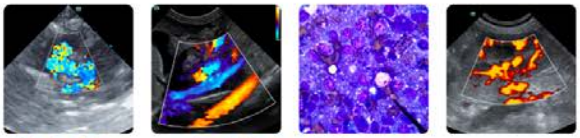

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PATIENT

Toby Currie

SPECIES

Canine

BREED

Maltese x

SEX

Neutered Male

AGE

13 Years 4 Months

WEIGHT

11.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Stoney Creek Veterinary Hospital

REFERRING VET

Dr. Eldred

INVOICE

72927

DATE

2/12/26

PRESENTING CLINICAL SIGNS

P presented for US due to GGT 32 and fast scan saw debris and sludge in gallbladder- concern for possible mucocele, T4 low, vomiting and weight loss of 4# over 3 months, P on Denamarin, Levothyroxine, Ursodiol, and low fat diet, Liver values normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly moderately distended with anechoic urine. The Bladder wall appear thickened, particularly in the dorsal wall, measuring 0.49 cm. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi.

The prostate is large, measuring 1.35 cm in height in the sagittal view, and is rounded with mixed echogenicity. There are punctate hyperechoic foci possibly consistent with mineralizations in the parenchyma, and the appearance of a “mass effect” measuring 1.16 cm x 1.13 cm.

The left kidney has a normal shape and size (4.9 cm) with hyperechoic pinpoint cortical mineralizations and striations. Overall echogenicity is slightly hyperechoic with poor 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.64 cm) with hyperechoic pinpoint cortical mineralizations and striations, and occasional small cortical cysts. Overall echogenicity is slightly hyperechoic with poor 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is “plump” measuring 0.68 cm at the cranial pole and 0.67 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 large, measuring 1.01 cm at the cranial pole and 0.76 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 (1.36 cm in height at the level of the hilus), 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 with irregular margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are occasional ill-defined hyper- and hypoechoic nodules in the parenchyma. A cystic lesion is visualized measuring 1.57 cm. The caudate lobe appears somewhat irregular, almost creating a

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"mass effect" measuring 4.19 cm. Additionally in this region there are two prominent nodules. A hyperechoic nodule measures 1.59 cm. A hypoechoic cystic/cavitated nodule measures 1.69 cm.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened (0.17 cm) 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 a large amount of fluid and ingesta. 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. Intraluminal ingesta and fluid interferes with full evaluation of the stomach. In some views it is difficult to differentiate ingesta from a possible mass effect.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with moderate fluid and ingesta. 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 0.36 cm. Jejunum wall measures 0.35 cm. Visualized peristalsis appears appropriate. The majority of the small intestine appears moderately fluid and chyme distended.

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 pancreas is prominent and hypoechoic as compared to the surrounding isoechoic 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.

PRIMARY FINDINGS

- Thickened urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Large, hypoechoic mixed echogenicity prostate with hyperechoic/mineralized foci and a poorly defined mass effect – Correlate with age of neutering. If the patient was neutered prior to puberty, this is highly concerning for prostatic neoplasia.
- Borderline bilateral adrenomegaly – Findings could be consistent with anatomic variation or bilateral hyperplasia.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.

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- Heterogeneous, irregular liver with a rounded, irregular caudate lobe with hyper- and hypoechoic nodules and a cyst. The caudate lobe appears irregular. This could be consistent with a large, irregular, rounded lobe, a poorly defined mass effect (adenoma, carcinoma, other). Similarly, the nodules could represent regenerative nodules or early neoplastic lesions.

- Large fluid and ingesta distended stomach and small intestine – Correlate with feeding history. If the patient was recently fed, this could represent normal post-prandial patient. If the patient was adequately fasted, there could be concern for delayed gastric emptying. Evaluation of the GI tract is impaired by ingesta/fluid, and focal adhered ingesta in the stomach is difficult to differentiate from a potential mass effect.

SECONDARY FINDINGS

- Age related changes visualized associated with both kidneys.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach and small intestine are significantly distended with fluid and ingesta. This interferes with evaluation of the GI tract and some abnormal non-shadowing material visualized within the stomach. It is difficult to differentiate from a potential mass effect. Correlate with feeding history. Consider reevaluation with a more prolonged fast and/or upper GI endoscopy to further evaluate.

The pancreas is somewhat prominent but does not appear overtly inflamed. Correlate with a PLI level. If this is significantly elevated, consider treatment for concurrent pancreatitis.

The prostate is large, irregular and mottled with some mineralization. This is an abnormal prostate for a neutered individual. If this pet was neutered late in life secondary to prostatic disease, this could represent a benign process. Strongly recommend a fine needle aspirate, as there is significant concern for prostatic neoplasia.

The caudate lobe of the liver is somewhat irregular compared to the rest of the liver. It is more heterogeneous with irregular margins and some focal nodules. The significance of this is uncertain. This could represent a poorly defined mass effect or a benign lesion with regenerative nodules, etc. Consider a fine needle aspirate of the caudate lobe and of the nodules if a safe window for sampling is available and coagulation parameters are normal.

Additionally, if more information is desired, you could consier a contrast CT scan to further evaluate the liver and GI tract with a more prolonged fast.

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

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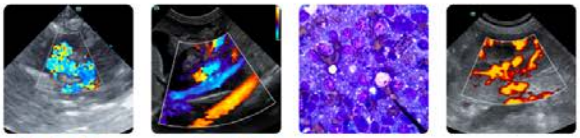

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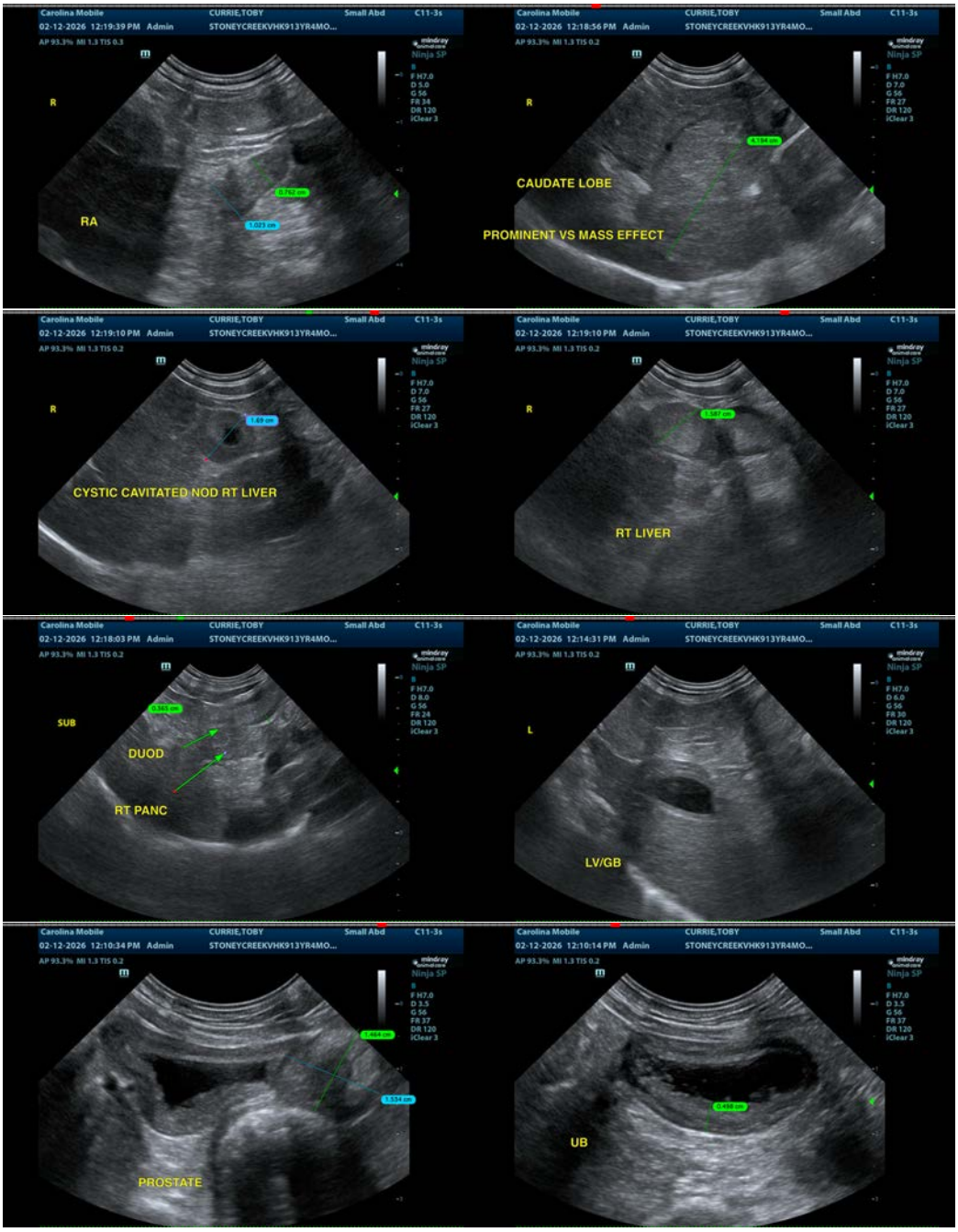

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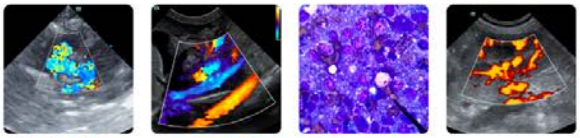

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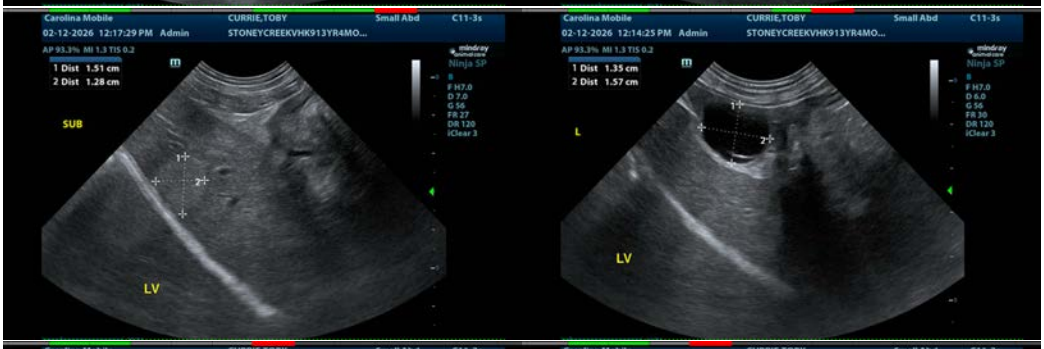

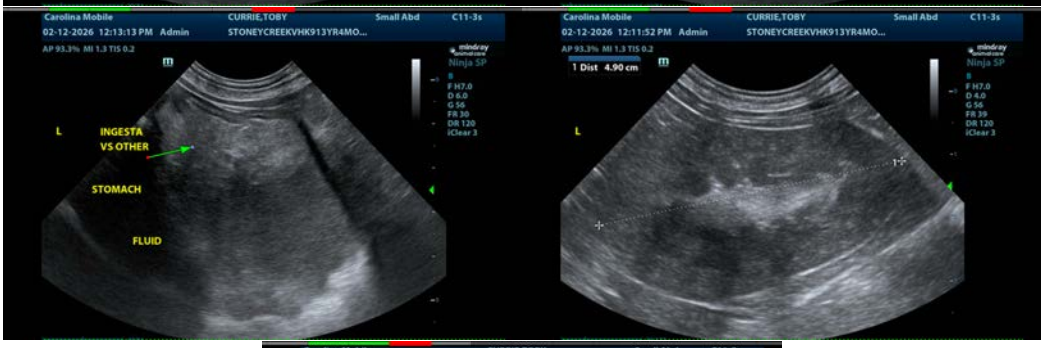

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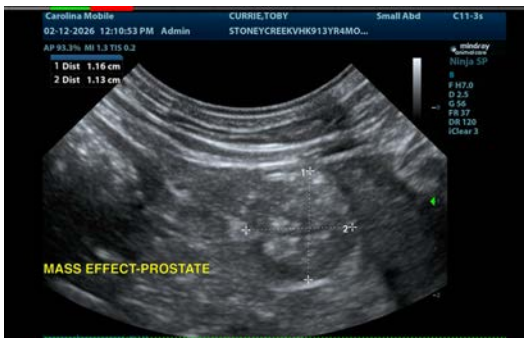

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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