

**PATIENT PRESENTING CLINICAL SIGNS**

Chevy Moore Presented for vomiting and lethargy since last night. - Ate around 5pm, snack at 8pm -Vomited white foam with undigested kibble at 11 pm, a few time since with white foam, no kibble -Owner unsure if drank anything since 11pm -Wandered into neighbour's yard, may have eaten something -Is a dog that will eat things (mainly sticks and food items) -Uncomfortable upon palpation of cranial abdomen meds: Trilostane 10mg, Apoquel 4mg (none given today yet)

**SPECIES**

Canine

**BREED**

CKCSX

**SEX**

Neutered Male

**AGE**

11 Years

**WEIGHT**

10.4 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Kelly Reschny

**HOSPITAL NAME**

Buck Animal Hospital

**REFERRING VET**

Dr. MacFarlane

**INVOICE**

36829

**DATE**

4/13/22

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is mildly/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, or masses. There are small, somewhat pinpoint mineralizations visualized in the dependent portion of the urinary bladder measuring 0.14 cm, 0.20, 0.16 cm, most consistent with very small stones. Recommend urinalysis and culture and correlate with radiographs.

The prostate is normal in size (0.89 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 (5.31 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (6.1 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 0.77 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.

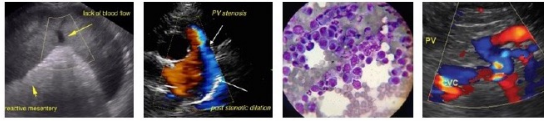
The right adrenal gland is large in size measuring 1.63 cm at the cranial pole, 1.24 cm at the caudal pole, and 3.17 cm in length. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is somewhat abnormal in appearance, in that the cranial pole of the right adrenal gland is very large and hyperechoic, creating a nodule type effect. There is no obvious evidence of vascular invasion visualized.

**Spleen**

The spleen is subjectively normal in size, 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 normal in size, and echogenicity with smooth peripheral 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 is a 1.11 cm hyperechoic nodule visualized within the parenchyma.



**PATIENT**

Chevy Moore

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

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**Gastrointestinal**

The stomach is dilated with a moderate to large amount of 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.

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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.

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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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**

**WEIGHT**

10.4 kg

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**

**INTERPRETED BY**

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

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.

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PERFORMED BY**

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**ULTRASONOGRAPHIC FINDINGS**

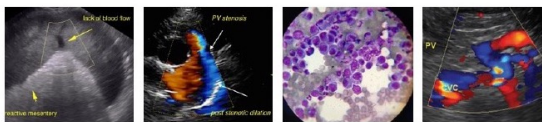
- Pinpoint bladder stones visualized - Recommend urinalysis and culture and radiographs to help correlate the size of these lesions.
- Mildly heterogeneous liver with hyperechoic nodule - The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.
- Moderate amount of shadowing material within the gastric lumen - could be consistent with ingesta (kibble, etc.), or with ingested foreign material. Differentials would include delayed gastric emptying or partial gastric outflow obstruction. Correlate with serial abdominal radiographs.
- Right adrenal mass -Right adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The stomach appears persistently dilated with ingesta. No obvious obstructive process is visualized, but this shadowing material does impair visualization of the pyloric outflow tract somewhat. Recommend serial radiographic evaluation to see if the stomach is emptying. If ingesta is retained, then concern for an obstruction or gastric ileus is much higher.

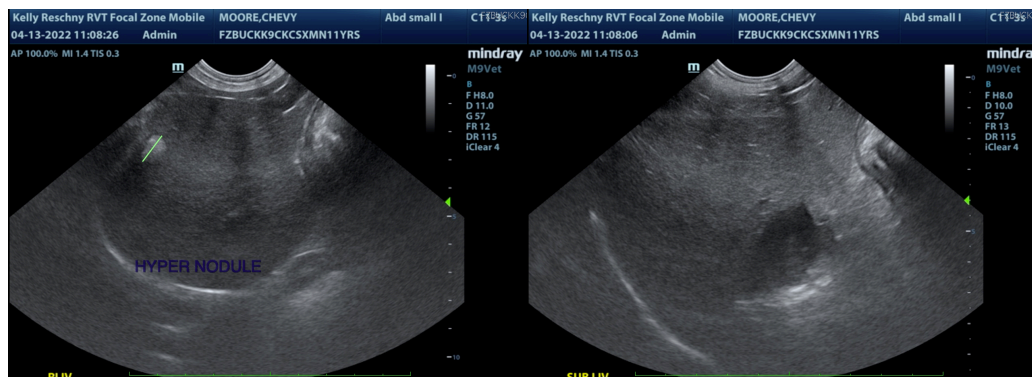
There are small pinpoint stones visualized within the urinary bladder. These are likely asymptomatic at this time, but are small enough to potentially obstruct the urethra. I believe these stones are evident on the radiographs submitted. Recommend urinalysis and culture.

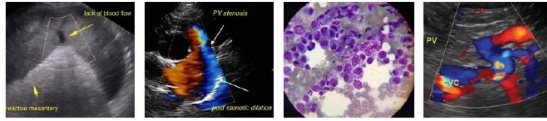
There is a mass present involving the right adrenal gland. This mass is irregular. I do not see evidence of clear vascular invasion, but this is still possible. These masses can be benign or malignant and can secrete hormones or be non-active.

This pet is currently on trilostane for cushings. If this adrenal mass has already been identified then options are surgical (typically more effective) or medical. If the mass is new information then this could be PDH with a mass or more likely adrenal dependent HAC. I suspect this is not associated with the vomiting reported. Options moving forward could include:

- If adrenal dependent cushings is suspected consider continued medical therapy with lysodren or trilostane and/or consider surgical removal (recommend referral to a board certified veterinary surgeon and possible pre op CT)-This can be a challenging surgery with significant risk for complication
- Recommend blood pressure evaluation-if hypertensive consider testing catecholamine levels for a possible pheochromocytoma
- Due to the invasive nature of these masses a CT scan is recommended to evaluate for metastasis and vascular invasion.
- Some aggressive adrenal tumors can grow quickly and there is risk for acute hemorrhage from vascular invasion.

In this dog I would recommend a CT scan (to evaluate for vascular invasion) and consideration for surgical removal as this has the potential to remove a cancerous lesion and resolve the HAC. But unfortunately risks are involved. Recommend 3 view thoracic radiographs.





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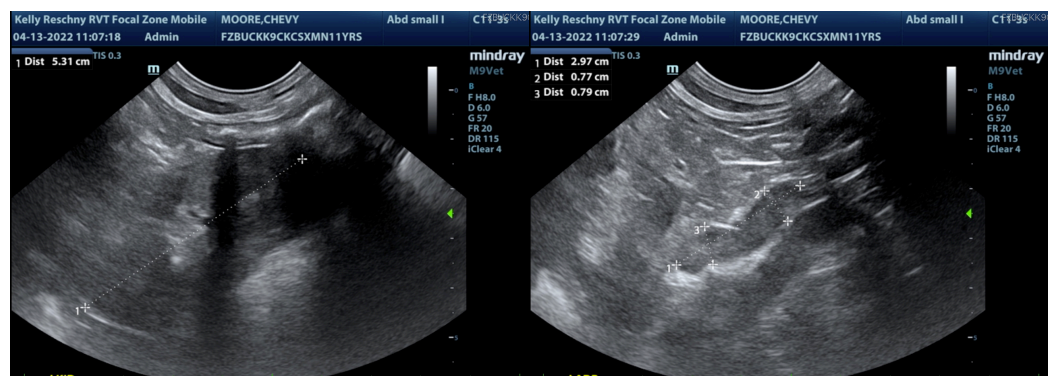
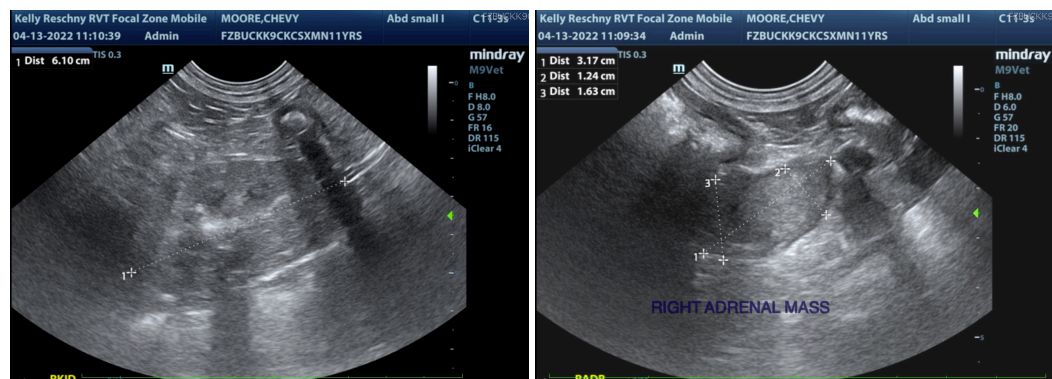
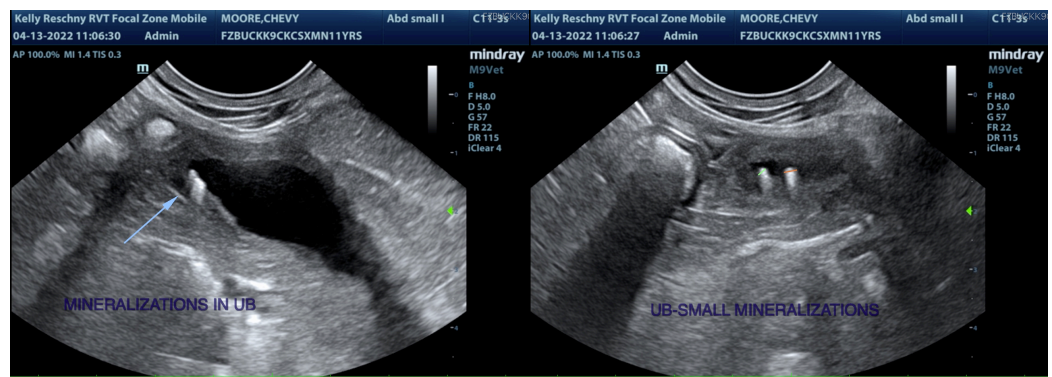
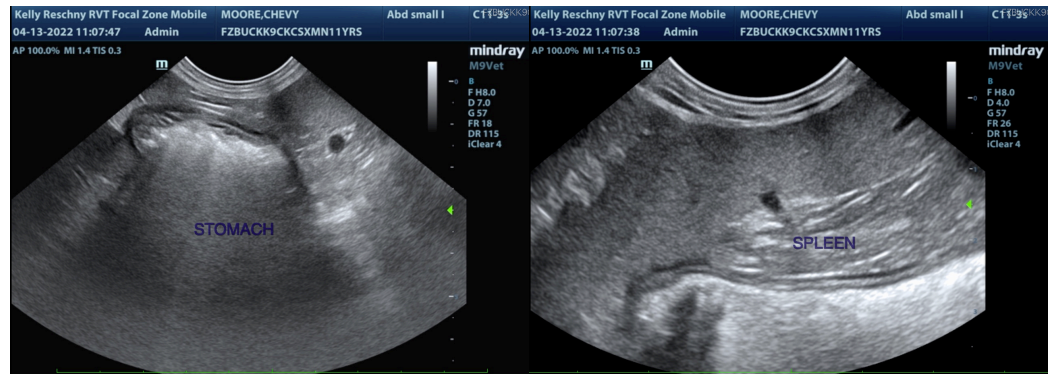
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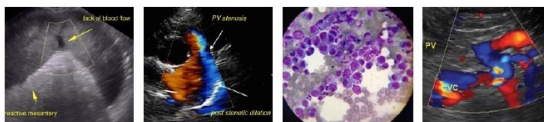
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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)

kathleen.sennello@sonopath.com

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