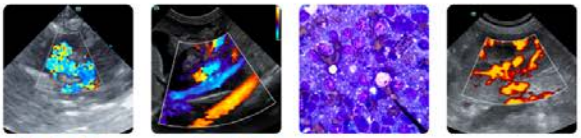

PATIENT

Penny Ludka

SPECIES

Canine

BREED

Labrador x

SEX

Spayed Female

AGE

12 Years

WEIGHT

58 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Nazareth Veterinary Center

REFERRING VET

Dr. Bankowski

INVOICE

72675

DATE

2/3/26

PRESENTING CLINICAL SIGNS

Vomiting, hyporexia, ^ LV & WBC

Abnormal PE/Chem/CBC/UA Results: ALT and ALP to high to read, repeat pending to lab. Tbili 1.2 was 8.8 yesterday at ER

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 left kidney has a normal shape and size (6.79 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (7.22 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is large and abnormal in shape, measuring 0.77 cm at the cranial pole and 3.76 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 it is generally enlarged with an isoechoic, poorly defined/enlarged caudal pole. No evidence of vascular invasion is visualized.

The right adrenal gland is “plump” measuring 1.67 cm at the cranial pole and 1.03 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 (1.99 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 subjectively mildly 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. There is some mildly striated/organized echogenic debris and a severely thickened, hypoechoic wall measuring 1.27 cm in thickness with surrounding inflammation. The cystic and common bile ducts are normal/not visible.

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Gastrointestinal

The stomach contains moderate shadowing 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. 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 0.48 cm. Jejunum wall measures 0.33 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 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

- Left-sided adrenal mass lesion – Possible differentials include adenoma, carcinoma, pheochromocytoma, other.
- Age related change visualized associated with both kidneys.
- Large, 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.
- Severely thickened, hypoechoic gallbladder wall with some mildly organized echogenic debris and surrounding inflammation – Findings are most consistent with severe cholecystitis and early mucocele. An underlying neoplastic process cannot be ruled out.
- Shadowing ingesta visualized within the gastric lumen – Correlate with feeding history. If the patient was adequately fasted, findings could represent delayed gastric emptying, ingested foreign material, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gallbladder is prominent with a very thickened, hypoechoic wall and some early striated/organizing intraluminal debris. There is surrounding reactive tissue. Findings are most consistent with severe

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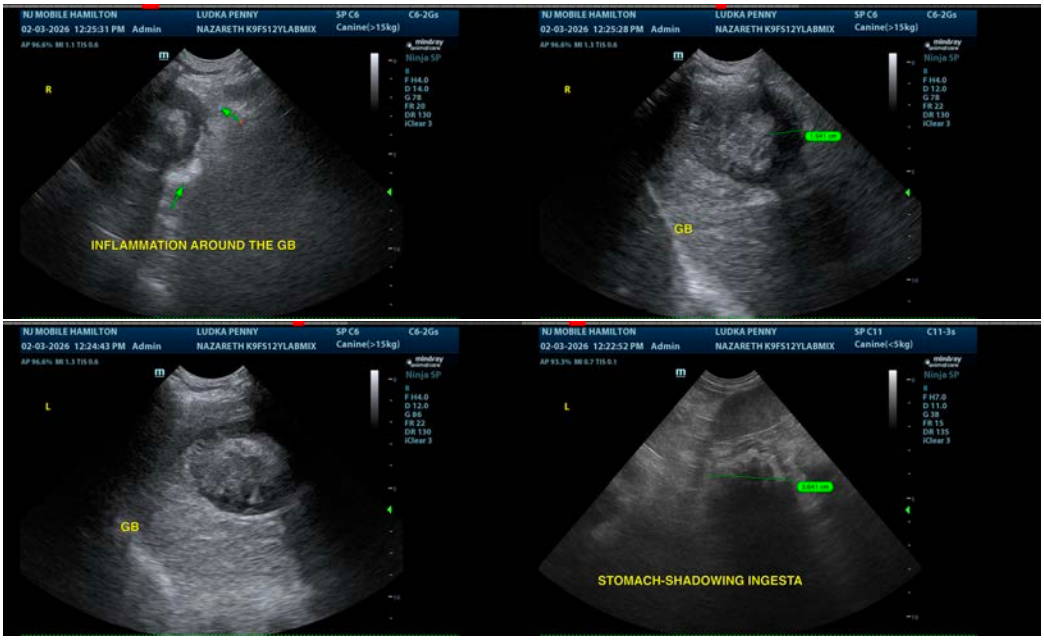
cholangitis/an early mucocele, although an underlying neoplastic process cannot be ruled out.

Additionally, there is a left-sided adrenal mass lesion. Correlate with the patient's chronic history. Has there been history of Cushing's symptoms? If so, adrenal function testing could be considered (once liver/gall bladder issues have resolved) as interpretation of results would be challenging with significant concurrent illness. Recommend a blood pressure evaluation. If hypertension is present, consider measuring catecholamine levels.

If the patient is stable, ideally a contrast CT scan would be performed to further evaluate the gallbladder and the left adrenal gland, as there could be the possibility of surgical cholecystectomy combined with adrenalectomy (would need to consult with surgeon). Based on the appearance of the gallbladder, surgical removal is likely recommended. If the patient is not stable or this is not an option, aggressive treatment for cholangitis recommended with reassessment. There is potential risk for gallbladder rupture in this scenario.

A fine needle aspirate of the gallbladder could be considered, but if the gallbladder wall is unhealthy, there could be risk for rupture.

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



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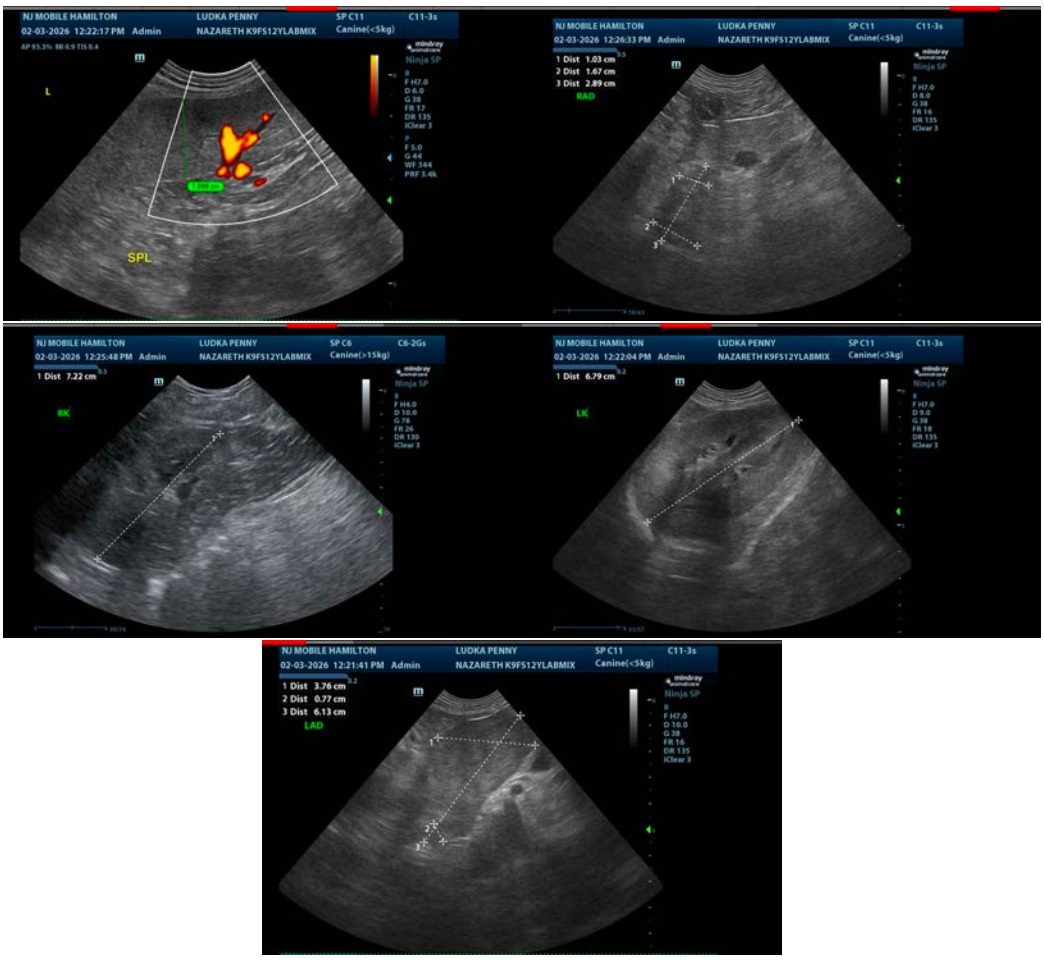

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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