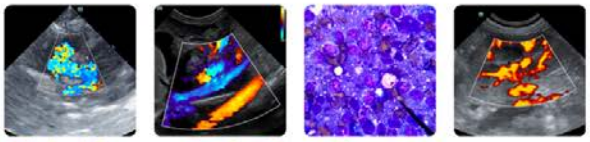


PATIENT

Rumble Macdonald

SPECIES

Canine

BREED

Welsh Corgi Pembroke

SEX

Spayed Female

AGE

11 Years 2 Months

WEIGHT

32.5 lbs

INTERPRETED BY

Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY

Brittney Beigel, DVM

HOSPITAL NAME

Bayside Animal Medical Center

REFERRING VET

Kathryn Buchana, VMD

INVOICE

72107

DATE

1/10/26

PRESENTING CLINICAL SIGNS

O reports diarrhea in last week, acute onset vomiting and anorexia this morning, urinated large amount of frank blood. On PE pt had lost 15lbs in a year and a half, o reportedly had been trying to achieve weight loss. PE revealed pale pink MM, sensitive/reactive on abdominal palpation. BW showed elevated WBC and neutrophils on CBC, stress hyperglycemia. UA pending. U/s pursued. P fasted for US scan, no sedation needed; painful while scanning L lateral abdomen

Abnormal PE/Chem/CBC/UA Results: Attached

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is minimally distended with anechoic urine, and luminal sediment is present. The bladder wall is diffusely thickened and there are irregularities to the mucosal surface. The ureteral papillae and trigone are of normal appearance; however, the urethra is also diffusely thickened, measuring 4.1 mm in diameter. The ureters are not visible (normal). No masses or calculi are noted. Urethra visualized to 3.0 cm.

The right kidney is of normal size (5.7 cm) and shape and exhibits appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal).

The left kidney is mildly diffusely enlarged with evidence of dilated renal calyces. There is a 1.4 cm heterogeneous nodule noted in the center of the renal medulla. The surrounding omental fat is hyperechoic, and there is perirenal free fluid observed. There is no evidence of nephrolithiasis or mineralization. The proximal ureter is not visible (normal). The left kidney measures 6.5 cm.

Adrenal Glands

The right adrenal gland is identified in its normal location. It is of normal size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The right adrenal gland height is 8.8 mm at the cranial pole and 6.4 mm at the caudal pole. The left adrenal gland is not distinctly visualized, but the region appears unremarkable.

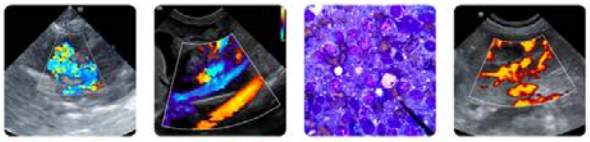
Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

There is a hyperechoic mass within the splenic parenchyma with no visible deviation of the splenic capsule. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

The gallbladder is moderately distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.



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Gastrointestinal

The stomach is empty. The gastric wall is subjectively normal in thickness, and exhibits appropriate wall layering, but cannot be accurately measured due to normal deviations of the rugal folds. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness with intact wall layering. The ileocecal junction is not seen.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is focal free fluid present with the abdomen in the region of left kidney. The associated omentum and intra-abdominal fat are hyperechoic. There is an approximately 4.0 cm x 2.0 cm homogeneous mass adjacent to the left kidney, most typical in appearance of an enlarged lymph node, although the possibility of this being the left adrenal gland cannot be exclude. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Hypoechoic nodule in the left kidney, with associated steatitis and free fluid
- ~ 4 cm x 2cm round mass adjacent to the left kidney, likely an enlarged renal lymph node, but an adrenal mass is not excluded, as the left adrenal is not clearly visualized.
- Thickened bladder wall and urethra

SECONDARY FINDINGS

- Hyperechoic liver nodule - consistent with an incidental myelolipoma

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The renal nodule, the enlarged (presumed) renal lymph node, and associated retroperitoneal inflammation support the presence of malignancy in the left kidney, such as renal carcinoma. An inflammatory lesion, such as a granuloma, is also possible.

The bladder wall appears thickened, even for the lack of distention. The pending urinalysis may provide additional insight into whether there is evidence of urinary tract infection. A urine BRAF test could also be considered to screen for urothelial neoplasia.

Additional recommendations for Rumble would include:

1. Three view chest radiographs
2. A CT scan, if available, would be helpful in definitively determining the origin of the nodule adjacent to the kidney (lymph node vs adrenal vs other)

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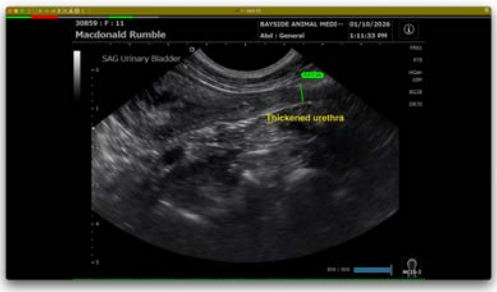
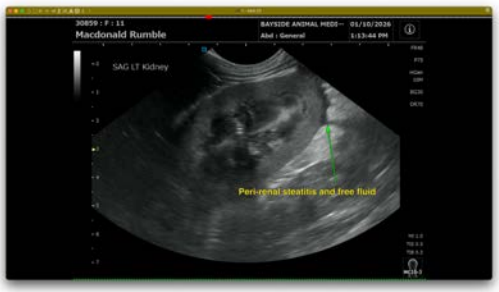
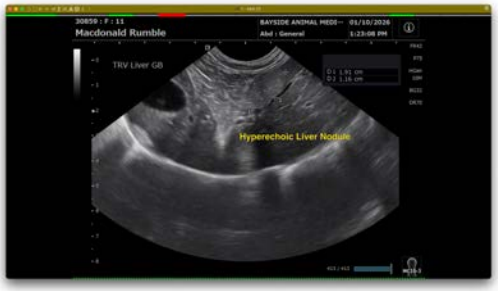
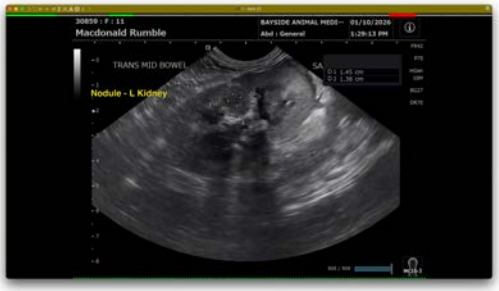
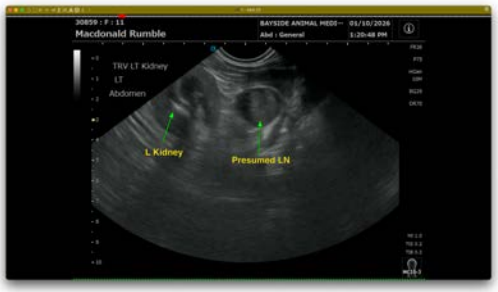
3. Fine needle aspiration of the renal lymph node (or less likely adrenal nodule), and the renal nodule itself, understanding that there is a risk of bleeding. Alternatively, abdominal exploratory for nephrectomy with histopathology could be considered for definitive diagnosis.

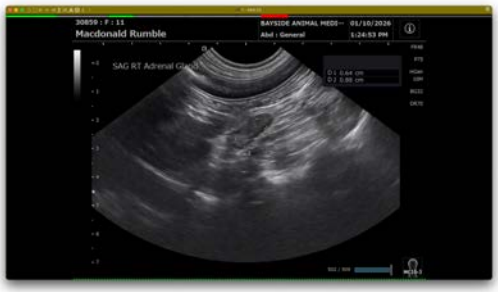


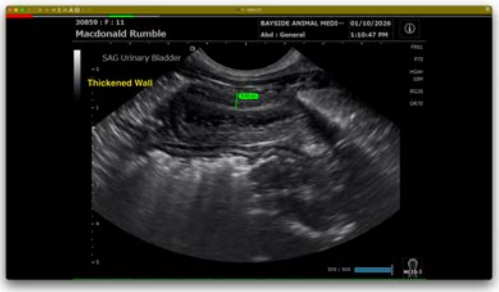


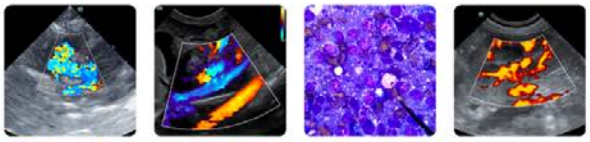












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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice)

info@SonoPath.com