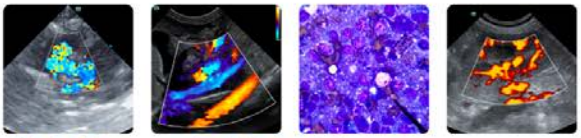

PATIENT

Jack Hoepfel

SPECIES

Canine

BREED

English Cocker Spaniel

SEX

Neutered Male

AGE

13 Years 2 Months

WEIGHT

42.3 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

St. Georges Veterinary Hospital

REFERRING VET

Dr. Patel

INVOICE

72335

DATE

12/4/25

PRESENTING CLINICAL SIGNS

Grade 2/6 hm, periodontal dz, pre- anesthetic. Otitis externa, mass removal surgery and dental workup.

Abnormal PE/Chem/CBC/UA Results: TP-7.6 Glob-2.4 ALKP-679 Amyl-1473 PSL-531 WBC-17.7 PLT-714 Neut-11328 Lymph-4956 Mono-1239 T4-<0.5 UA-prot- 1+ UPC-0.7 USG-1.017

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 visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (5.94 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal. Cranial to the left kidney there is significant focal inflammation. A source of the inflammation is not definitively identified.

The right kidney has a normal shape and size (6.2 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 not clearly visualized. In the region of the left kidney there is focal inflammation and a somewhat obscured mass effect measuring at least 2.52 cm x 1.9 cm. Based on the location and presentation, an adrenal mass could be an issue, but a distinct adrenal gland is not visualized.

The right adrenal gland is normal in size measuring 1.14 cm at the cranial pole and 0.65 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 (1.58 cm), 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. There is a diffuse nodular pattern with poorly defined small, hypoechoic nodules throughout the parenchyma.

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

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 0.51 cm. Jejunum wall measures 0.31 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 area of 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.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is focally hyperechoic in the region of the left kidney.

ULTRASONOGRAPHIC FINDINGS

- Focal irregular tissue/inflammation visualized in the region of the left kidney/cranial to the left kidney – Findings are concerning for a ruptured adrenal mass lesion. Other possibilities could include a caudal lesion involving the left limb of the pancreas, an unseen lesion associated with the spleen, etc.
- Heterogeneous, diffusely nodular liver – Findings could be consistent with benign regenerative nodules. Given the concern for an abdominal mass lesion, metastatic disease cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is abnormal hyperechoic, irregular tissue visualized cranial to the left kidney. This is obscured somewhat by edge artifact and the inflammation in the region. Based on the location and the lack of visualizing a normal adrenal, an adrenal mass lesion would be a significant concern. Additionally, the liver is somewhat nodular. Recommend a fine needle aspirate of the liver and a contrast CT scan to further evaluate the region of the left kidney/left adrenal.

If a CT scan is not possible, further evaluation possibly with sedation, multiple views (standing, etc.) could potentially provide more information but regional inflammation obscures visualization.

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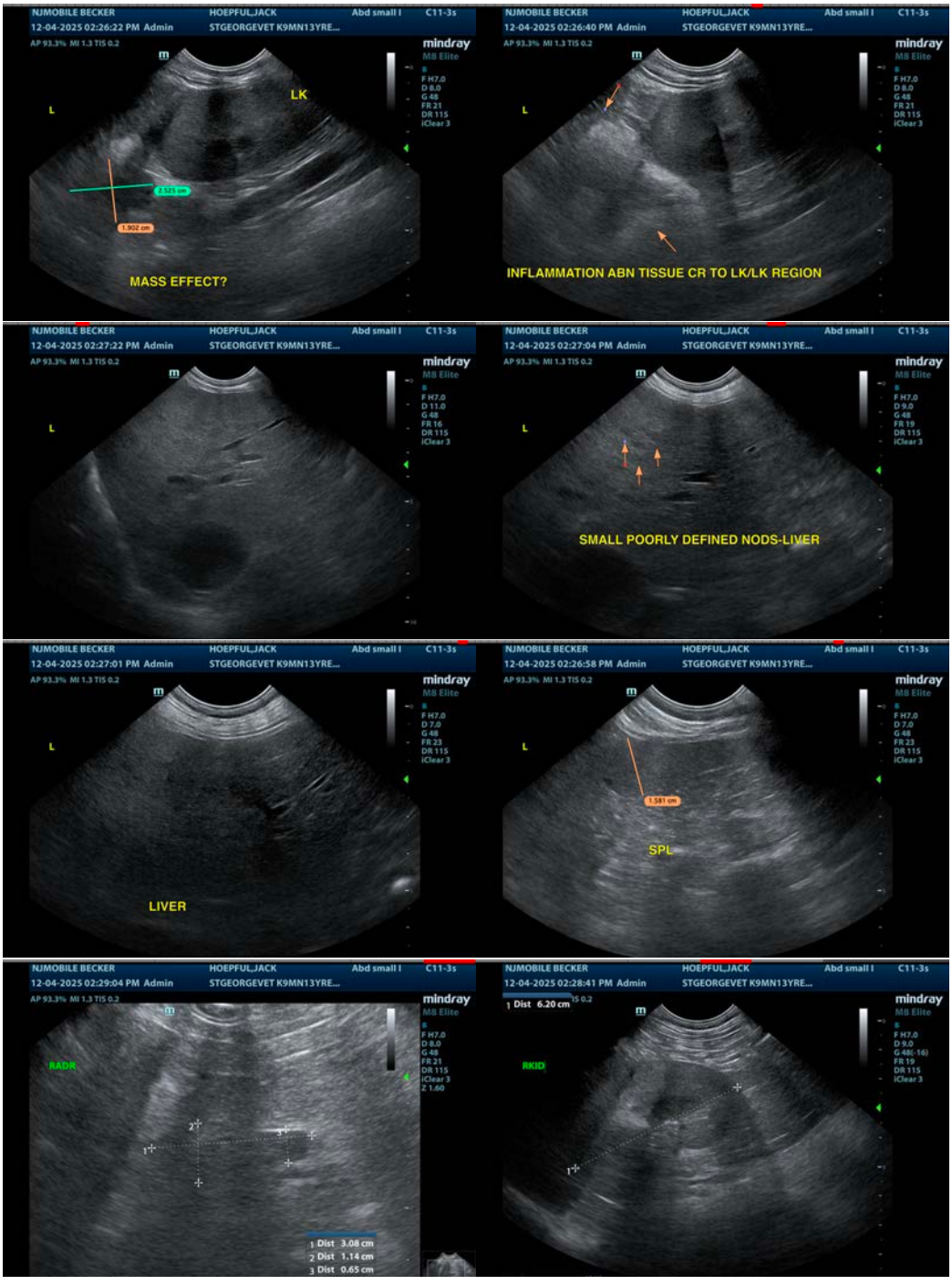
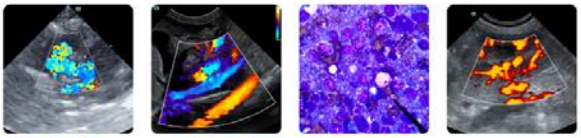
Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).



New Jersey Mobile
FUELED BY SONOPATH VETERINARY ULTRASOUND



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Educational Teleconsultation Services™

SonoPath www.SonoPath.com info@sonopath.com 800.838.4268

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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.

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

info@sonopath.com