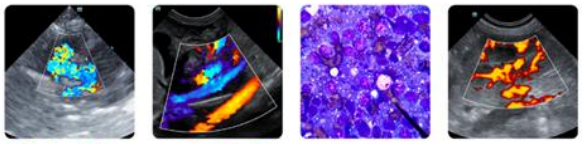


PATIENT

Millie Cummins

SPECIES

Canine

BREED

Husky Mix

SEX

FS

AGE

10.5yr

WEIGHT

21.1kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Lindsay Powell, CVT

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Brittany Lang

INVOICE
22327

DATE
12/23/2025

PRESENTING CLINICAL SIGNS

presented 12/22 PM for acute onset of vomiting, lethargy, painful abdomen, weakness in her hind end Mucous membranes pale pink/hypersalivating tachycardic Tense, painful on cranial abdominal palpation slow to rise in hind limbs, mild muscle atrophy hind limbs delayed CPs bilateral hind limbs POCUS: No free fluid appreciated CBC: HCT 48.6%, Reticulocytes 159.8K Chem: Glu 237, ALT 127, GGT 30 EPOC: pH 7.309, BE -7.5, K 3.3, Lac 7.36, Glu 232, HCT 43% CPL: WNL

Abnormal PE/Chem/CBC/UA Results: Rads: 1. Small amount of gastroesophageal reflux, secondary to lateral recumbency +/- sedation. Otherwise normal thorax. 2. Retroperitoneal soft tissue opacity/fluid causing a mass effect, differential diagnosis: This is likely secondary to hemorrhage or less likely urine within the retroperitoneal space. Hemorrhage may originate from a ruptured neoplastic process, e.g. adrenal gland tumor (e.g. pheochromocytoma) or renal neoplasia. A retroperitoneal neoplasia is considered less likely. Rupture of a vessel, e.g. secondary to tumor is considered less likely as there is no history of trauma. Ureteric rupture is also considered less likely for the same reasons. NiBP: 100/70 (79)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.1 cm in length. The right kidney measured 5.8 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

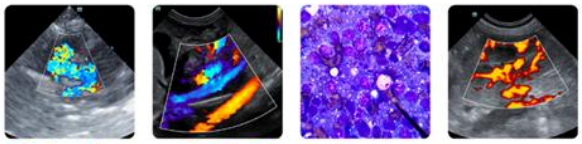
The right adrenal gland was indistinctly visualized owing to increased periadrenal to retroperitoneal artifact. The right adrenal gland possibly measured 0.57 cm caudal pole width. The left adrenal gland was not definitively visualized owing to left retroperitoneal mass.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

Liver/Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Normal vascular volume. The hepatic



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and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild non-shadowing ingesta sonographically suggestive of food echogenicity with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen/Retroperitoneal Space

A moderately sized to caudally expanding non-homogenous retroperitoneal mass was present primarily adjacent to and caudal to the left kidney extending to the approximate level of the cranial urinary bladder measuring ~ 8 cm in diameter but likely larger as the entire mass would not fit into a single viewing window.

Associated primarily left to mild right retroperitoneal effusion was present with concurrent mild volume peritoneal effusion.

No obvious visualized significant mid-abdomen mesenteric lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

Primary

- Retroperitoneal mass with associated retroperitonitis.
- Intact age related renal changes.
- Sonographically unremarkable spleen.
- Normal non-congested liver.
- Normal gastrointestinal tract with mild non-shadowing gastric ingesta.
- Concurrent mild volume peritoneal effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The retroperitoneal mass is highly suggestive of neoplastic criteria with non-specific inflammation, consolidated abscess or non-obvious / non-reported trauma or other non-neoplastic etiology thought less likely. Under sedation and assuming normal clotting status, mass FNA cytology could be considered for further clarification.

Thoracic radiographs suggested if not done. No evidence of definitive ureteral pathology given no evidence of left or right pyelectasia or hydronephrosis. If possible or for further clarification an abdominal CT could be considered.

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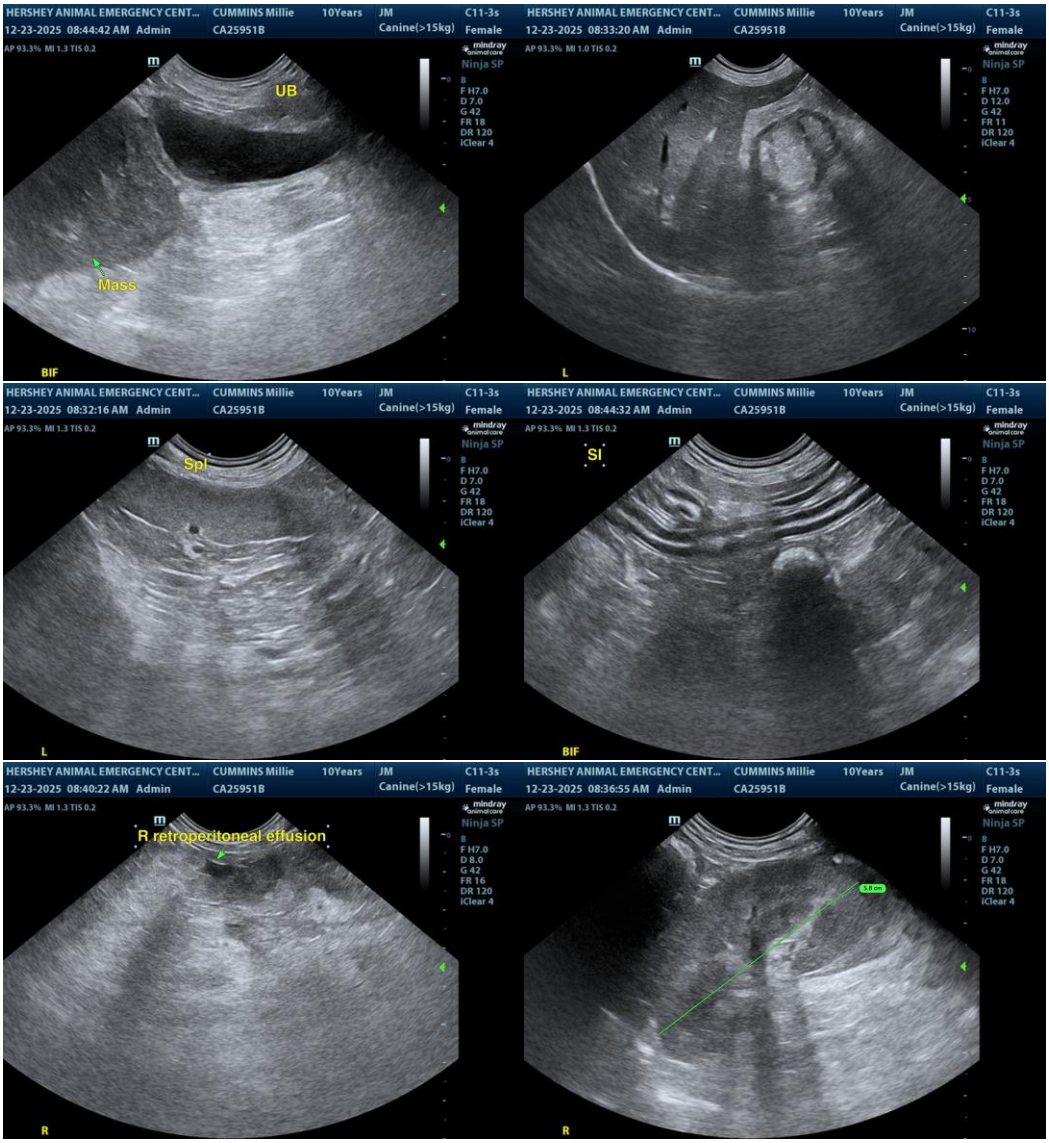

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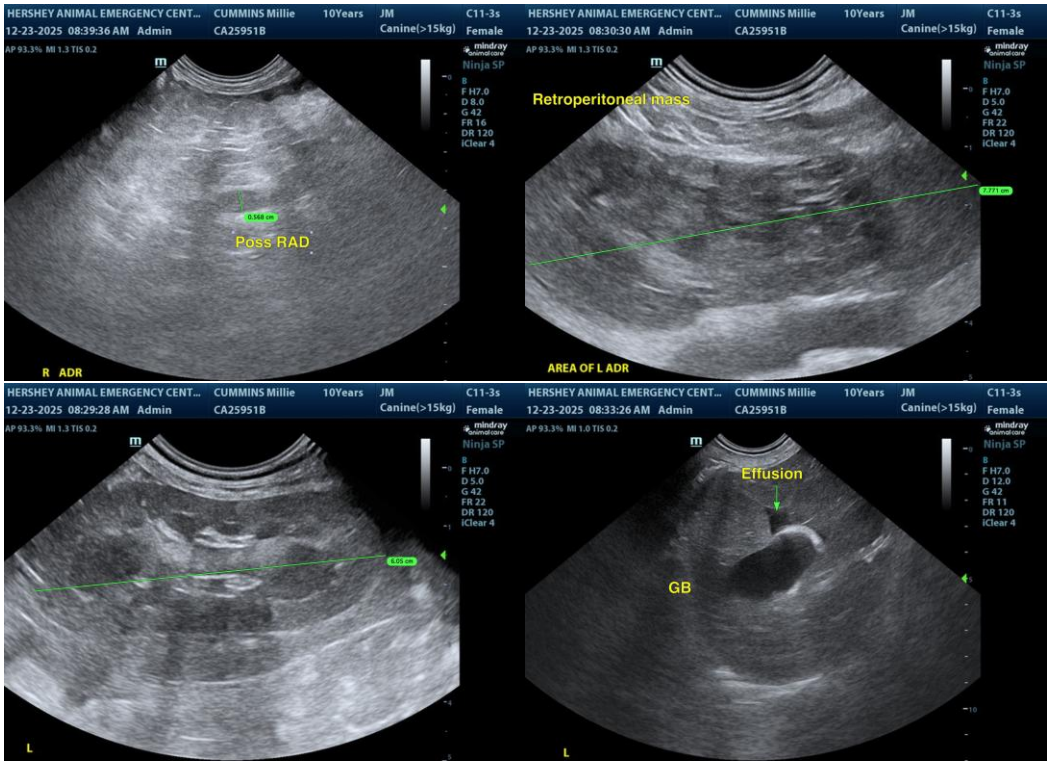

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com