



**PATIENT**

Callie Duffy

**SPECIES**

Canine

**BREED**

Staffordshire Terrier  
Mix

**SEX**

FS

**AGE**

13yr

**WEIGHT**

35.5kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Patti Mayfield DVM

**HOSPITAL NAME**

Tumalo Animal  
Hospital

**REFERRING VET**

Dr. Westbrook

**INVOICE**

13157ag

**DATE**

03/13/2023

**PRESENTING CLINICAL SIGNS**

HISTORY FROM MR: - Chronic UTIs - Anxiety - Elbow Dysplasia (bilateral) - Heart Dz- Murmur Grade II/VI, Mitral Valve Endocradosis, Myxomatous mitral valve degeneration (MVVD), Ventricular Arrhythmia - Hepatomegaly - CKD Stg 2 Current complaint: - Panting and drinking a lot. O giving meds with cold cuts. Client believes that may be cause for increased thirst. P is doing better now when P is not getting them and is not drinking that much anymore. Patient sedated with dexdomitor and butorphanol IV due to profound anxiety

Abnormal PE/Chem/CBC/UA Results: PE: -- Heart murmur, arrhythmia (previously detected as VPC's), mild dental disease, overweight (BCS: 7/9), thickened elbows with historical OA 2/13/2023: CBC: -- WNL CHEM: -- BUN: 55 mg/dL (7-27) -- ALT: 315 U/L (10-125) -- ALP: 1371 U/L (12-212 2/17/23: Free catch UA -- yellow, clear, USG: 1.026, pH: 7 -- No pyuria, no bacteriuria, no hematuria - - Inactive sediment

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder was mildly distended in size with normal tone. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were 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 to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.6 cm in length. The right kidney measured 6.6 cm in length.

The area of the aortic trifurcation was free of pathology.

**Adrenal Glands**

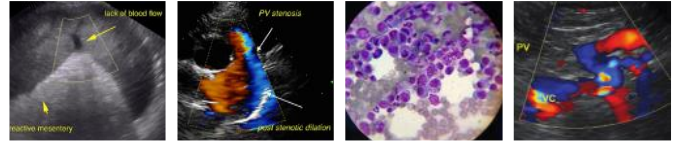
The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. Possible discrete to pinpoint dystrophic right adrenal mineralization was present, considered an age related change and incidental. No adrenal tumors. The left adrenal gland measured 2.8 cm length and 0.89 cm width in the caudal pole. The right adrenal gland measured 3.0 cm length and 0.89 cm width in the caudal pole.

**Spleen**

The spleen exhibited mild enlargement which may be secondary to sedation or patient variant. Generalized mild parenchyma heterogeneity with focal to intermittent subtly expansive to hypoechoic nodules were present, an example measured 1.3 cm in diameter. 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. No splenic masses noted.

**Liver/Gallbladder**

The liver presented enlarged in size owing to a caudally expansive symmetrical isoechoic mass/lesion extending to the level of or distal to the gastric axis measuring ~ 7-8 cm in diameter. The mass lesion was solid with no evidence of cavitation. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in



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margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content and mild non-organized echogenic debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

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**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.

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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 ileus, obstruction or foreign material.

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

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**Pancreas**

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum, likely consistent with age related changes and considered incidental. No signs of active inflammation or neoplasia.

**AGE**

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**Free Abdomen**

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

**WEIGHT**

35.5kg

**ULTRASONOGRAPHIC FINDINGS**

- Hepatomegaly with ventrocaudal solid to isoechoic mass lesion-nonspecific, vacuolar hepatopathy, inflammatory/immune mediated disease, hematopoiesis, hyperplasia, hepatoma like mass lesion, fibrosis or neoplasia all potentials.
- Mild gallbladder debris (non-mucocele).
- Mild to moderate chronic renal changes.
- Age related adrenal changes.
- Subtle to mildly expansive splenic nodules-hyperplasia, hematopoiesis, focal splenitis, potential for emerging neoplastic criteria thought less likely yet cannot be definitively excluded.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Assuming normal clotting status and using a 25g needle, hepatic parenchyma, hepatic mass lesion and splenic nodule FNA for screening cytology is warranted for further assessment. Hepatosupportive medications such as Denamarin and Ursodiol with sonographic monitoring of the hepatic mass lesion and splenic nodules for evidence of progression would be a more conservative approach.

The reported clinical signs in conjunction with USG >1.020 is not overtly suggestive of adrenal disease as a contributing factor yet if progressive or recurrent PU/PD, polyphagia etc. an adrenal work up or UCCR could be considered. Subjectively given the size and location of the hepatic mass lesion, complete surgical resection would be likely if clinically indicated.

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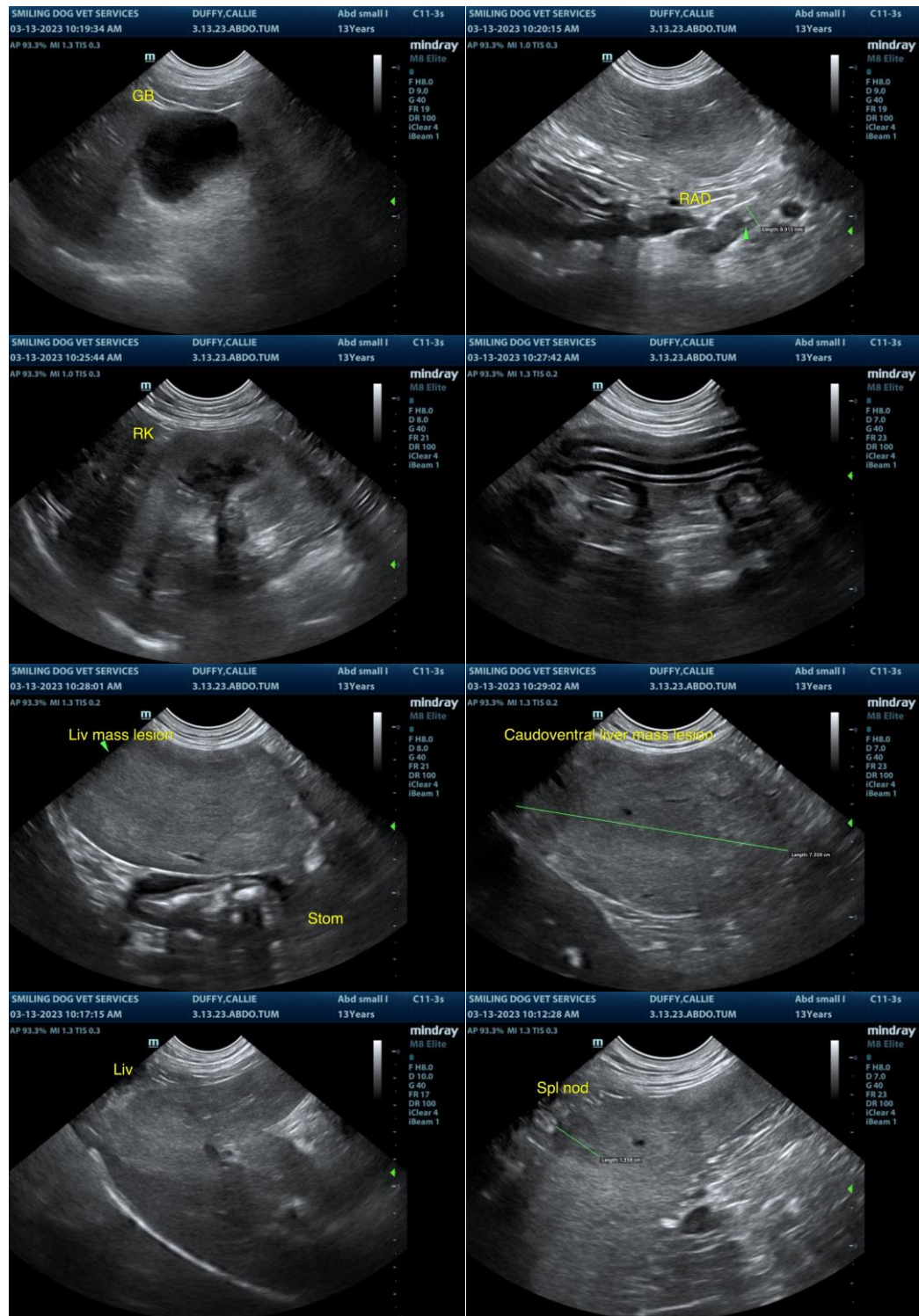
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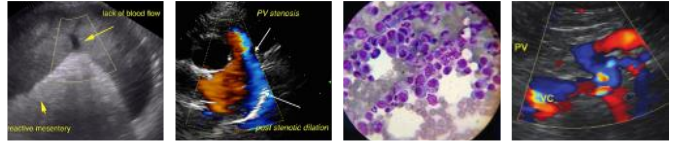
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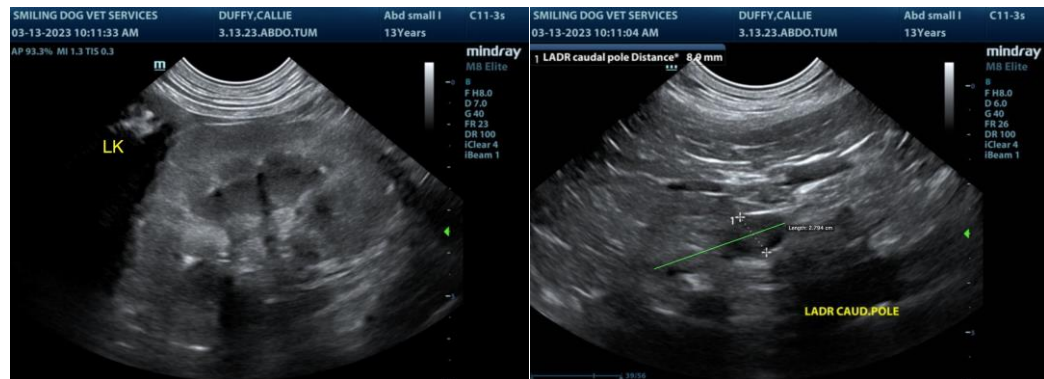
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)  
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