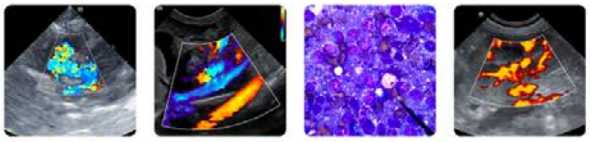
Spleen

The spleen is normal in size and echogenicity with a normal echotexture. There are multifocal hyperechoic lesions throughout the spleen in perivascular locations, most likely consistent with benign myelolipomas.

Liver

The liver presents normal size and shape with smooth lobar margins. There are multifocal hypoechoic, ill-defined lesions present diffusely throughout the liver. A representative lesion measures 6.3 cm x 10.6 mm. Intrahepatic bile ducts are normal. Normal vascular pattern.

The gallbladder presents normal size. It contains a moderate amount of gravity dependent echogenic debris. Normal gallbladder wall. No evidence of bile duct distention or obstruction. No surrounding hyperechoic fat or free fluid.



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Gastrointestinal

The stomach wall is diffusely thickened at 9.1 mm in width. The wall is diffusely mildly hypoechoic. The patient appears to have diffuse gastritis. The small 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.

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Benign appearing liver lesions - These lesions are most likely benign regenerative nodules, and less likely neoplasia.
- Hyperechoic lesions in the spleen – Most likely benign myelolipomas.
- Left-sided adrenal mass at the cranial pole – Differentials include adrenal hyperplasia versus possible adrenal cortical carcinoma or adrenal medullary carcinoma.
- Echogenic debris within the gallbladder – The patient appears to have mild cholangitis. Given that liver enzymes are not reported to be elevated, and bilirubin is not reported to be elevated, this is most likely an incidental finding.
- Diffuse gastritis – Most likely secondary to the underlying cause of the patient's illness. Gastric disease is most likely not a primary disease in this patient.
- Right kidney cyst.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consider fine needle aspirates of the hepatic lesions and submit for cytology to rule out neoplasia.

Recommend screening the patient for hyperadrenocorticism with either a low-dose Dexamethasone suppression test or ACTH stimulation test. A low-dose Dexamethasone suppression test is preferred, given the improved sensitivity and specificity over the ACTH stimulation test.

Also recommend a systemic blood pressure in the patient. If patient is found to be hypertensive or there are possibly clinical signs of a pheochromocytoma, submit a urine metanephrine test. If adrenal mass is functional treat accordingly.

Regarding the gallbladder debris, consider starting Ursodiol at 15 mg/kg by mouth split into two daily doses. Continue this treatment for up to 3 months and recheck gallbladder at the end of treatment course to determine if gallbladder debris has resolved or is improving.

Recommend treating gastritis supportively with anti-nauseas and prokinetic medications.

Regarding the right renal cyst, recommend fine needle aspirate of cystic fluid and submission for cytology and bacterial culture to rule out renal abscess.

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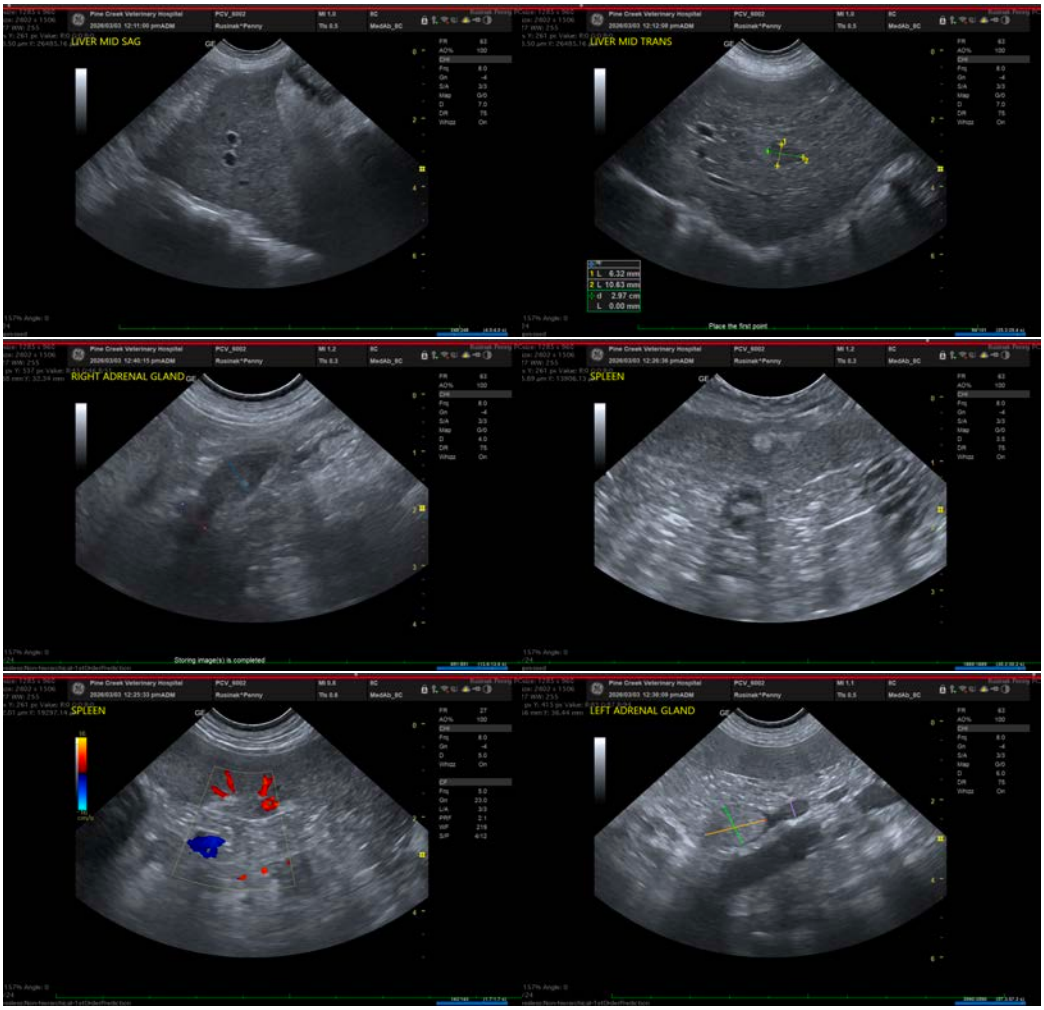
It is unlikely that any of the findings on this ultrasound explain the patient's clinical signs. No specific cause for vomiting or diarrhea is seen on this exam other than the diffuse gastritis, which is most likely secondary to either recent medical management or to the patient's underlying disease process causing the inability to open their mouth and their dysphagia.

Given the reported clinical signs, recommend a neurology consult for possible MRI, CSF tap for the patient's difficulty opening mouth and dysphagia. This would be assuming that the 2 M antibody titer testing that is pending is negative, and I would recommend further imaging of the skull to screen the patient for possible neurologic disease.



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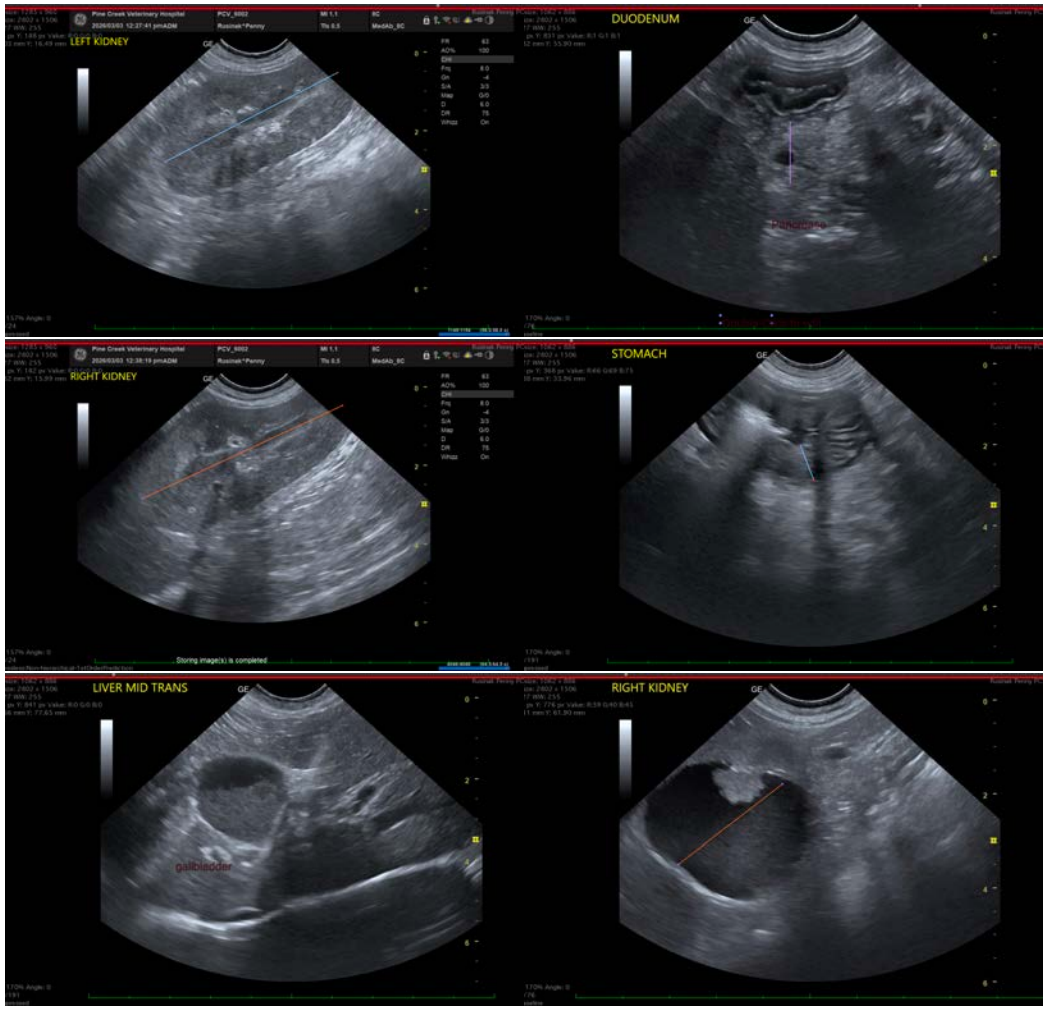

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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