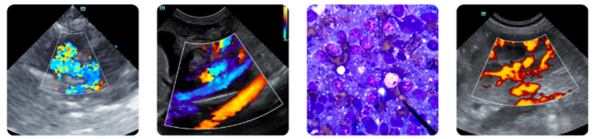


PATIENT

Felix Stiely

SPECIES

Canine

BREED

Chihuahua Mix

SEX

Male Neutered

AGE

13y 4m

WEIGHT

7.42 kgs

INTERPRETED BY

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

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Dr. Kristen Kicenuik (oncology)

INVOICE

13325

DATE

3/25/26

PRESENTING CLINICAL SIGNS

History:

- Recheck AUS following metastatic anal sac carcinoma. Evaluating for stability of disease vs further potential metastatic spread. Consulting with Oncology at Blue Pearl Malvern. Diagnosis: R sided apocrine gland anal sac adenocarcinoma (~ 10 cm) with sublumbar lymph node metastasis: Incompletely excised Nov 2025 (along with metastatic lymph node). MI>40. No lymphovascular invasion. The right and left anal glands and enlarged sublumbar lymph node were surgically removed in mid-November 2025. Biopsy of the right anal gland confirmed an incompletely removed anal sac adenocarcinoma, MI>40 with lymph node metastasis (biopsied but not removed). The left anal gland contained benign changes. Started on Palladia in December 2025 (planned for long-term). Lab work performed 1 mo post treatment showed no concerns. He was seen on 2/9 for diarrhea. Palladia and carprofen were discontinued and metronidazole was started. You slowly reintroduced all medications including fenbendazole and raw diet.
- PMH: Mitral valve insufficiency (stage B1).
- Meds: Palladia 10 mg (Tablet): Give (2) tablets by mouth on M-W-F. Rimadyl, 25 mg tablets: Give 1/2 tablet by mouth on Tu-Thur-Sat-Su. Gabapentin, Metronidazole PRN D+, Cerenia PRN, Turmeric and Turkey Tail. Fenbendazole: Strongly advise discontinuing. Raw diet: Strongly advise discontinuing

Abnormal PE/Chem/CBC/UA Results: Chemistry panel: BG mildly increased (163), phos mildly low (2.1) Chest x-rays: Pending review, no evidence of metastasis noted. AFAST: R sublumbar lymph node measures ~ 4.1x 2.2 cm.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

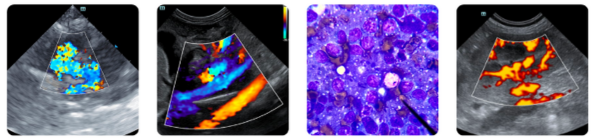
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

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

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 4.4 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.49 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.49 cm width at the caudal pole.



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

Liver

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. The hepatic 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 was empty 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 ileus, obstruction or foreign material.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

Previously noted progressive, asymmetrically enlarged, non-homogeneous medial iliac/sublumbar lymph node caudal to the iliac trifurcation and dorsal to the urinary bladder. The lymph node measured ~4.8 cm x 2.7 cm (previous measurements 3.9 cm x 2.3 cm). Pinpoint hyperechoic parenchymal foci visualized within the lymphadenopathy directly adjacent to perilymphatic vasculature on color doppler.

Solitary to intermittent, mildly prominent to enlarged mesenteric nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of lymph node measurement was 1.6 cm x 0.4 cm. No evidence of peritoneal or retroperitoneal effusion.

ULTRASONOGRAPHIC FINDINGS

- Progressive, irregular non-homogeneous medial iliac/sublumbar lymphadenopathy exhibiting potential for pinpoint mineralization
- Intermittent, mild mesenteric lymphadenopathy exhibiting normal width to length ratio

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The previously noted medial iliac/sublumbar lymphadenopathy is consistent with metastatic criteria and appears progressive compared to the previous study. The mild mesenteric lymphadenopathy did not overtly meet neoplastic criteria yet sonographic monitoring is advised. No other additional sonographic evidence of intraabdominal major organ metastatic criteria present.

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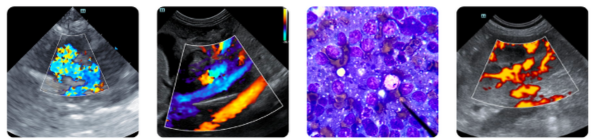

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Educational Teleconsultation Services™

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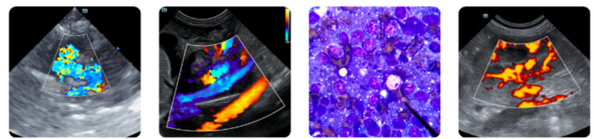

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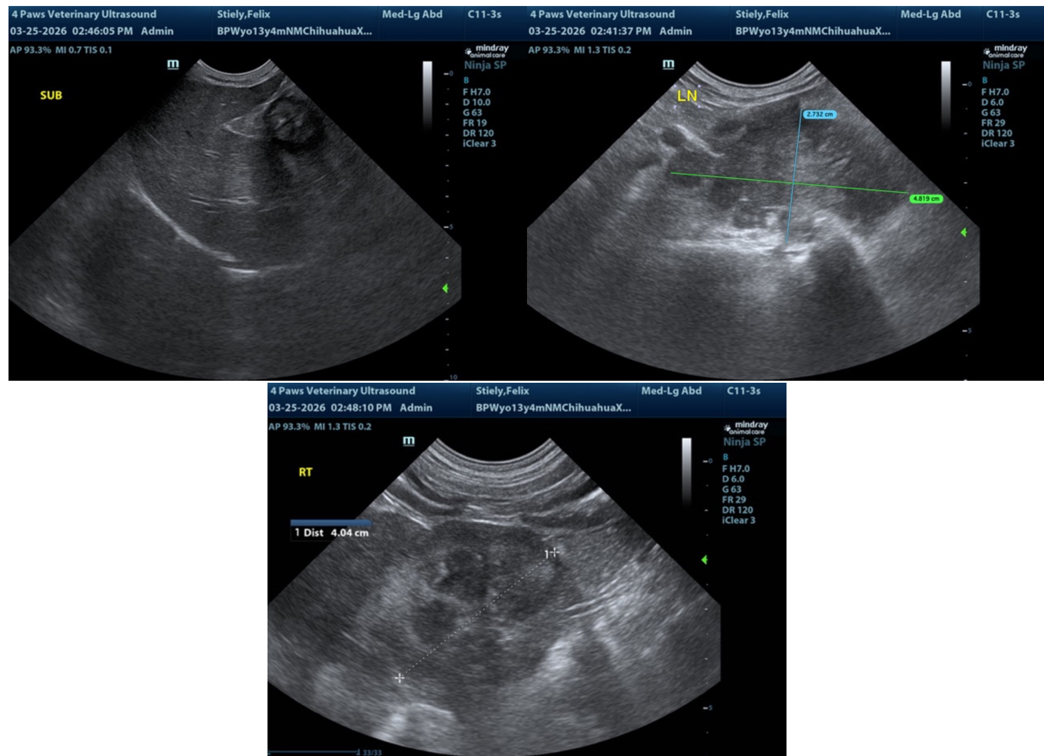

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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