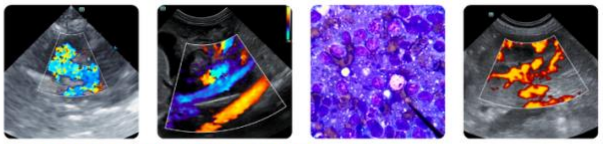



**PATIENT**

Felix Stiely

**SPECIES**

Canine

**BREED**

Chihuahua Mix

**SEX**

Neutered Male

**AGE**

13 Years 7 Months

**WEIGHT**

6.6 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Renee Trionfetti, VMD

**HOSPITAL NAME**

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**INVOICE**

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**DATE**

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## PRESENTING CLINICAL SIGNS

Recheck AUS following a right sided apocrine gland anal sac adenocarcinoma (~10cm) with sub lumbar LN metastasis: Incompletely excised Nov 2025 (along with metastatic LN). MI > 40. No lymphovascular invasion at prev AUS. Currently receiving Palladia and being followed at BP Malvern for Oncology. Now with weight loss and hyporexia. Meds: Palladia, Rimadyl, Gabapentin, Metronidazole, Cerenia, Tumeric and Trukey Tail, Omeprazole, Entyce. PMHx: Mitral valve insufficiency, Stage B1

CBC: Hct 48.6% (normal though slightly decreased), Plts 427k-n; Neut 74200/uL-n - Chem: Phos 2.2-mildly L - CXR: no evidence of metastasis noted - AFAST: Sublumbar LN 3.8 x 2.6 cm - AUS 3/25/26 (Sonopath): Progressive, irregular non-homogeneous medial iliac/sublumbar lymphadenopathy exhibiting potential for pinpoint mineralization • Intermittent, mild mesenteric lymphadenopathy exhibiting normal width to length ratio. 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).

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone was nondistended with urine prohibiting full evaluation of the bladder wall. No evidence of urinary bladder tumors. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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 change were noted.

The area of the residual prostate appeared normal and free of pathology measuring 0.89 cm.

Normal size and margination was 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 4.6 cm in length. The right kidney measured 4.3 cm in length.

### *Adrenal Glands*

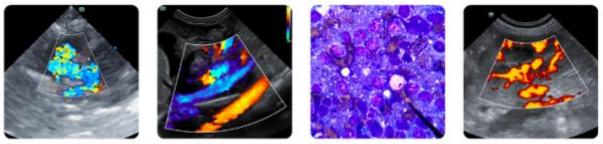
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.44 cm width at the caudal pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.50 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 thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

### *Liver & Gallbladder*





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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 minor nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

### *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. Mild nonspecific hyperechoic duodenojejunal mucosal speckling.

Normal visible colon wall layers were present with no distention and semi formed to soft fecal matter.

### *Pancreas*

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

### *Free Abdomen*

No visualized significant current mesenteric lymphadenopathy or peritoneal effusion was present.

Previously noted possibly mild progressive irregular non-homogenous marked medial iliac/sublumbar lymphadenopathy/mass measuring approximately 5.5 cm x 3.3 cm. The mass was noted subjectively just distal to the level of the iliac trifurcation. Potential mild colon impingement although no evidence of obstruction to fecal outflow. Mild surrounding hyperechoic tissue. No overt retroperitoneal effusion.

## ULTRASONOGRAPHIC FINDINGS

- Previously noted possible mild progressive irregular non-homogenous marked medial iliac/sublumbar lymphadenopathy or mass.
- Structurally normal gastrointestinal tract with mild non-specific duodenojejunal mucosal speckling.
- Non-homogenous remodeled pancreas.
- Minor gallbladder debris (non-mucocele).
- Mild age-related renal changes.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The medial iliac/sublumbar marked lymphadenopathy/mass is consistent with metastatic criteria. Recheck FNA cytology (assuming normal clotting status) and an oncology consult could be considered.

The intestinal mucosal speckling is non-specific yet may suggest mild non-specific enteritis. Assessments for evidence of cranial abdomen or sub-xiphoid discomfort on palpation which may correlate with mild chronic pancreatitis and assessment of lipase level is recommended. Gastrointestinal support is indicated. No overt sonographic evidence of additional major organ or mid abdomen lymphatic metastatic criteria.

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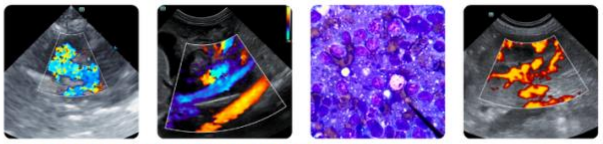

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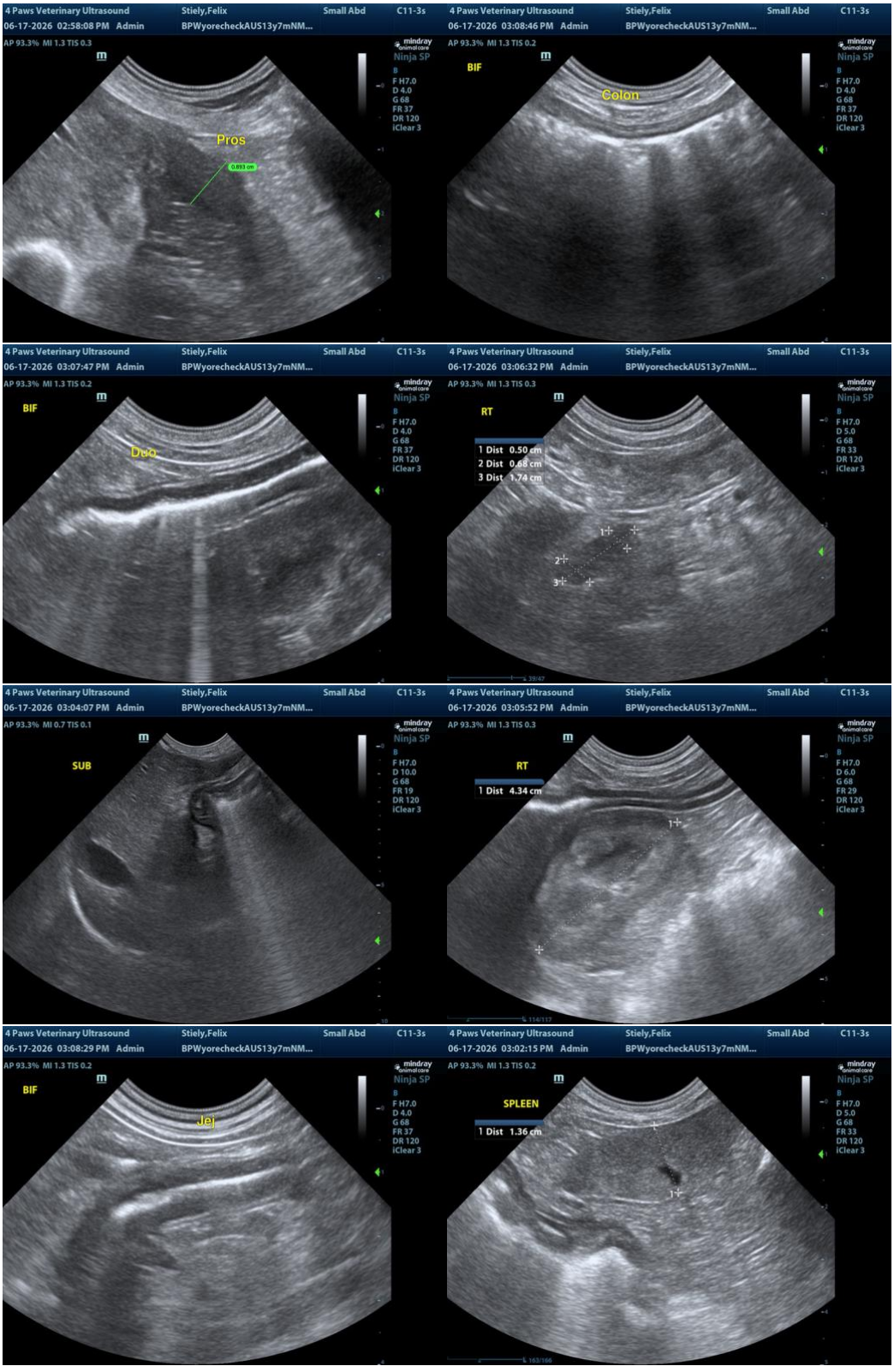

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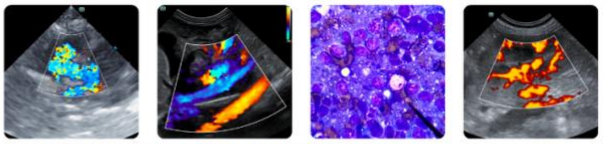

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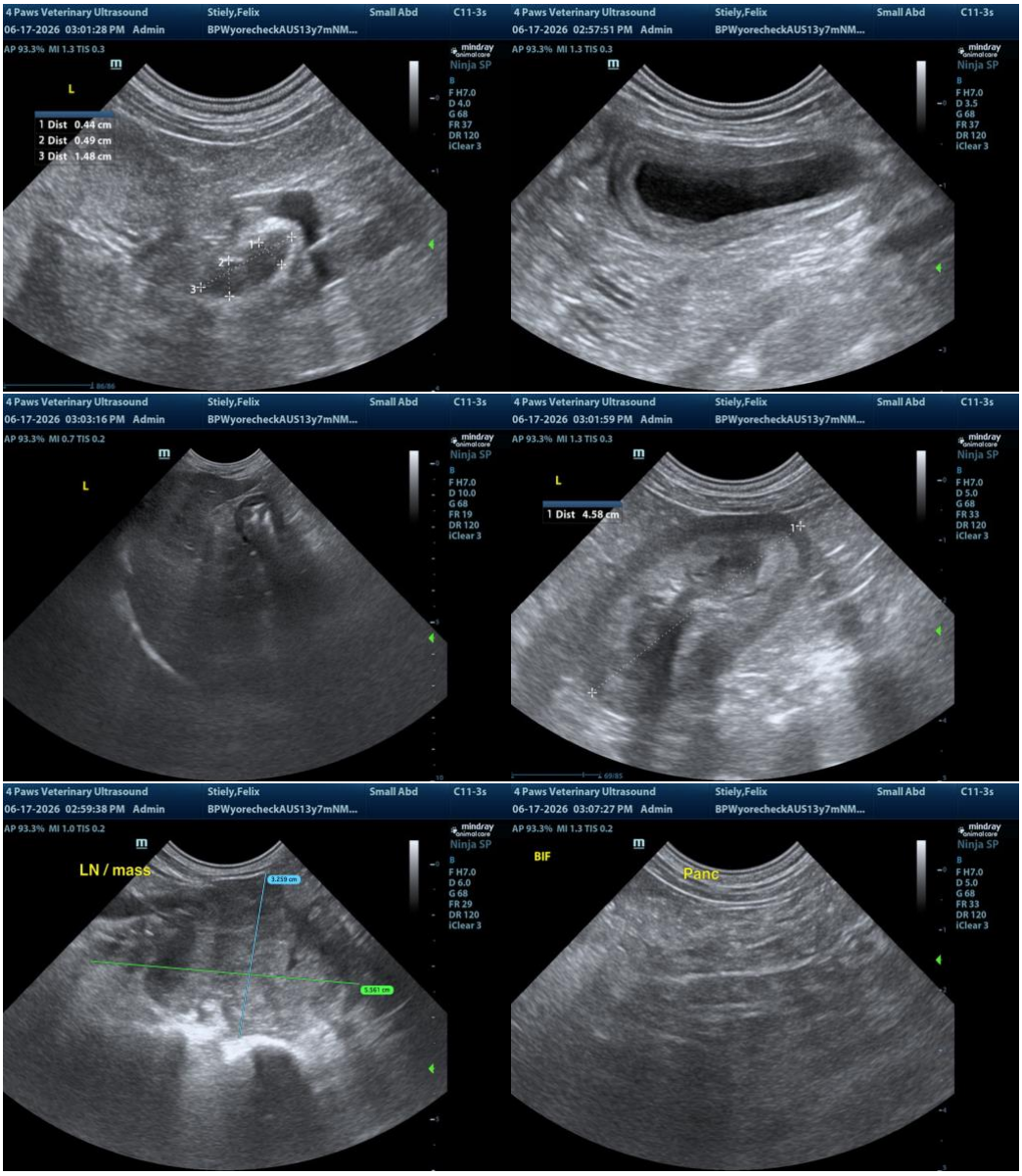


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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)**

info@SonoPath.com