



**PATIENT PRESENTING CLINICAL SIGNS**

Wrex Grieser Lethargy, Reverse Sneezing, Bloating Abdomen, Swallowing Hard-SEDated 0.05ml dex/torb IV- MEDS Clavamox 500mg/125mg 1 bid, Neo/Poly/Dex Oint Both eyes BID, Cerenia 60mg SID PRN, Gabapentin 300mg 1 eveyr 8-12 hours, Hills I/D- Working diagnosis Pancreatitis, Dehydration, Reneal Disease

**SPECIES**

Canine Abnormal PE/Chem/CBC/UA Results: Elevated TP 8.4, Elevated Glob 5.3, Elevated ALT 335, Elevated ALKP 1579, Chol Elevated 336, Snap CPL Positive

**BREED**

German Shepherd X

**SEX**

Neutered Male

**AGE**

11 Years

**WEIGHT**

29.6 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Loetitia Saint-Jacques, LVT

**HOSPITAL NAME**

Peavine AH

**REFERRING VET**

Dr. Redshaw

**INVOICE**

44673

**DATE**

8/15/23

**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 (1.03 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 (8.15 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.

The right kidney has a normal shape and size (7.3 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. There is a somewhat cystic hypoechoic lesion visualized in the caudal pole measuring approximately 0.94 cm x 0.90 cm, most consistent with a complex renal cyst or a nodule.

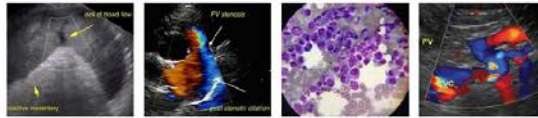
**Adrenal Glands**

The left adrenal gland is large and irregular, measuring 0.79 cm at the cranial pole, 1.25 cm at the caudal pole, and 3.46 cm in length. It is observed in its normal position cranial to the left renal artery. It is abnormal in appearance in that there is an irregular hyperechoic nodule at the caudal pole measuring approximately 1.3 cm x 2.45 cm. The phrenicoabdominal artery and vein do not show evidence of blood flow on color doppler, increasing concern for possible vascular invasion in this region.

The right adrenal gland is normal in size measuring 0.71 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.


**PATIENT** *Liver*

Wrex Grieser

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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 a large, hyperechoic, solid mass effect visualized dorsal to the gallbladder on the right side measuring 5.97 cm x 7.37 cm. Additionally, there is an ill-defined hypoechoic nodule measuring 2.27 cm x 4.06 cm.

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

***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. Duodenum wall measures 0.49 cm. Jejunum wall measures 0.37 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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***

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. There are two large, irregular, hypoechoic, heterogeneous mass effects in the region of the sublumbar lymph nodes. The left side measures 3.77 cm x 5.73 cm. The right measures 4.38 cm x 5.04 cm. The omentum is generally of normal echogenicity.

**ULTRASONOGRAPHIC FINDINGS**

- Large, irregular, hyperechoic nodule associated with the caudal pole of the left adrenal with possible early vascular invasion – Adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other. Definitive invasion is not visualized but there is reduced blood flow visualized associated with the phrenicoabdominal artery and vein.
- Large, hyperechoic, solid hepatic mass lesion and a poorly defined hypoechoic lesion – The hyperechoic lesion visualized is most consistent with a primary hepatic mass lesion based on its size (adenoma, carcinoma, etc.), although a metastatic lesion cannot be ruled out. The significance of the hypoechoic lesion is uncertain. It generally appears less defined and less significant. Continued monitoring is warranted.



**PATIENT**

Wrex Grieser

- Cystic hypoechoic lesion visualized in the caudal pole of the right kidney – Findings could be consistent with a complex benign renal cyst or an early nodule.

**SPECIES**

Canine

- Severely enlarged sublumbar lymph nodes – Findings are highly concerning for a neoplastic/metastatic lesion. Recommend a fine needle aspirate.

**BREED**

German Shepherd X

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The sublumbar lymph nodes are significantly enlarged, creating two mass lesions. These findings are highly concerning for possible anal gland carcinoma or other neoplastic lesion involving the caudal aspect/pelvic limbs of the patient. Recommend a rectal exam and further examination of these regions. A fine needle aspirate of the sublumbar lymph nodes could be considered if a primary lesion is not readily identified.

**SEX**

Neutered Male

There is a hyperechoic nodule visualized associated with the left adrenal gland. This is irregular and there is questionable early vascular invasion. This could represent a primary adrenal mass lesion, benign or neoplastic. It also could represent a metastatic lesion. Options moving forward for further evaluation would include a contrast CT scan, and even adrenal function testing, but this would be very difficult to interpret in light of the concurrent systemic disease.

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There is a large hyperechoic mass effect visualized associated with the liver. This has the appearance most consistent with a primary hepatic mass lesion, although a metastatic lesion cannot be ruled out. This lesion is likely too deep to easily aspirate.

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Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

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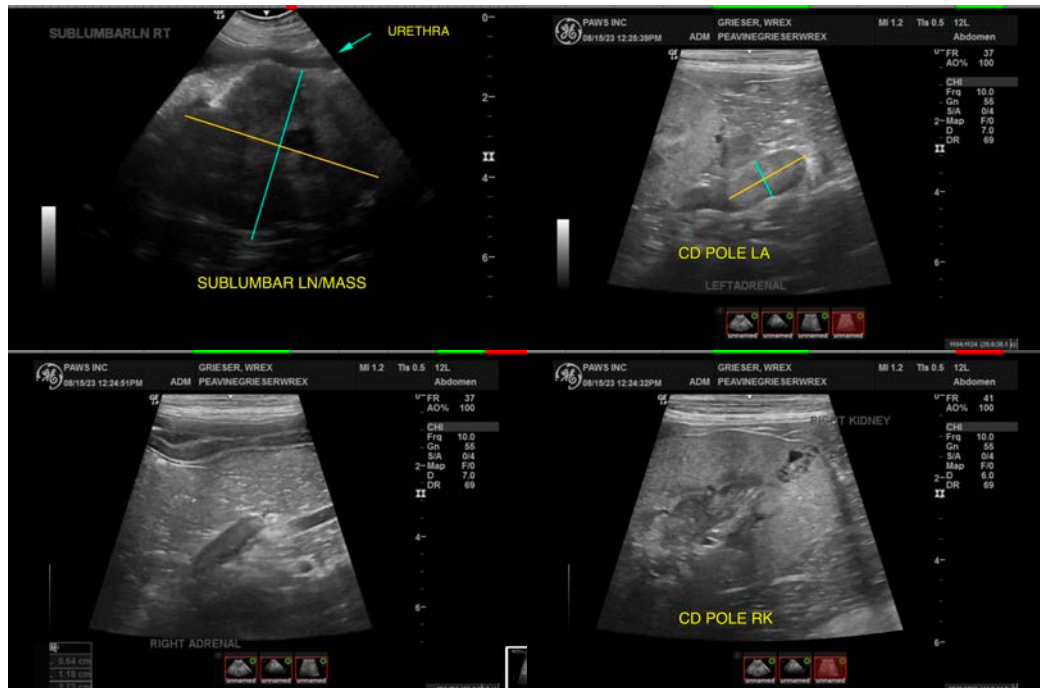
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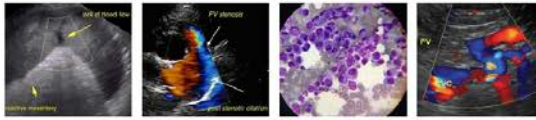
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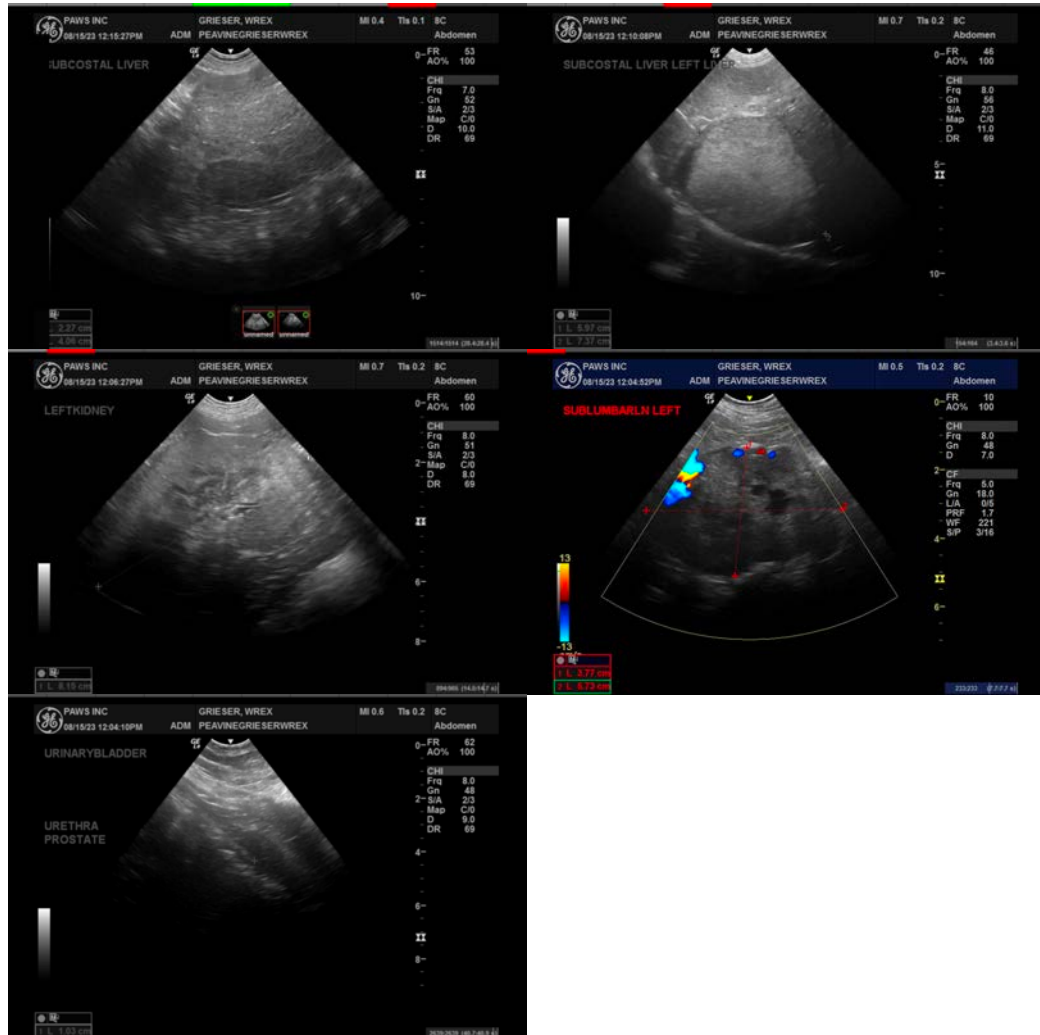
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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