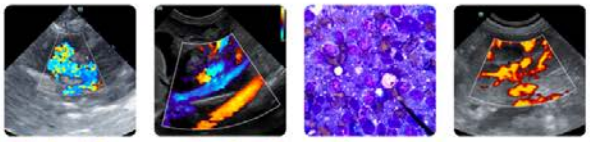


PATIENT

Shorty Kerns

SPECIES

Canine

BREED

Corgi

SEX

Neutered Male

AGE

14 Years

WEIGHT

13 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Justin Freeby

HOSPITAL NAME

Abby Road Veterinary Hospital

REFERRING VET

Dr. Justin Freeby

INVOICE

72427

DATE

12/9/25

PRESENTING CLINICAL SIGNS

P presented for ~7 day duration of profuse diarrhea (watery) with inappetence (complete). Initial supportive treatment resulted in formed/soft stools and improved appetite. However, after finishing medications P is now vomiting and acting lethargic. P has hx liver mass according to O.

Abnormal PE/Chem/CBC/UA Results: Attached

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 (4.44 cm) with mild pyelectasia at 0.20 cm. Overall echogenicity is slightly hyperechoic with mildly reduced 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.33 cm) with pyelectasia at 0.32 cm. Overall echogenicity is slightly hyperechoic with mildly reduced 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,nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is large and irregular in shape, measuring 0.85 cm at the cranial pole and 1.45 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is abnormal in appearance in that the caudal pole is large and somewhat mottled, measuring 1.66 cm x 1.77 cm. No definitive evidence of vascular invasion is visualized.

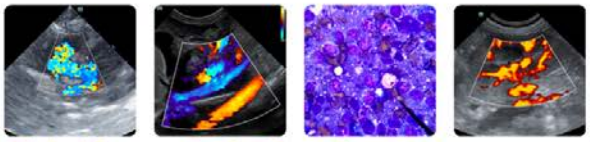
The right adrenal gland is normal in size measuring 0.63 cm at the cranial pole and 0.57 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is normal size, mottled, and slightly rounded in shape, measuring 1.64 cm in width at the level of the hilus. The blood flow through the hilus and splenic parenchyma appears normal. There is a poorly defined hypoechoic nodule towards the head of the spleen measuring 0.62 cm.

Liver

The liver is large in size and rounded. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is



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a poorly defined rounded area in the mid left region of the liver most consistent with a poorly defined mass effect or rounded liver lobe measuring 2.68 cm x 4.87 cm.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains moderate fluid. 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. Jejunum wall measures 0.34 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with non-formed fecal material and gas shadowing distally. The descending colon wall appears slightly thickened with intact wall layering, measuring at 0.27 cm.

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.

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 of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mild age related changes and bilateral pyelectasia visualized associated with both kidneys – Pyelectasia of the kidney(s)could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- Mildly heterogeneous nodule associated with the caudal pole of the left adrenal – Possible differentials include focal hyperplasia, an adenoma, carcinoma, pheochromocytoma, other.

- Mildly mottled spleen with a poorly defined hypoechoic nodule – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Heterogeneous liver with an ill-defined “mass effect” – 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. The mass effect visualized could be consistent with a rounded liver lobe or a poorly defined primary

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hepatic mass lesion such as adenoma or carcinoma.

- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

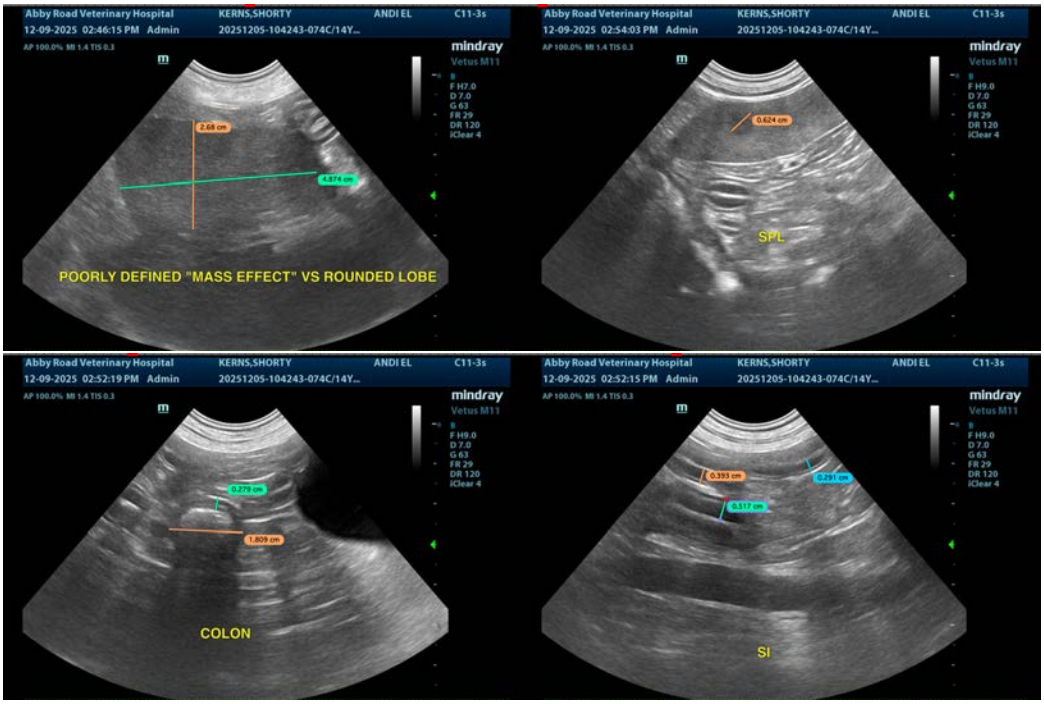
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the stomach or small intestine to explain the diarrhea reported. Unfortunately, there are many causes for diarrhea that cannot be definitively diagnosed by ultrasound alone. If not already done, recommend a hydrolyzed protein prescription diet, and consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate, looking for evidence of exocrine pancreatic insufficiency, B12 deficiency, etc. If not already administered, probiotics can be considered. If symptoms are persistent, eventually biopsies of the GI tract may be warranted to further evaluate (large and small bowel based on symptoms described).

There is a mottled nodule visualized associated with the caudal pole of the left adrenal gland. This could represent a benign or neoplastic lesion. If symptoms consistent with Cushing's are present, you could consider adrenal function testing, but this should be done when the patient is not clinically ill. I suspect the adrenal is not related to the current symptoms but is a separate issue. Further evaluation could include a contrast CT scan to evaluate the adrenal for possible surgical removal. The liver could also be evaluated at this time to try to determine if a more discrete mass effect is present.

The liver is mildly heterogeneous. This is a non-specific finding. Further evaluation could include a liver function test and a fine needle aspirate of the liver.

The spleen appears subjectively mottled with a poorly defined hypoechoic nodule. Options moving forward would include a fine needle aspirate of continued monitoring with ultrasound.



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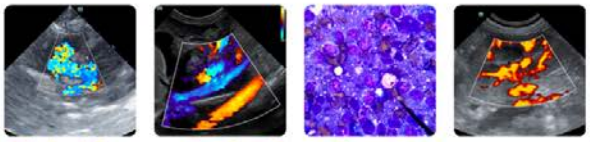

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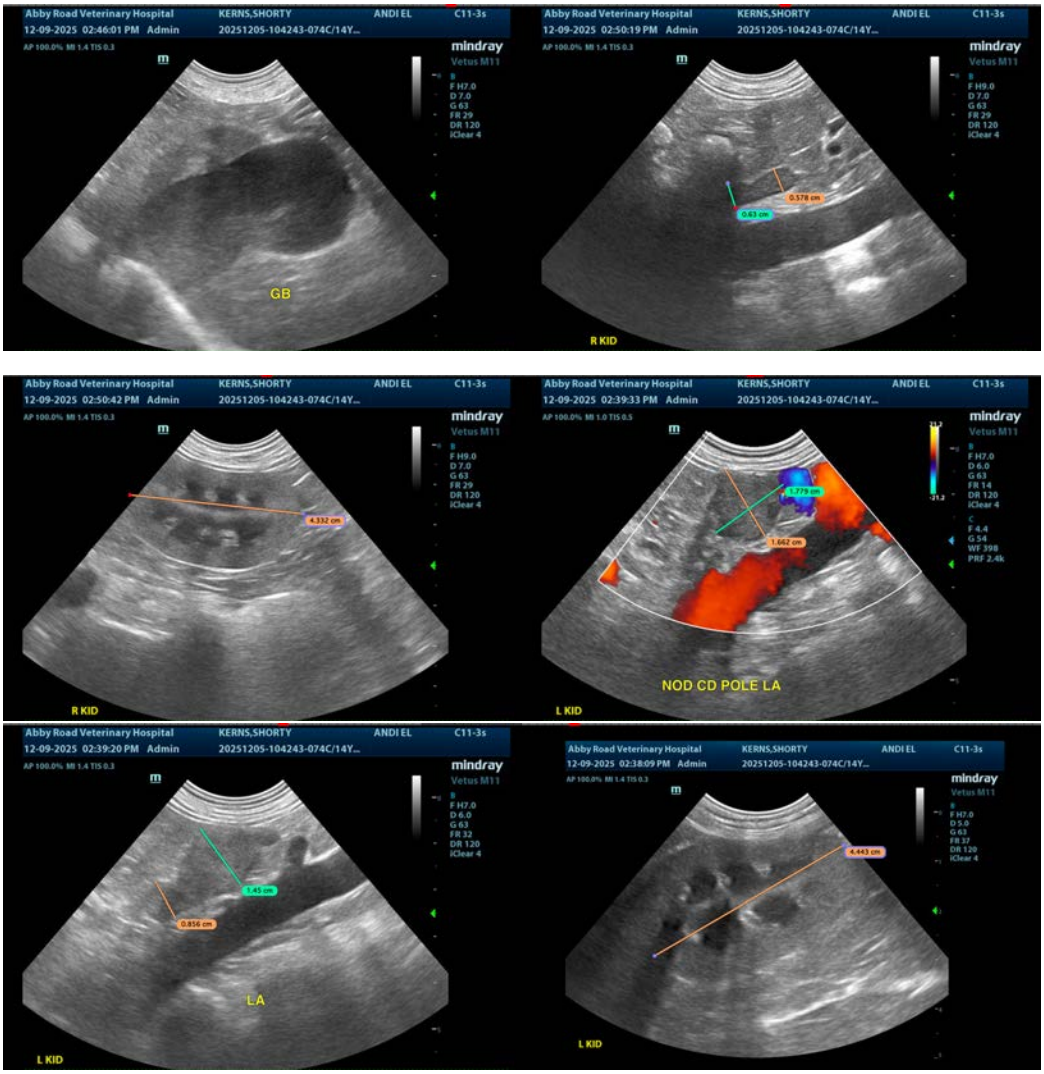

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com