PATIENT

Bodie Kennedy

SPECIES

Canine

BREED

Australian Shepherd

SEX

Intact Male

AGE

11 Years

WEIGHT

80.5 Pounds

INTERPRETED BY

Tam Mengine DVM, DABVP (Canine/Feline Practice)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Steele Creek AH

REFERRING VET

Dr. Schuver

INVOICE

36750

DATE

4/24/26

PRESENTING CLINICAL SIGNS

History: Patient presented for US due to intermittent cough triggered by abdominal palpation, weight gain of approx 3#, High ALKP and Low Phosphorous. *P sedated with Dex and Torb after iliac trifurcation- very tense

Abnormal PE/Chem/CBC/UA Results: Alk Phosphatase 653 5 - 131 IU/L HIGH Phosphorus 1.8 2.5 - 6.0 MG/DL LOW.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). There are multiple small uroliths present. The bladder wall is normal. No masses are noted. Urethra visualized to 5.0 cm

The prostate is diffusely enlarged measuring 4.7 cm x 4.4 cm with a hyperechoic parenchyma and smooth capsule. The prostatic urethra is not dilated.

Both testicles are visualized, and there is a 9.0 mm in diameter hyperechoic nodule noted within the parenchyma of the left testicle period.

The kidneys are of normal size and shape and exhibit 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 7.2 cm in length. The right kidney is 7.2 cm in length.

Adrenal Glands

The adrenal glands are both identified in their normal locations. There is a small hyperechoic nodule arising from the cranial pole of the left adrenal gland. They are otherwise normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland height is 6.4 mm at the cranial pole and 5.5 mm at the caudal pole. The right adrenal gland height is 9.0 mm at the cranial pole and 5.9 mm at the caudal pole

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

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. There is a 1.8 cm x 1.4 cm irregularly marginated heterogeneous mass located in the left caudal aspect of the liver. The surrounding omentum is normal. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a small amount of freely-moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and

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common bile ducts are normal / not visible.

Gastrointestinal

The stomach is mildly distended with gas. The gastric wall is 5.0 mm with normal deviations due to rugal folds and exhibits appropriate wall layering. 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, up to 1.8 mm, with intact wall layering. The ileocecal junction is visualized and appears normal.

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 no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

Other

The visualized portion of the heart exhibits appropriate systolic function, with no masses or effusions noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Small heterogeneous mass arising from the left caudal aspect of the liver
- Small hyperechoic left testicular nodule

Secondary Findings

- Small non-obstructive bladder stones
- Small hyperechoic left adrenal nodule
- Benign prostatic hyperplasia, as expected for patient age and neutering status

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The mass in the liver could represent neoplasia, such as a carcinoma, or a benign hepatoma. Recommendations include:

- Laparoscopic biopsy or ultrasound-guided biopsy for definitive diagnosis. Alternately, fine needle aspirate could be performed for cytology but may not be diagnostic as compared to biopsy.

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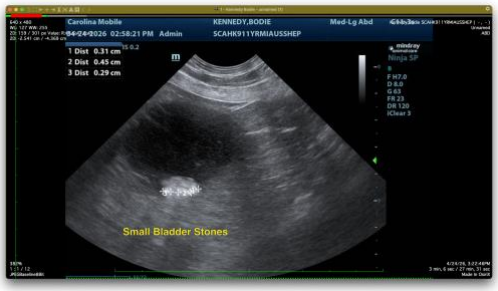
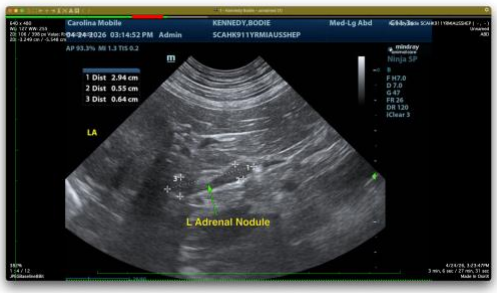
- An abdominal exploratory could be considered as an alternative to biopsy, to attempt to remove the mass *en bloc* as part of a liver lobectomy.
- 3-view chest radiographs
- Monitoring the mass for changes in size or appearance, via serial ultrasounds at 6-8 week intervals would be recommended if biopsy is not pursued.

The testicular nodule may also represent a benign or malignant process and castration with histopathology would be recommended for definitive diagnosis. A cystotomy could also be performed at this time, with stone analysis to determine whether dietary adjustment is indicated. If cystotomy is not performed, then the client should be cautioned to monitor for evidence of urethral obstruction.

The nodule on the left adrenal gland may be indicative of adrenal hyperplasia, a benign adrenal adenoma, or an early malignancy such as pheochromocytoma or adenocarcinoma. Recommendations include:

- Blood pressure measurement to screen for pheochromocytoma
- If signs of Cushing's disease are present, then adrenal function testing (either a low-dose dex-suppression test or ACTH stimulation test) is recommended
- Monitoring the nodule for changes in size or appearance, via serial ultrasounds at 6-8 week intervals would be recommended if fine needle aspirate is not pursued.





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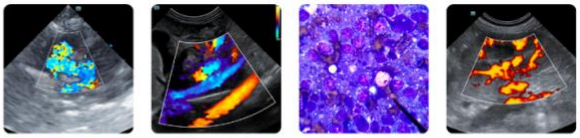

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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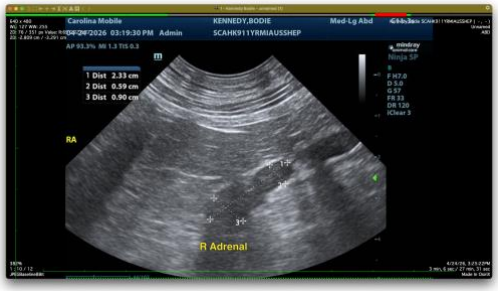

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com