



PATIENT

Rusty Cheesebrew

SPECIES

Canine

BREED

Cavalier King Charles
Spaniel

SEX

MN

AGE

10

WEIGHT

20.4

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Reyes

HOSPITAL NAME

Graceful Paws Pet
Clinic

REFERRING VET

Dr. Reyes

INVOICE

11842

DATE

4/30/2026

PRESENTING CLINICAL SIGNS

History of PU/PD, panting and hair loss. On PE a 1.45 x1.42 cm mass was found on perineal area. Cytology showed: apocrine gland anal sac adenocarcinoma. Concerned for Cushing's disease but also screening abdomen.

Abnormal PE/Chem/CBC/UA Results: CBC Neut: 12.635 Mono: 1.073 Chem Tco2: 30 ALT: 448 AST: 65 ALP: 1,460 GGT: 130 Chol: 653 Lip: 809 UA: SG: 1.017 Protein: 1+ bacteria: marked rods T4: wnl 4Dx: negative Cytology: INTERPRETATION: Consistent with an apocrine gland anal sac adenocarcinoma.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears mildly diffusely thickened and slightly irregular measuring at 0.41 cm. In the dependent portion of the urinary bladder, there are multiple hyperechoic shadowing stones. Examples measure 0.35 cm, and 0.33 cm. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass, lesions, or calculi.

The prostate is normal in size (0.59 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 (4.96 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 (5.15 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

There's a large hypoechoic mass effect in the region of the left adrenal measuring 3.11 cm in diameter, most consistent with a left adrenal mass lesion. No evidence of vascular invasion is visualized at this time.

The right adrenal gland was not clearly visualized.

Spleen

The spleen is subjectively normal in size (0.84 cm) 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. No focal parenchymal abnormalities are visualized.

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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. There are numerous pinpoint hyperechoic foci throughout the parenchyma, most consistent with dystrophic mineralization.

The gall bladder lumen is significantly distended. Some areas of the wall appear thickened with adherent debris. Some areas have early mucosal stranding and organization of the debris into an early mucocele. Some of the debris is mineralized, consistent with sandy debris/small choleliths. There's no evidence of bile duct dilation visualized.

Gastrointestinal

The stomach is moderately dilated with large 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 to moderate fluid/chyme 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 (0.39 cm.) Visualized peristalsis appears appropriate. Areas of fluid and gas distension are most consistent with a non-fasted patient.

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, 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

- Mildly thickened urinary bladder wall with dependent cystoliths. Correlate with a urinalysis, culture and radiographs.
- Left adrenal mass lesion. Possible differentials include an adenoma, carcinoma, pheochromocytoma other.
- 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.
- Gallbladder mucocele with mineralized intraluminal material/small choleliths.



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- Fluid/chyme distended stomach and small intestine. Findings are most consistent with post-prandial patient. FI the patient was adequately fasted this could represent gastrointestinal ileus.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large hypoechoic mass effect in the region of the left adrenal gland. This is concerning for a true mass lesion. Based on the symptoms described, there would be concern that this is secreting hormone. Recommend adrenal function testing and a blood pressure evaluation. If hypertension is present, recommend measuring catecholamine levels looking for a possible pheochromocytoma.

The liver is large and heterogenous. Most consistent with a vacuolar hepatopathy, although other hepatopathies are possible. If further evaluation is desired, consider a fine needle aspirate of the liver.

The gallbladder has a large amount of intraluminal debris which appears somewhat mineralized and adhered to the gallbladder wall with some mucosal stranding. Concerning for an early gallbladder mucocele with some mineralization. Recommend starting ursodiol therapy and treatment for cholecystitis. While evaluating other medical issues, as a cholecystectomy may be warranted in the future.

There are numerous small stones visualized in the urinary bladder. Correlate with urinalysis, culture, and radiographs to better assess the number and size of stones present. If an infection is present these may be struvite stones and there could be the option for medical dissolution. Interpret these findings in light of the urinalysis to try and assess medical versus surgical options for management.

Recommend a contrast CT scan to further evaluate the left adrenal mass lesion for possible surgical removal. This would also further evaluate the gallbladder to try and make a medical and surgical plan for this individual.

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

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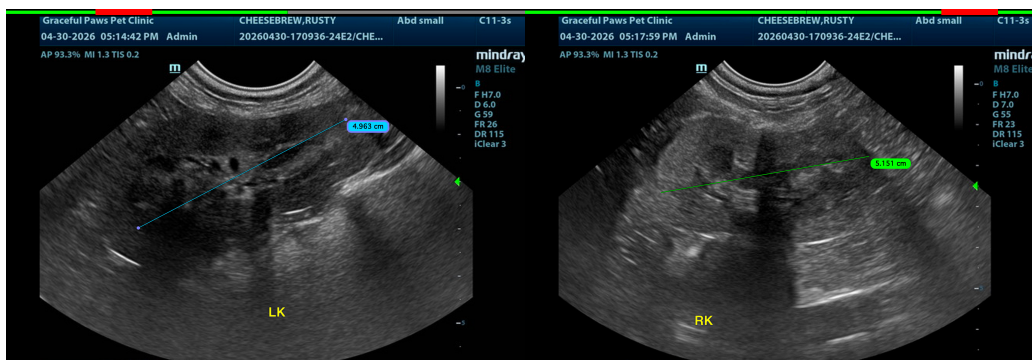
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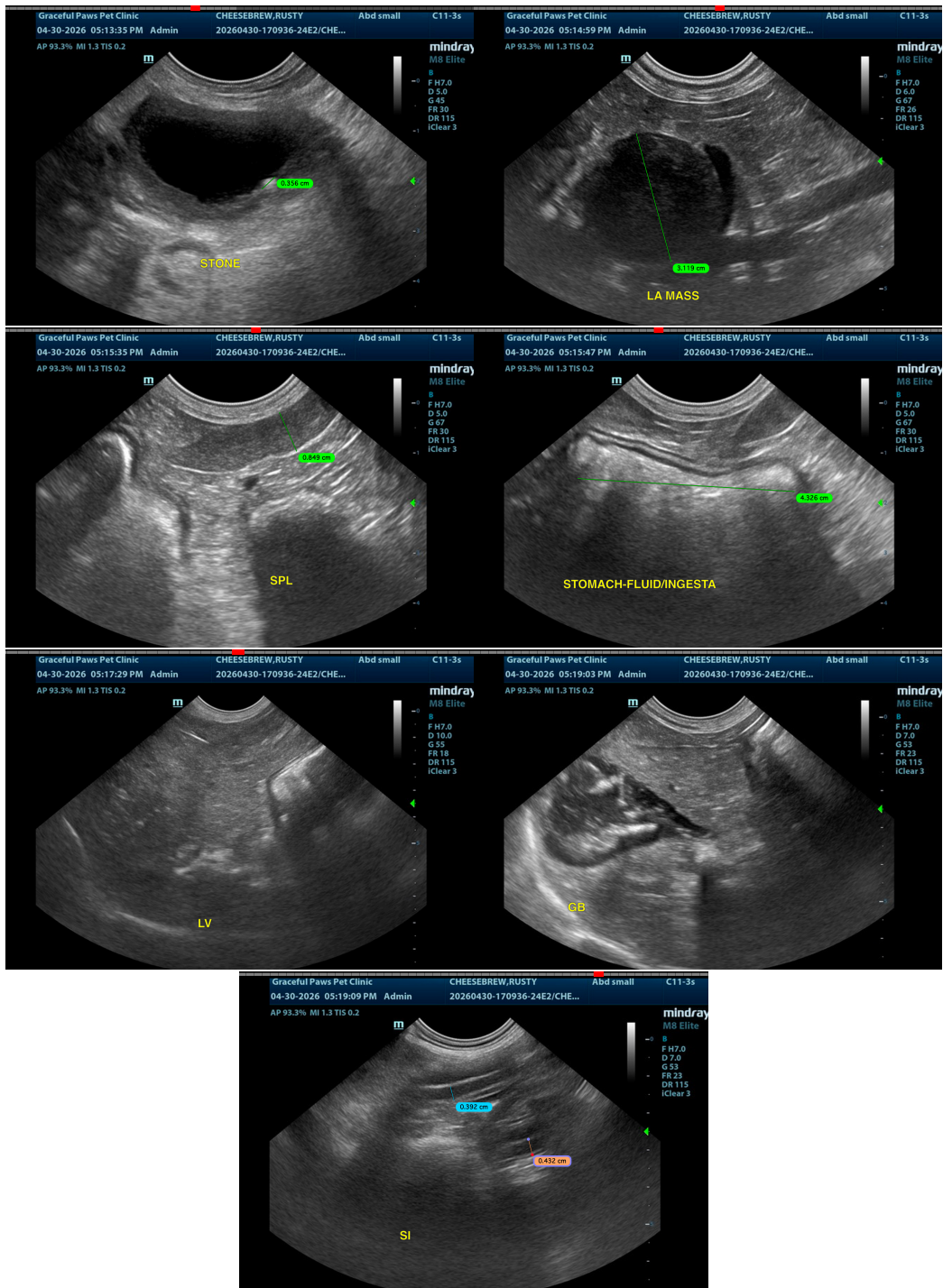
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.



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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)

info@sonopath.com