



PATIENT

Petey Dennison

SPECIES

Canine

BREED

Beagle

SEX

Spayed Female

AGE

12 Years 8 Months

WEIGHT

27 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. John Ammeraal

HOSPITAL NAME

Sova Animal Hospital

REFERRING VET

Dr. John Ammeraal

INVOICE

24599

DATE

8/12/21

PRESENTING CLINICAL SIGNS

Presenting for exam , has had less energy lately, Pendulous abdomen , awaiting urine results . Getting pickier w food as well

Abnormal PE/Chem/CBC/UA Results: ALKP 861 U/L, ALT 583 U/L, GGT 304 U/L, Chol: 713 mg/dL
Glucose 143 mg/dL T4: < 0.5 ug/dL , Free T4 8.3 CBC: Monocytes 732/uL, Neutr 10436/uL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. There are at least two small focal mass effects in the bladder wall, more towards the apical portion of the bladder, one measuring 1.0 cm x 0.56 cm, the other measuring 1.3 cm x 0.65 cm. Additionally, there is a very small irregularity more cranial in the bladder. The 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 (1.05 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. (See notes under secondary findings)

The left kidney has a normal shape and size (5.88 cm). Overall echogenicity is slightly hyperechoic with poor 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 (5.54 cm). Overall echogenicity is slightly hyperechoic with poor 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 large in size measuring 1.14 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 1.15 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, 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 heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is an ill-defined, irregular, slightly cystic mass effect measuring 3.8 cm x 1.88 cm visualized.

The gallbladder lumen is significantly distended. The wall of the gall bladder appears mildly thickened and has a slightly irregular mucosal surface. There is a moderate amount of non-organized debris



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present, but some hyperechoic stranding, consistent with early organization of debris. The cystic and common bile ducts are normal/not visible. There is no surrounding inflammation.

Gastrointestinal

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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.

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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.

SEX

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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.

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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.

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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.

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PRIMARY FINDINGS

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- Large, heterogeneous liver with ill-defined mass effect – 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.
- Bilateral adrenomegaly – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.
- Two (possibly three) very small, focal bladder masses – likely consistent with an early TCC, but cannot rule out other neoplasia or benign polyps.
- Mildly mottled spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

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SECONDARY FINDINGS

- Decreased corticomedullary distinction in both kidneys – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

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- Suspect normal prostate observed – History reports that Petey is a female. If this is true, this could be thickened urethra.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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I suspect this patient has pituitary dependent hyperadrenocorticism based on the appearance of the liver and the adrenal glands. A cause for the reduced appetite is not clearly evident. This can happen with some PDH patients if they have a pituitary macroadenoma. Advanced imaging (i.e., CT scan) of the brain would be necessary to evaluate for this. Otherwise, consider a liver function test and fine needle aspirate of the abnormal tissue in the liver.

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Additionally, there are 2-3 suspected bladder masses. They are small and may be difficult to sample. Consider BRAF mutation testing. If BRAF test is positive, I would be suspicious for a TCC, and consider consultation with a veterinary oncologist. If BRAF test is negative, this is non-diagnostic and does not rule out the possibility of a TCC. With ultrasound guidance, a traumatic catheterization could be performed as an alternative. Also consider urinalysis and culture to rule out inflammatory polyps due to chronic UTIs. Recommend starting Ursodiol for the bladder and continued monitoring.

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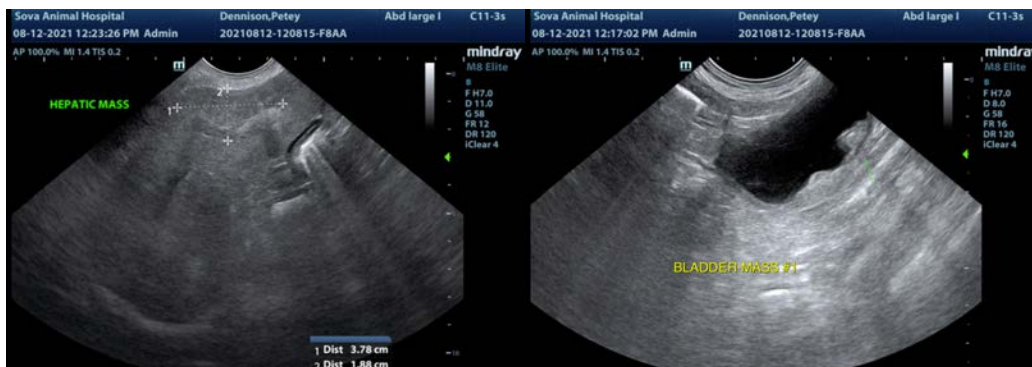
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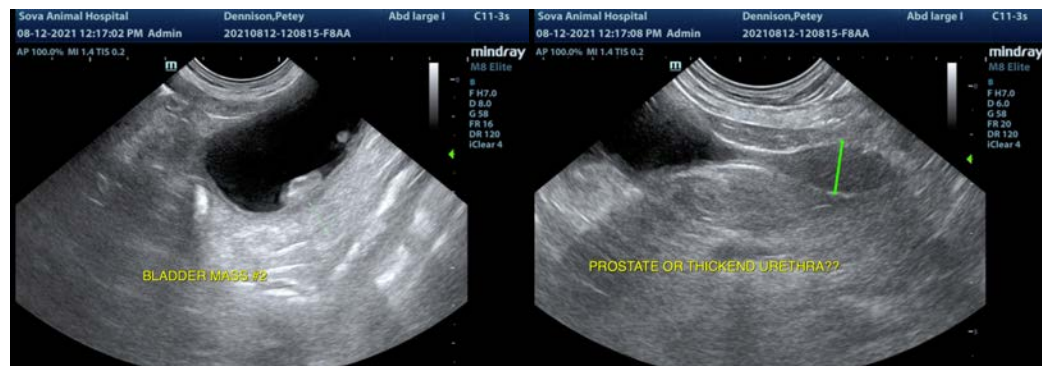
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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