PATIENT

Cheeto Costanza

SPECIES

Canine

BREED

Shih Tzu Mix

SEX

MN

AGE

11 years

WEIGHT

11.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView

REFERRING VET

Dr. Violeta Gordillo

INVOICE

11385

DATE

2/26/2026

PRESENTING CLINICAL SIGNS

- History: r/o Cushing's disease - P has been restless, PU/PD, LDDS test pending.

Abnormal PE/Chem/CBC/UA Results: LABS 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 prostate is normal in size (0.66 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 (5.42 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 (5.23 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 0.55 cm at the cranial pole and 0.66 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 in size, and abnormal in appearance measuring 1.07 cm at the cranial pole and 0.88 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 abnormal in appearance in that there's a poorly defined hyperechoic nodule visualized measuring 0.86 cm x 1.03 cm, with some cranial irregularity which appears to extend and invade into the caudal vena cava. Soft tissue density is visualized within the vena cava measuring 0.47 cm x 0.48 cm.

Spleen

The spleen is subjectively normal in size and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There's a hypoechoic mixed echogenicity mass effect visualized associated with the spleen measuring 1.23 cm x 1.8 cm. This does not deform the splenic margins. Additionally, there is a small well-defined hyperechoic nodule measuring 0.67 cm, most consistent with a benign myelolipoma.

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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.

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 is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering 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. The duodenum measured as normal (0.48 cm in wall thickness) and the jejunum measured as normal (0.32 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 pancreas is prominent and mottled in the right limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid. In the cranial abdomen, near the pyloroduodenal junction, there is focal mesenteric inflammation. The source of the inflammation is not definitively visualized. It could be associated with the cranial aspect of the right limb of the pancreas.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. There's focal hyperechoic mesentery in the region of the pyloroduodenal junction. A definitive source of this inflammation is not readily visualized.The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mixed echogenicity splenic mass. A focal solid mixed echogenicity mass is visualized associate with the spleen. This mass distorts the splenic capsule. Differentials include: benign lesions (lymphoid hyperplasia, hemangioma etc..) or cancerous lesions (hemangiosarcoma, lymphoma, histiocytic sarcoma etc..)

- Large, heterogenous liver. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy.

- Moderate gallbladder debris. The significance of the aggregated gallbladder debris is

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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.

- Mottled pancreas with questionable pancreatitis in the cranial right limb.
- Large, irregular right adrenal mass with evidence of vascular invasion into the caudal vena cava. Possible differentials include a carcinoma, pheochromocytoma, other.
- Inflammation in the region of the pyloroduodenal junction. Findings could be consistent with focal pancreatitis, bowel wall inflammation, etc. A definitive source is not clearly identified.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

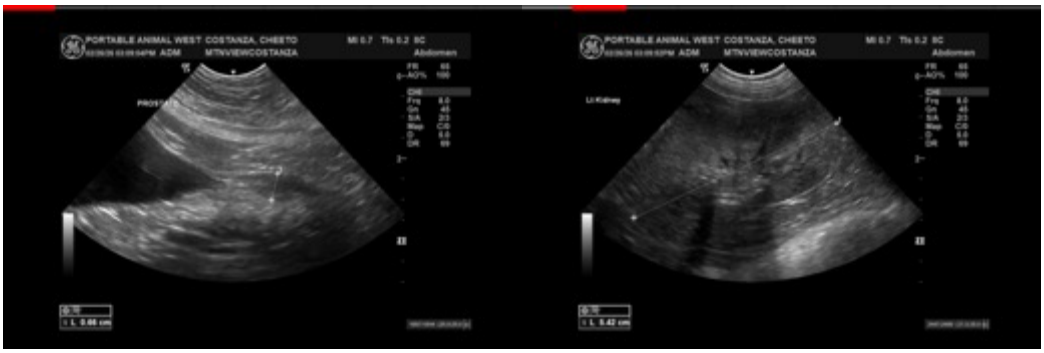
The right adrenal gland is enlarged and irregular in the cranial pole with evidence of extension into the caudal vena cava. Findings are most consistent with an adrenal mass lesion (carcinoma, pheochromocytoma, other.) Based on the suspected symptoms consistent with hyperadrenocorticism, a cortisol secreting tumor would be possible. Recommend adrenal function testing (currently pending) as well as a blood pressure. If hypertension is present, recommend measuring catecholamine levels, looking for a possible pheochromocytoma.

Recommend a contrast CT scan to further evaluate the right adrenal and confirm the likely early vascular invasion. It's possibly that surgical removal is still an option for this individual.

There is some focal inflammation visualized at the pyloroduodenal junction. The source of this inflammation is not readily visualized. There is some pancreas in the region, so mild focal pancreatitis is possible. Recommend continued monitoring. If a contrast CT scan is performed, this area should be evaluated as well.

There is a mixed echogenicity hypoechoic lesion visualized associated with the spleen. Options moving forward would include a fine needle aspirate, and continued monitoring with ultrasound or potentially a splenectomy at the time of adrenalectomy if this is pursued.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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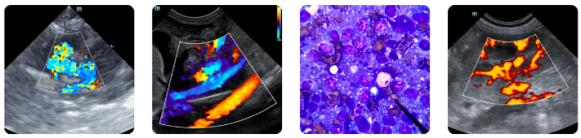

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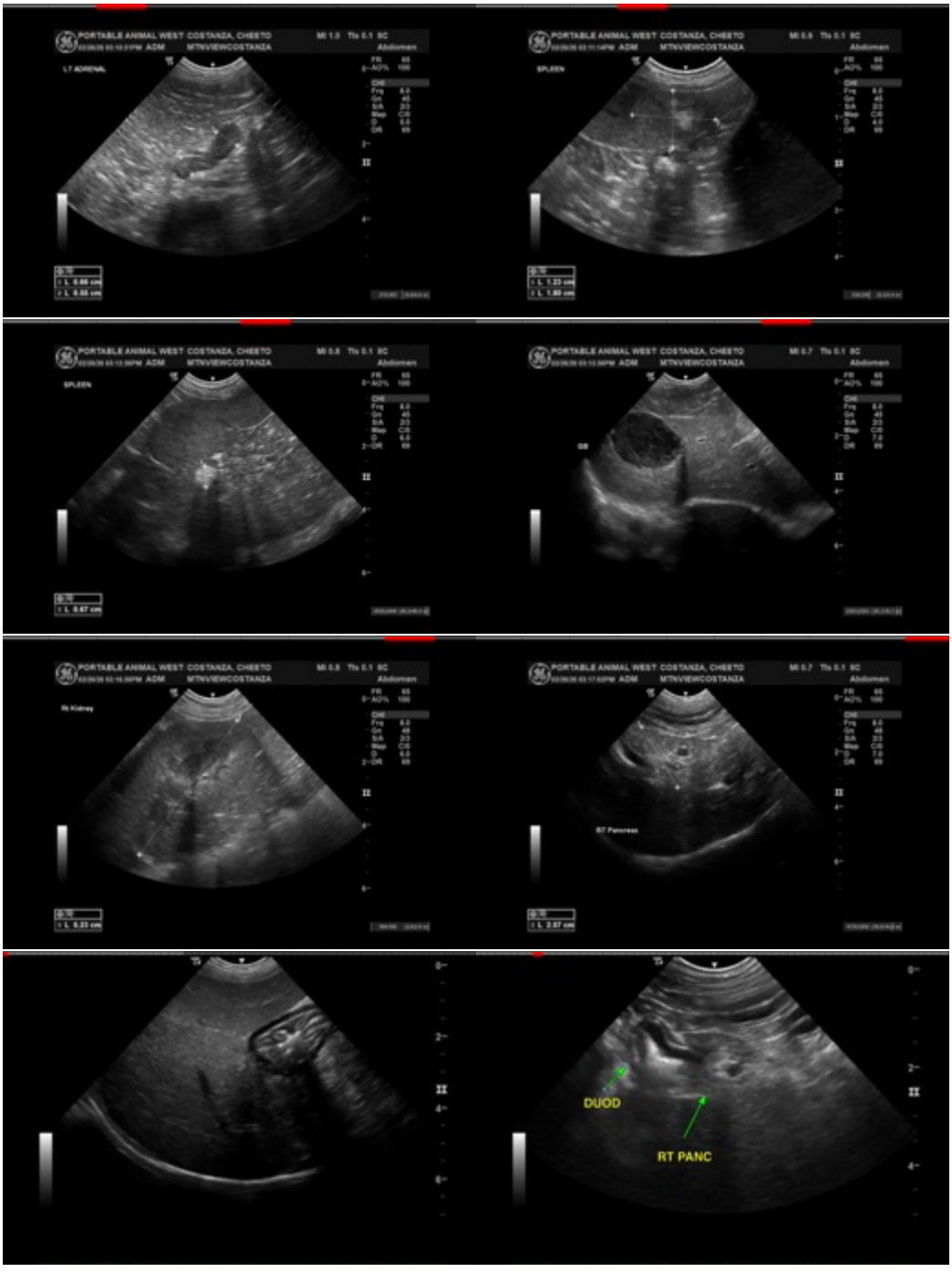

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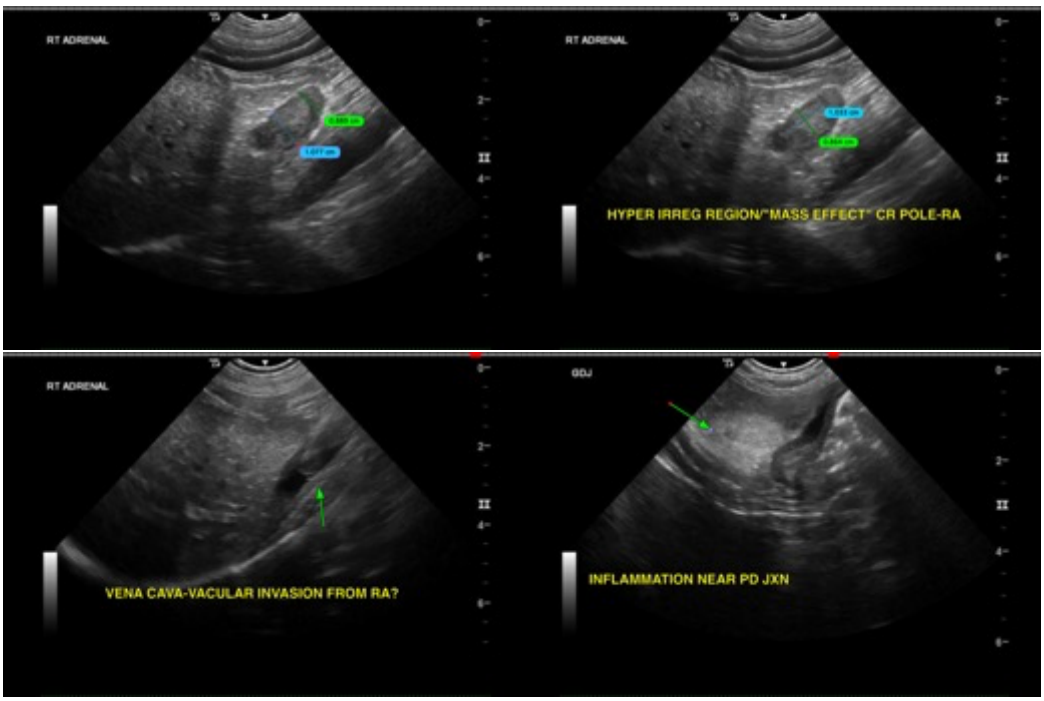

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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