PATIENT

Teodolfo Cornfoot

SPECIES

Canine

BREED

Maltese

SEX

MN

AGE

11 years

WEIGHT

18.3 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Fairgrounds AH

REFERRING VET

Dr. RCK

INVOICE

12009

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5/27/2026

PRESENTING CLINICAL SIGNS

P is still PU/PD. BCS 6 – Overweight. 101body temp. Pulse 130. Resp 40. MM Pink/Healthy. CRT <2 sec. Dental 2 – Mild. Appetite 1 – None. NPO for sx. Attitude BAR SUMMARY FOR AUS: FEB 2026- PT was seen for being PU/PD and urinating in the house, which O reported was unusual for the PT. PT has a hx of appearing potbellied as well as incipient cataracts, iris atrophy, nuclear sclerosis and asteriod hyalosis and dental disease. Clin path abn include several years of persistent reticulocytosis without anemia, hyperproteinemia and hyperglobulinemia, mild and mildly elevated ALP (see attached labs). Discussed possible dif dx with O such as Cushing's dz, neoplasia (hepatic, adrenal, splenic, other.)

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 (0.69 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 (4.56 cm). Overall echogenicity is slightly hyperechoic with poor 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 (4.81 cm). Overall echogenicity is slightly hyperechoic with poor 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 in size and irregular in shape, measuring 1.46 cm at the cranial pole and 0.41 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 and rounded, consistent with a nodule measuring 1.33 cm x 1.57 cm. No evidence of vascular invasion is visualized.

The right adrenal gland is large in size, most consistent with a mass effect visualized measuring approximately 3.15 cm. This is visualized cranially between the right kidney and the caudal vena cava. No definitive evidence of vascular invasion is visualized. It measures 3.15 cm in diameter.

Spleen

The spleen is subjectively normal in size and slightly irregular in shape. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a small rounded, hypoechoic nodule at the tail of the spleen measuring 1.09 cm in diameter.

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The liver is large in size with rounded margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is a small mixed echogenicity nodule visualized in the left side measuring 0.93 cm x 1.23 cm.

The gall bladder lumen is significantly distended. The wall is prominent and hyperechoic measuring at 0.29 cm with adherent debris and there is organization and stranding of this debris into a mucocele. There is minimal surrounding inflammation and no obvious free fluid observed. The bile duct is normal/not visible. Findings are consistent with a mucocele. Consider close monitoring and initial medical management

Gastrointestinal

The stomach contains minimal luminal contents. 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 (0.27 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 visible/mottled in the right limb. 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.

Other

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

There is a large, hypoechoic mass effect visualized just caudal to the cystourethral junction measuring 1.4 cm x 1.9 cm. This is in the region of the prostate but does not appear to have a visualized association with the prostate. Possible consistent with a large lymph node or other mass effect.

PRIMARY FINDINGS

- Hypoechoic nodule in the cranial pole of the left adrenal gland. Possible differentials include an adenoma, carcinoma, pheochromocytoma, other.

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- Hypoechoic splenic nodule at the tail of the spleen. There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Large heterogenous, rounded liver with an ill-defined mixed echogenicity nodule. 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. The mixed echogenicity nodule has the appearance most consistent with a benign lesion, but an early neoplastic lesion cannot be ruled out.
- Mature gallbladder mucocele with a thickened prominent gallbladder wall.
- Suspect right adrenal mass lesion. Based on the size of this lesion, there would be increased concern for a neoplastic process such as a carcinoma or a pheochromocytoma. Other differentials are possible.
- Caudal pelvic enlarged lymph node/mass effect. Recommend a digital rectal exam to evaluate for anal gland mass lesions, or to see if this lesion is palpable.

SECONDARY FINDINGS

- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with chronic pancreatic remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both adrenals have lesions; the left adrenal cranial pole is enlarged. Based on the relatively mild enlargement a benign lesion would be more likely although an early neoplastic lesion cannot be ruled out. In the area of the right adrenal gland there is a larger mass effect. Based on the size of this lesion a neoplastic lesion would be much more concerning. Recommend a blood pressure evaluation. If the patient is hypertensive, consider measuring catecholamine levels looking for possible pheochromocytoma. Additionally, consider adrenal function testing looking for a possible cortisol excess.

There's a hypoechoic nodule in the spleen. This could represent a benign or an early neoplastic lesion. This is a very peripheral lesion which could increase concern for possible rupture, but it is small at this time. Options include continued monitoring or a fine needle aspirate.

The liver is large, heterogenous, and rounded. These changes could represent a vacuolar hepatopathy although other hepatopathies such as cholangiohepatitis, etc. are also possible. Consider a fine needle aspirate of the liver.

The gallbladder has a large amount of intraluminal debris which is starting to organize into a mucocele, and the wall appears hyperechoic and mildly thickened. There is no evidence of significant surrounding inflammation at this time. Recommend starting ursodiol therapy and consider denamarin, and antibiotic therapy. Ideally, this would be surgically removed but given the other medical issues, a comprehensive plan will need to be determined.

If not already done, recommend Three View Thoracic radiographs.

Ultimately, a contrast CT scan would be strongly recommended for this patient. This would allow

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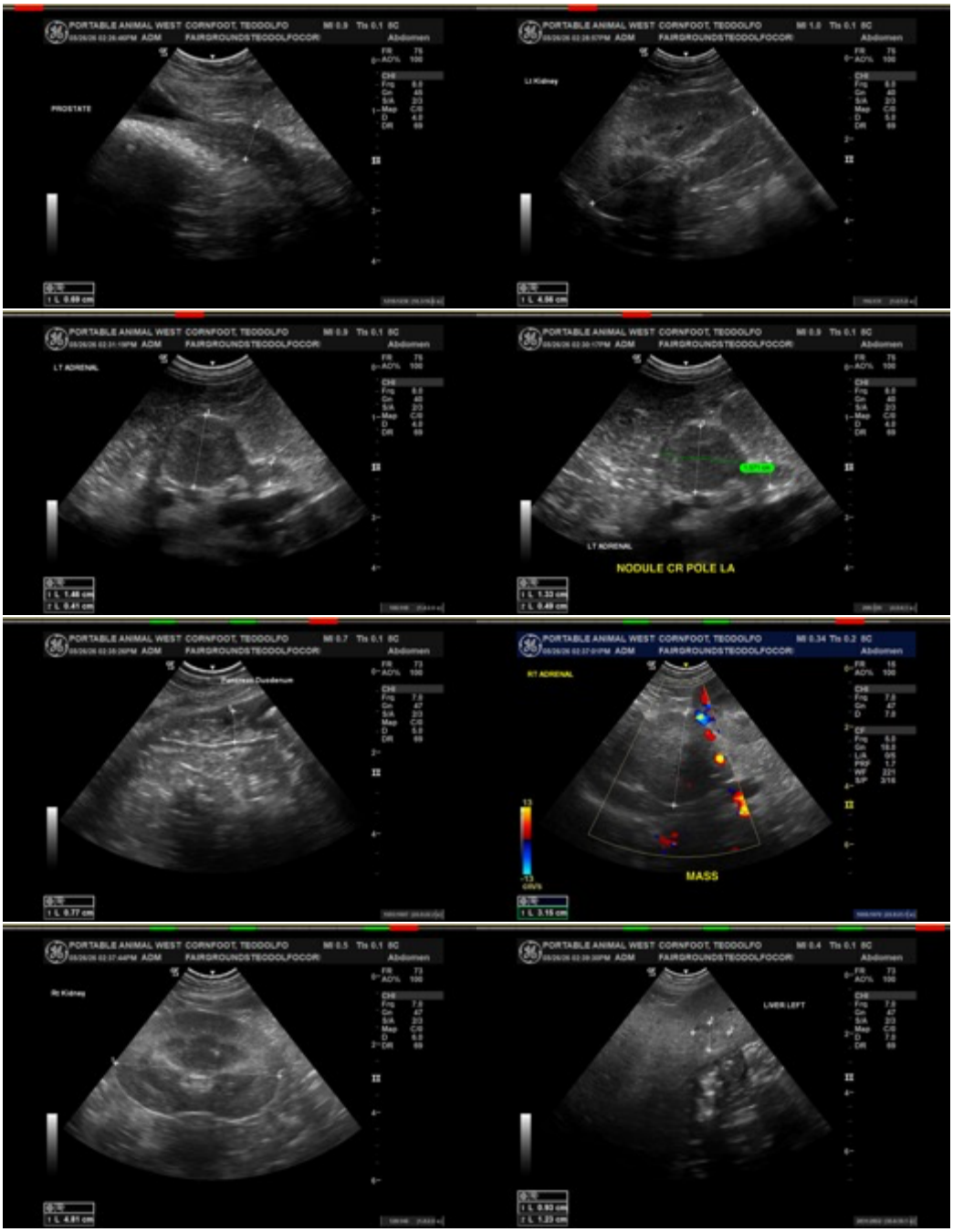
further assessment of both adrenals for possible vascular invasion and surgical removal (rarely both can be removed or possibly the larger lesion) at the same time, this would allow for further evaluation of the gallbladder, splenic lesion, and the caudal abdominal mass effect/lymph node. A fine needle aspirate of the caudal abdominal/pelvic lesion should be considered.



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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