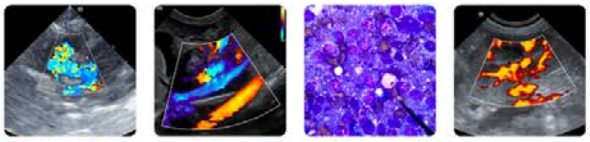

PATIENT

Jane Fox

SPECIES

Canine

BREED

Poodle x

SEX

Spayed Female

AGE

16 Years

WEIGHT

5.3

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Gavin Casper

HOSPITAL NAME

Hometown Animal Hospital (Florida)

REFERRING VET

Dr. Gavin Casper

INVOICE

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DATE

3/10/26

PRESENTING CLINICAL SIGNS

Recent hx of weight loss (was 7.5lbs on 3/2025), mild lethargy and inappetence. Receives librela injections monthly for OA maintenance.

Abnormal PE/Chem/CBC/UA Results: Underconditioned; Grade 3/6 L HM 2/18 labs: Chem- hypoglycemia (28, suspect artifactual), mild inc SDMA (15), mild inc BUN (40, prev 33), mild inc TP (9.0), mod dec albumin (2.0- dec prod vs inc loss), marked inc glob (7.0, prev 5.7- dehydration vs inflamm vs neoplasia), marked inc ALP (1265, prev 404), mod inc amylase (2147), marked inc lipase (843). Cardiopet proBNP - Abnormal (1,593). UA [cysto] - SG 1021, ph 5.5, mild pyuria, mod hematuria Urine culture - negative Tt4- <0.4 - euthyroid sick vs hypothyroid)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended with anechoic urine. The Bladder wall appears mildly thickened and irregular, particularly in the apical region, measuring 0.55 cm. No significant lesions are visualized associated with the trigone. Full evaluation of the urinary bladder is limited due to lack of urine distention.

The left kidney has a normal shape and size (3.32 cm) with a small cortical cyst noted. 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 (3.06 cm) with pinpoint non-obstructive mineralizations. 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, infarcts or hydroureter. Renal vasculature is normal.

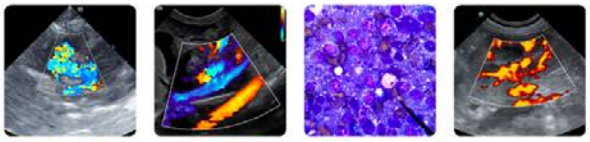
Adrenal Glands

The left adrenal gland is large and irregular in shape, measuring 1.03 cm at the cranial pole and 0.49 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 cranial pole is enlarged, measuring 0.92 cm x 1.26 cm. No evidence of vascular invasion is visualized.

The right adrenal gland is normal in size measuring 0.50 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

A very small amount of normal spleen is visualized. In the region of the spleen there is a large, irregular, solid, hypoechoic mass effect visualized measuring 3.31 cm x 6.58 cm, which appears to be arising from the spleen. Additionally, there is a 2nd hypoechoic structure visualized measuring 3.39 cm x 0.96 cm, which is suspected to be arising from the tail of the spleen, curling under the larger mass lesion.



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Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. 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 contains mild/moderate fluid/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. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) 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. No significant lymphadenopathy. The omentum is hyperechoic around the large mass lesions.

PRIMARY FINDINGS

- Large cranial pole of the left adrenal gland – The current appearance is most consistent with a benign lesion such as an adenoma. An early neoplastic lesion cannot be ruled out.
- Age related changes visualized associated with both kidneys.
- Large, irregular, hypoechoic mass effect visualized in the region of the spleen with a smaller hypoechoic mass lesion – 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..) **The lesions are strongly suspected to be associated with the spleen, but a limited amount of normal splenic tissue makes the association difficult to confirm.*

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SECONDARY FINDINGS

- Thickened apical region of the urinary bladder – 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.

- 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.

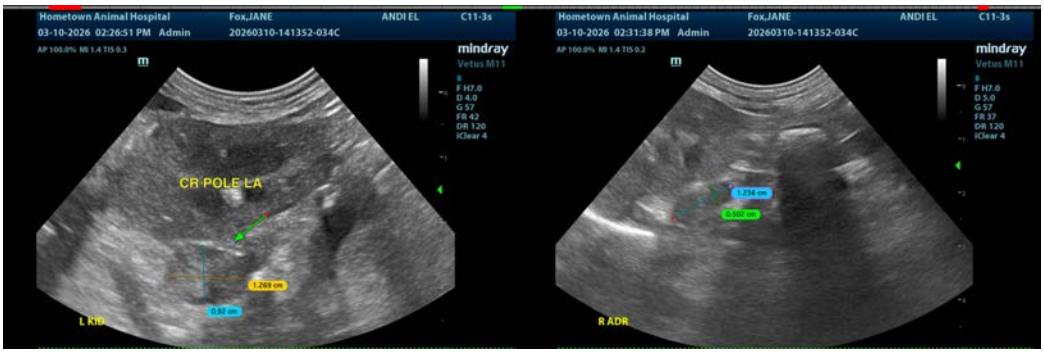
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are at least two hypoechoic, irregular mass lesions visualized in the left mid abdomen. These are strongly suspected to be of splenic origin, and a small sliver of normal spleen is visualized. A neoplastic lesion is suspected, particularly because there is more than one lesion, but this is not definitive, and a benign lesion is possible. Options moving forward would include a splenectomy for both diagnostic and therapeutic purposes with samples evaluated with histopathology, or you could consider a fine needle aspirate prior to surgery if this changes the plan.

There are bilateral renal changes most consistent with age related chronic renal disease.

The cranial pole of the left adrenal gland is large and slightly mottled. This has the appearance most consistent with a focal adenoma. If signs of Cushing's are present, you could consider adrenal function testing. Additionally consider a blood pressure evaluation. If hypertension is present, this could be due to underlying renal disease, or possibly an early pheochromocytoma. You could consider measuring catecholamine levels, looking for possible pheochromocytoma. Recommend continued monitoring of the left adrenal closely, looking for progressive enlargement (recheck in 8-12 weeks).

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



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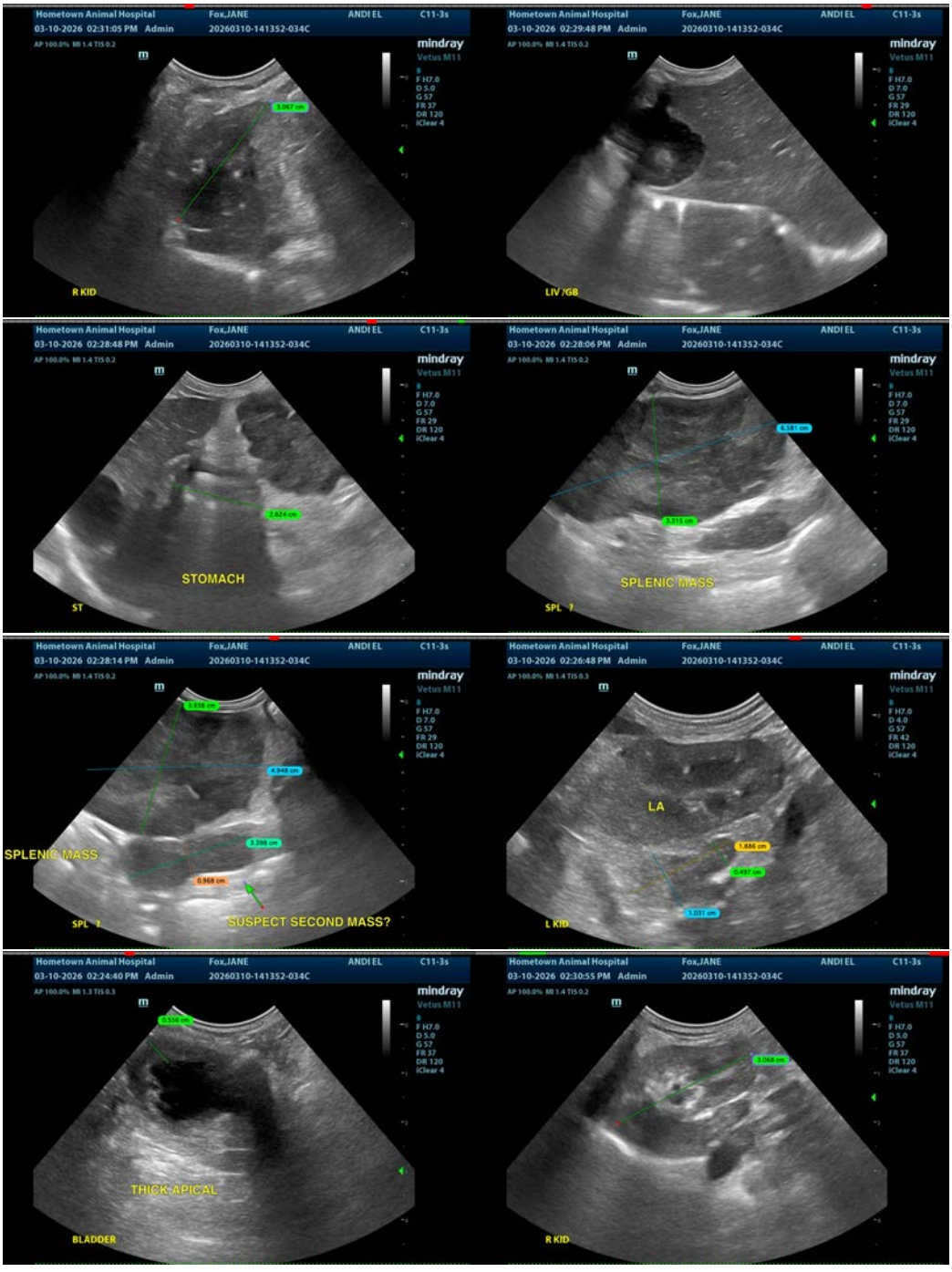

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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