



**PATIENT**

Peekaboo McDonough

**SPECIES**

Canine

**BREED**

Pit Bull Mix

**SEX**

Neutered Male

**AGE**

10 Years

**WEIGHT**

72 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Amy Mayhew, LVT

**HOSPITAL NAME**

SVS Imaging Michigan

**REFERRING VET**

Pinecrest AH

**INVOICE**

14700

**DATE**

4/11/22

**PRESENTING CLINICAL SIGNS**

History: Not eating as much. Urinating more, not having accidents. Urinating every other hour when owner is home. Increased urination started Friday. Gave Fortiflora because stomach was growling. Will sniff food bowls and walk away. Licking L front paw. Has eaten less since the day after getting rabies (3/17). Have tried chicken and rice, P will not eat it. Has put food in Kong ball and P will eat some. Did eat dinner yesterday (dog chow) Drinking and defecating normally. Current diet? Science diet energy/mentation? Laying around a lot more since vaccine No c/s/v/d Fortiflora, Mirtazapine, Amitriptylinetense and mildly painful; no masses or fluid-wave noted

Abnormal PE/Chem/CBC/UA Results: L MCV - 60.4 fL L RETIC-HGB 20.5 pg Inflammatory leukogram - WBC 17.71 K/uL H Globulins 4.7 H ALKP 249

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 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. Aortic trifurcation was normal without evidence of medial iliac or sublumbar lymphadenopathy.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture, measuring 1.2 cm in diameter.

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 loss of corticomodullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. A solitary thinly walled cranial cyst (1.8 cm in diameter) containing anechoic fluid was present in the left kidney. The left kidney measured 7.1 cm in length. The right kidney measured 7.4 cm in length.

**Adrenal Glands**

Both adrenal glands were prominent in size. Subtle capsule asymmetry was present with nonhomogeneous parenchyma. The left adrenal gland measured 3.7 cm in length x 0.87 cm at the caudal pole in width. The right adrenal gland measured 2.9 cm in length x 1.2 cm at the caudal pole in width.

**Spleen**

The spleen exhibited subjective normal size. Maintained symmetrical capsule contour with generalized mild splenic parenchyma heterogeneity. Solitary, mildly expansive, hypoechoic nodule was present in the caudal spleen, measuring 1.3 cm in diameter.

**Liver**

The liver exhibited mild subjective generalized enlargement. 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. Intermittent to multifocal, nondisruptive discreet hypoechoic parenchymal nodules were present. An example of liver nodule measured 1.8 cm in diameter.



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The gallbladder was non distended in size with mild gallbladder debris. The cystic duct and common bile ducts were normal without evidence of dilation.

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**Gastrointestinal**

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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.

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

**SEX**

**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.

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**Free Abdomen**

An unspecified hypoechoic to mild asymmetrical mass was present in the cranial abdomen, directly caudal to the stomach and subjectively medial to the spleen. The mass was primarily solid, exhibiting hypoechoic to mild mixed echogenicity. The mass measured approximately 7.0 cm in diameter. Subtle evidence of regional reactive mesentery was noted around the mass. No overt free fluid or evidence of overt concurrent mesenteric lymphadenopathy.

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**ULTRASONOGRAPHIC FINDINGS**

**INTERPRETED BY**

- Mild chronic renal changes with cranial left kidney cyst
- Nonspecific prominent to nonhomogeneous bilateral adrenal glands
- Hepatic parenchymal remodeling with intermittent to multifocal discreet intraparenchymal nodules
- Mild gallbladder debris (non-mucocele)
- Mildly expansive splenic nodule
- Unspecified cranial abdominal mass, caudal to the stomach and medial to the spleen

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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Although sampling is required for further assessment, the unspecified cranial abdominal mass is consistent with neoplastic criteria. Potential for nonneoplastic etiology, i.e., granuloma, nonneoplastic significant lymphadenopathy, etc. possible yet thought less likely. Given the location and size of the mass, directly effacing or adjacent to multiple structures, an obvious or definitive origin of the mass was difficult to ascertain. Lymphatic, pancreatic, omental, nonobvious gastric, splenic or less likely hepatic origin could be present. Assuming normal clotting status, ultrasound guided FNA of the unspecified mass is warranted for screening cytology.

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The hepatic presentation may indicate vacuolar hepatopathy with benign parenchymal remodeling, discreet areas of hematopoiesis or hyperplasia, while the splenic nodule may indicate focal lymphoid hyperplasia, extramedullary hematopoiesis, focal splenitis, granuloma or similar. However, the



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possibility of hepatosplenic metastatic disease, given the unspecified cranial abdominal mass cannot be excluded. Concurrent hepatosplenic FNA for further staging would be appropriate.

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The clinical signs in this patient are not overtly suggestive of adrenal hyperfunction.

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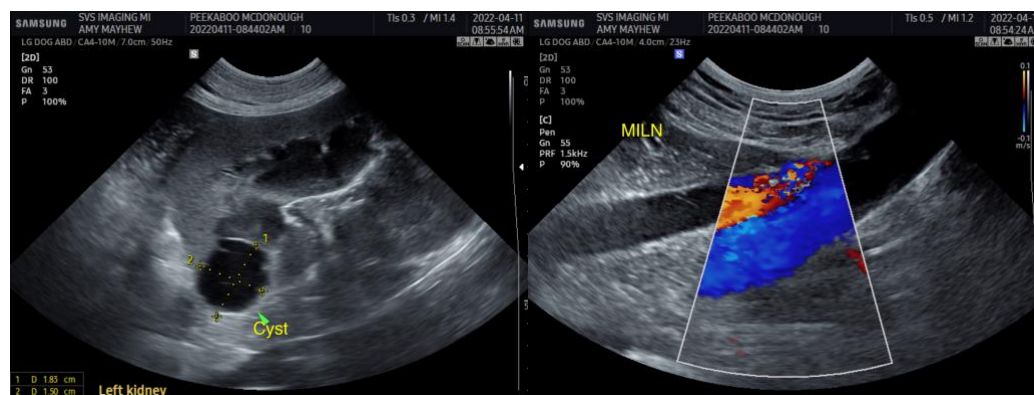
Assuming no evidence of pathology on three-view chest radiographs, further assessment may include abdominal CT with potential for surgical planning, as well as assessment for metastatic disease versus exploratory laparotomy with potential biopsy or resection of the mass, hepatic biopsies and/or splenectomy based on gross inspection.

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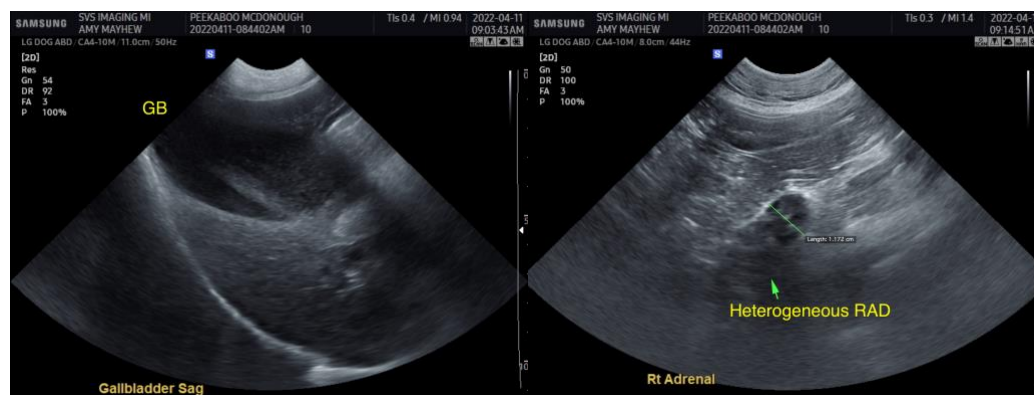
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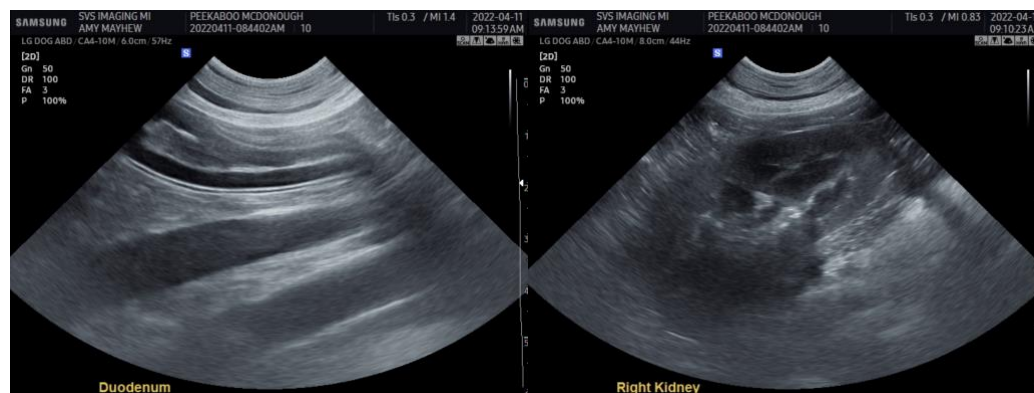
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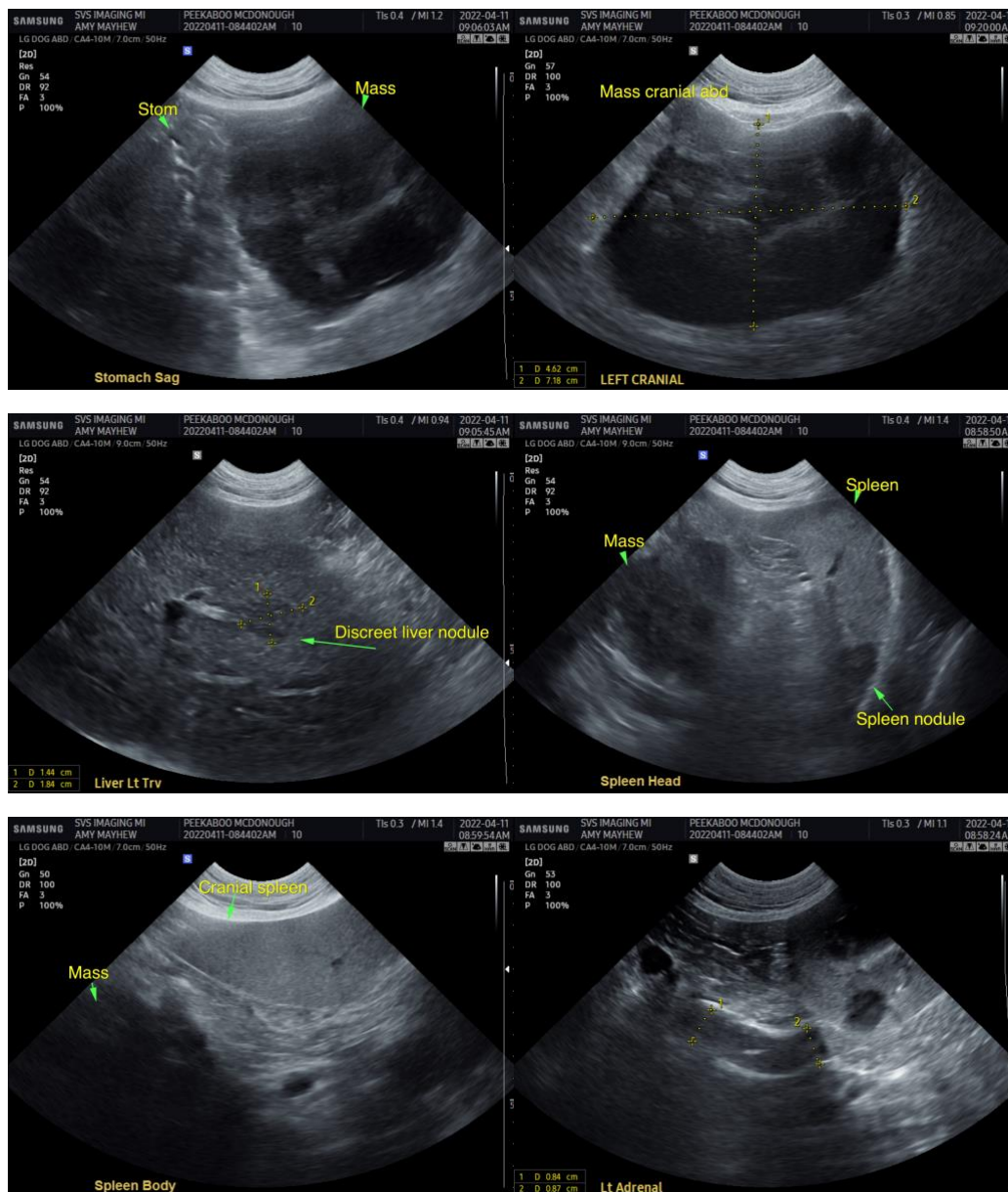
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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