



PATIENT

Buster Tierney

SPECIES

Canine

BREED

Bernese Mtn Dog

SEX

Neutered Male

AGE

8 Years

WEIGHT

47.2 kg

INTERPRETED BY

Kathleen Sennello DVM,
MS, Diplomate ACVIM
(Small Animal Internal
Medicine)

**IMAGING
PERFORMED BY**

Dr. Nigel Gumley

HOSPITAL NAME

Cedarview AH

REFERRING VET

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DATE

11/22/22

PRESENTING CLINICAL SIGNS

Presented for generalized truncal superficial folliculitis/pyoderma. No weight loss, urinating, appetite normal, BMs normal, drinking normal. Weak in hind legs from prior IVDD and cruciate disease.

Abnormal PE/Chem/CBC/UA Results: Elevated ALT (324) and ALP (242); normal CBC Chest radiographs show radiodense mass in caudoventral thorax at periphery of lung field. FNA from abdominal mass suggestive for reactive lymph node (cytopathology pending but no neoplastic cells noted).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The prostate is normal in size (2.0 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (6.77 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (7.3 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.64 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.67 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.



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The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

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Gastrointestinal

The stomach is dilated with a moderate to large amount of fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of 0.34 cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

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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. Duodenum wall measures 0.40 cm. Jejunum wall measures 0.36 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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Pancreas

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are slightly prominent caudal abdominal lymph nodes. The left iliac measures 0.74 cm. The right iliac measures 0.52 cm. The omentum is hyperechoic in the cranial abdomen.

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Other

There is large hypoechoic mass effect visualized caudal to the stomach, measuring 3.44 cm x 5.5 cm. No obvious association with the liver, spleen, or stomach is visualized. This has the appearance of a severely enlarged lymph nodes.

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ULTRASONOGRAPHIC FINDINGS

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- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.
- Large, distended gallbladder with a large amount of hyperechoic intraluminal material that appears to be adhering to the gallbladder wall – The gall bladder changes are most consistent with a developing mucocele. Consider medical management and close monitoring for progression of this lesion.

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- Moderate amount of shadowing ingesta within the gastric lumen – Correlate with feeding history and abdominal radiographs. If the patient was adequately fasted, consider such differentials as delayed gastric emptying or a partial outflow tract obstruction (none observed).

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- Prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

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- Large, hypoechoic, solid cranial abdominal mass – This is visualized caudal to the stomach and appears most consistent with a severely enlarged lymph node, although an association with the pancreas, stomach, spleen, or liver is possible.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are no focal mass lesions observed other than the sampled cranial abdominal mass. Recommend submission for cytologic evaluation. This would be very unusual for a reactive lymph node. If a cytologic diagnosis cannot be obtained, then you could consider resampling a tru-cut or incisional biopsy.

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Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

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The liver is large and heterogeneous. This is a non-specific finding. No focal lesions were visualized associated with the liver. Consider the following:

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- Consider close evaluation of history for possible toxic changes examine medications, diet, dietary indiscretion etc...
- Consider PCR on urine/serum for leptospirosis (if not on antibiotics)/serology if recent antibiotic history
- If not already done, consider pre and post prandial bile acids to evaluate liver function
- Consider Fine needle aspirate if round cell neoplasia is on your differentia list (25 g needle, normal coags)
- If no response to supportive care (Denamarin, fluids, antibiotics, +/- ursodiol etc.) Consider liver biopsy with samples obtained for histopathology, culture, and copper levels.

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The gallbladder is large and distended with a large amount of adherent intraluminal debris. In some images, a small amount of inflammation may be seen around the gallbladder. Recommend starting chronic Ursodiol therapy +/- antibiotics and close monitoring of liver enzymes and this lesion for any evidence of progression to a surgical lesion.

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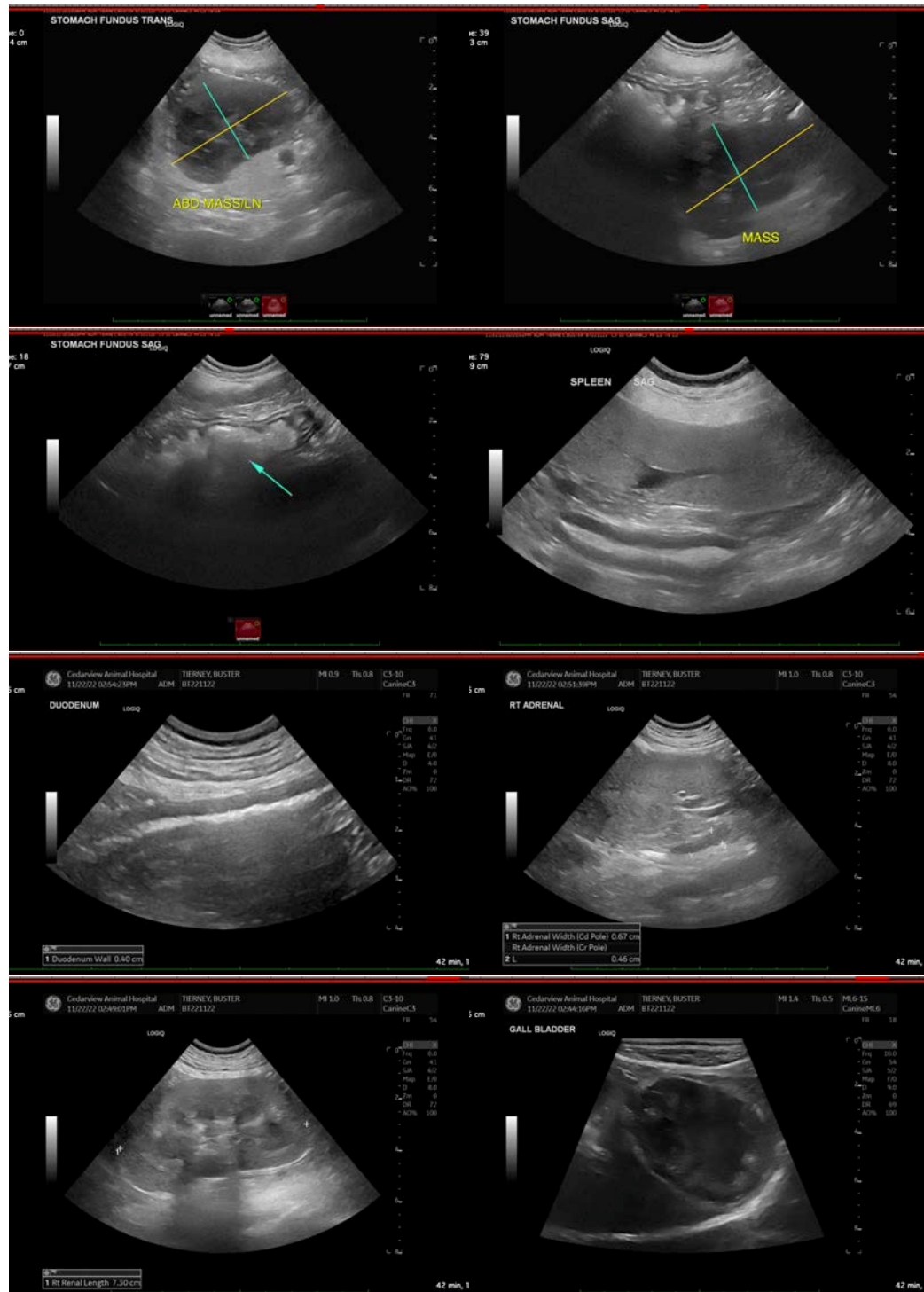
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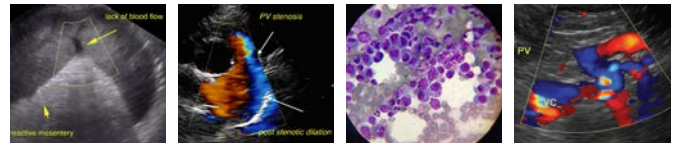
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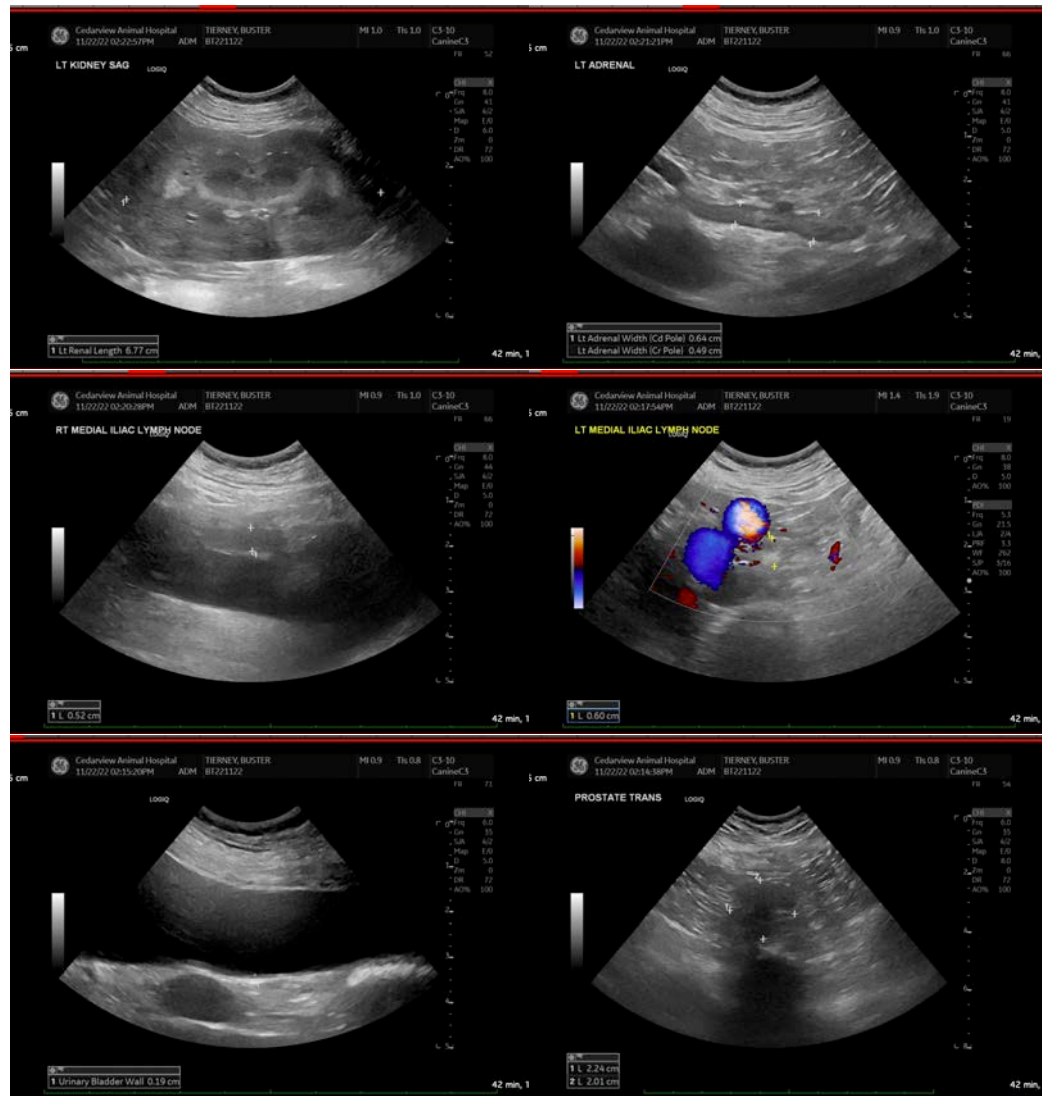
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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