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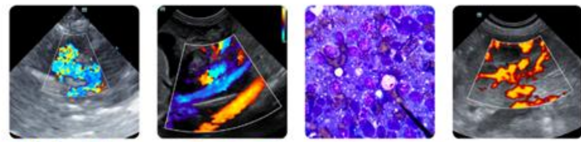


Clinical Sonography & Telecytology

Educational Teleconsultation Services™

PATIENT

Buddy Sims

SPECIES

Canine

BREED

Mixed Breed

SEX

MN

AGE

11yr

WEIGHT

10.3kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing, ER

REFERRING VET

Blue Pearl Wyomissing

INVOICE
23181

DATE
12/9/2025

PRESENTING CLINICAL SIGNS

AUS to further evaluate acute vomiting and anorexia. Presented laterally recumbent, tachycardic, hypotensive, hypoglycemic into the ER. Elevated LES, GGT, T.bili, Cr, and elevated WBC, and Neut. Currently hospitalized. Hx of weakness in the hind end over the past few weeks. ER stabilization: Administered 10 ml/kg bolus, Administered 1 mg/kg Cerenia, Administered 0.015 mg/kg Buprenorphine IV, Administered 1 ml/kg dextrose IV diluted 1:2, Unasyn 25 mg/kg IV TID

Abnormal PE/Chem/CBC/UA Results: ER Diagnostics: PCV/TS - 54/8.8 CBC - WBC - 22.75 x 10^3, Neut - 21.47 x 10^3, RBC - 9.11 x 10^6 Chem - ALT - too high to read, ALP >993, GGT - 92, Bili - 5.6, Glob - 4.0, BUN - 38, Creat - 2.4, BG - 66 EPOC - Creat - 2.3, BG - 57, K - 3.4, Lac - 4.11, BUN - 27 No GDV - did a right lateral on presentation

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. Minimal anechoic urine was present in the lumen with ventroapical lumen vs potentially adhered or less likely mild mural mineralization. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the residual prostate appeared normal and free of pathology.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Bilateral areas of medullary mineral and mild pyelectasia were present. The left kidney measured 5.2 cm in length. The right kidney measured 5.4 cm in length.

The area of the aortic trifurcation was free of pathology.

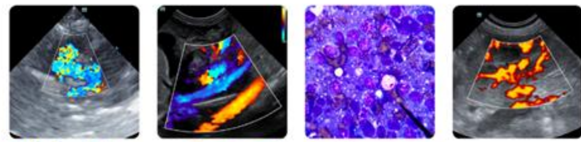
Adrenal Glands

The left adrenal gland was irregularly enlarged with non-homogenous parenchyma. Extension of the left adrenal parenchyma into the left phrenicoabdominal vein and regional caudal vena cava was present. The right adrenal gland exhibited subjective concurrent enlargement with non-homogenous to mixed echogenic parenchyma.

The left adrenal gland measured ~ 3.3 cm x 1.9 cm. The right adrenal gland measured 1.0 cm width at the caudal pole.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. 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



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

The liver was mild to moderately enlarged. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. An indistinct non-homogenous caudal intraparenchymal nodule was present measuring 2.2 cm in diameter.

The gallbladder was distended in size with echogenic thickening of the gallbladder wall. There was biliary sludge that appeared to be non-mobile and organized. A stellate pattern to the organized biliary sludge was present. Evidence of pericholecystic/cranial abdomen omental inflammation and mild volume effusion was present. The distal common bile duct was visualized mildly dilated at the level of the duodenal papilla. Overt evidence of obstructive duodenal papilla pathology was not obvious.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Subjective prominent duodenal wall with mild non-obstructive duodenal ileus.

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

Pancreas

Regional omental hyperechogenicity, inflammation or steatitis in the area of the right pancreatic limb.

Free Abdomen

No overt omental lymphadenopathy was present.

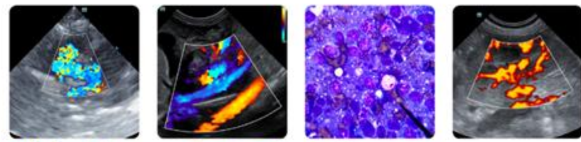
ULTRASONOGRAPHIC FINDINGS

Primary

- Bilateral adrenomegaly with left adrenal mass exhibiting vascular invasion.
- Acute on chronic hepatopathy pattern with indistinct hepatic nodule.
- Gallbladder mucocele with regional inflammation and suspect bile peritonitis.
- Mild distended distal common bile duct level of the duodenal papilla with subjective concurrent duodenitis.
- Indistinctly visualized right pancreas with peripancreatic to right cranial abdomen hyperechoic omentum - extensive peritonitis secondary to gallbladder mucocele, potential for concurrent right pancreatitis not excluded.

Secondary

- Chronic renal changes exhibiting mild medullary mineral and pyelectasia.

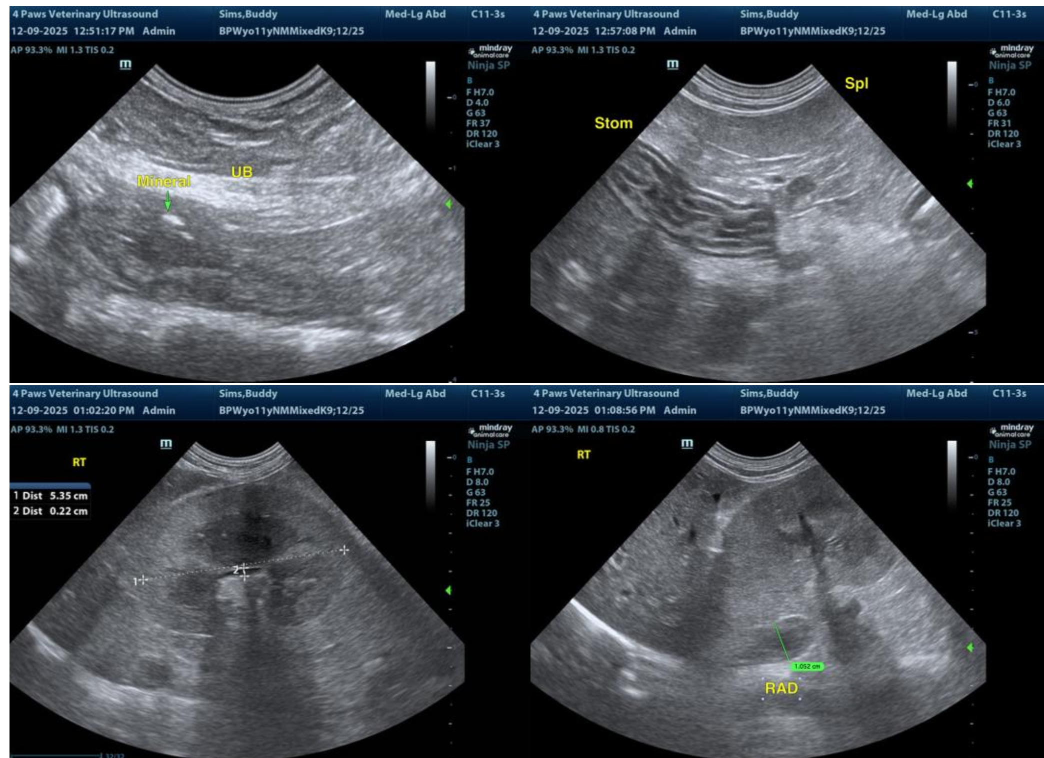


- Non-distended urinary bladder with ventroapical lumen surface possibly adhered or less likely mural mineral

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both adrenal glands appear abnormal, revealing possibility of bilateral adrenal pathology with the left adrenal gland consistent with neoplastic criteria given evidence of vascular invasion. Potential for hepatic metastatic nodule vs nodular hyperplasia or granuloma. Assuming no pathology on three view chest radiographs further evaluation with abdominal CT would be ideal.

An unfavorable prognosis even with surgical intervention probable.



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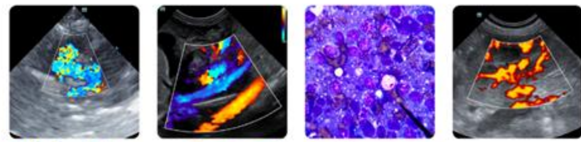

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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