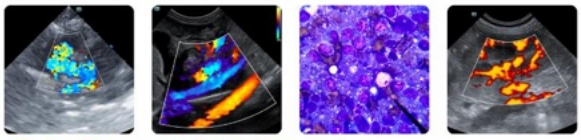


DATE

2/16/26

PATIENT

Libby Cambria

SPECIES

Canine

BREED

Jack Russell terrier

SEX

Female, spayed

AGE

2/15/2013

WEIGHT

19.2 lbs.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Shannahan

INVOICE

13479

PRESENTING CLINICAL SIGNS

Patient History: Pt presented as a STAT. pt is lateral and got into trash today pale gums. Date: 02-16-2026 Notes: Signalment: 13yo female dog Presenting Complaint: Libby presents for acute lethargy and non-responsiveness after ingesting plastic wrapper from ice cream sandwich Patient History: - Earlier today ingested plastic wrapper from ice cream sandwich found in trash - Also given beefy stick, tolerated well initially - Normal until approximately 12-1pm when became lethargic and non-responsive - No interest in food (declined cat food, which she normally enjoys) - Abnormal behavior during car ride (did not attempt to hide under seat as usual) - No vomiting or diarrhea noted - Possible access to litter box - Diet: Science Diet 7+ - Supplements: Greenies for skin and coat - History of lipoma removed from shoulder area approximately 2 years ago - Normally sneezes in the morning - No other past medical problems - No coughing.

Current Medications: Ondansetron, Unasyn, Cerenia.
Labwork Results: CBC- white count 43,000 with a neutrophilia, lymphocytosis and monocytosis. Creat 2.7, BUN 34, ALT 865, ALP 520, T-bili 2.5, 4DX negative
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Declined.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small amount of echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.68 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.03 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (0.88 cm at cranial pole) (0.88 cm at caudal pole) with swollen peripheral contours. A 0.50 x 0.40 cm hyperechoic to heterogeneous nodule is observed at the caudal pole. The remaining glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is enlarged (1.74 cm at cranial pole) (3.41 cm at caudal pole)(5.34 cm in length) and irregular with a mass effect. The parenchyma is heterogeneous with loss of glandular detail. There is suspected compression and/or invasion of the caudal vena cava.

Spleen

The spleen is overall normal in size (0.97 cm in width at the level of the hilus) with slightly irregular peripheral contour. A 2.4 x 1.7 cm isoechoic to slightly heterogeneous macronodule is observed approximately mid-body. The lesion slightly expands the splenic capsule. The remaining parenchyma is homogeneous. Splenic vasculature is normal with no evidence of thrombosis.

Liver
The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, partially dependent sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas
The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph nodes
The abdominal lymph nodes are normal/not visible.

Free Abdomen
There is no obvious evidence of free fluid.

Other
A brief visualization of the thorax reveals several suspected B-lines.

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

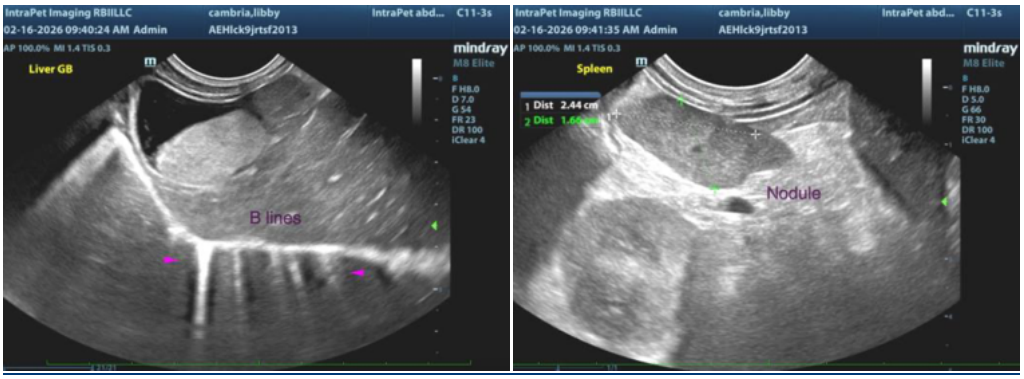
- Right adrenal mass with compression and/or invasion into the caudal vena cava. Neoplasia (i.e., adenocarcinoma, pheochromocytoma, hemangiosarcoma) is suspected with a lower possibility of a non-neoplastic process. Left adrenomegaly is also present. The left adrenal nodule at the caudal pole could be consistent with focal nodular hyperplasia, adenoma or less likely, adenocarcinoma, pheochromocytoma, other.
- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), Leptospirosis, hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof.
- Excessive gallbladder sludge. Considerations include cholestasis, fasting or an emerging mucocele.
- The suspected B-lines in the thorax are suggestive of pulmonary parenchymal disease.

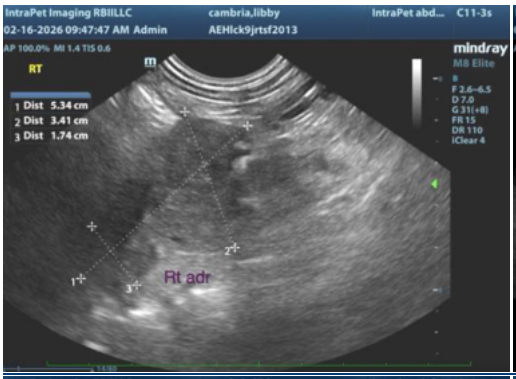
Secondary Findings:

- Bilateral, nonspecific, chronic renal changes
- The splenic macronodule could be consistent with emerging neoplasia (i.e., sarcoma, round cell tumor) or a benign process (i.e., focus of lymphoid hyperplasia or similar).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the adrenal and splenic findings, three-view thoracic radiographs are recommended to assess for pulmonary metastatic disease.
- To further revaluate for a functional right adrenal tumor, consider further testing (i.e., low-dose dexamethasone suppression test, urine/blood catecholamine levels). A baseline blood pressure measurement is also recommended to assess for systemic hypertension.
- Regarding the splenic macronodule, consider fine needle aspiration assuming normal clotting status. A 25-gauge needle should be used.
- Regarding the elevated liver values, consider the following:
    1. Leptospirosis testing (i.e., blood and urine PCR, serology)
    2. Pre and post-prandial serum bile acids
    3. Hepatic tissue sampling (i.e., aspirates or biopsies). If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed.
    4. If a conservative approach is desired, consider empirical treatment for bacterial cholangiohepatitis/Leptospirosis (amoxicillin-clavulanic acid, Denamarin). If no improvement in the liver values is seen within 7-10 days of initiating therapy, antibiotics should be discontinued, and hepatic tissue sampling reconsidered. If liver values improve, continue therapy for at least 4-6 weeks and 1 week beyond normalization of the liver values.

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1 Dist 5.34 cm
2 Dist 3.41 cm
3 Dist 1.74 cm
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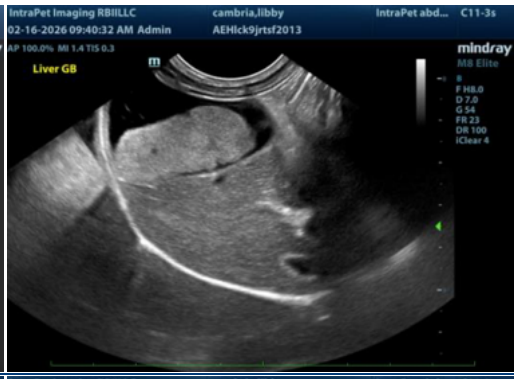
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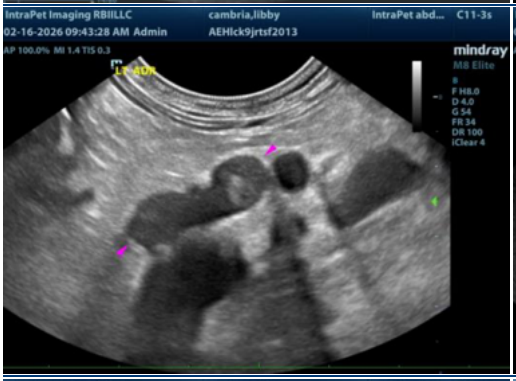
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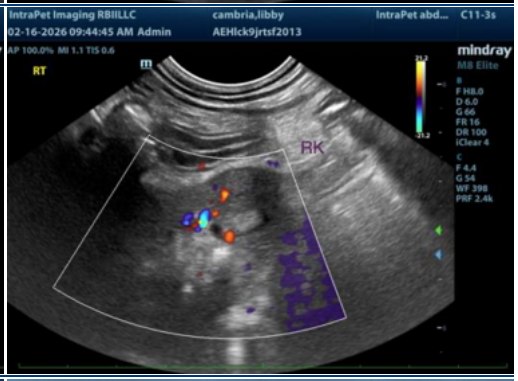
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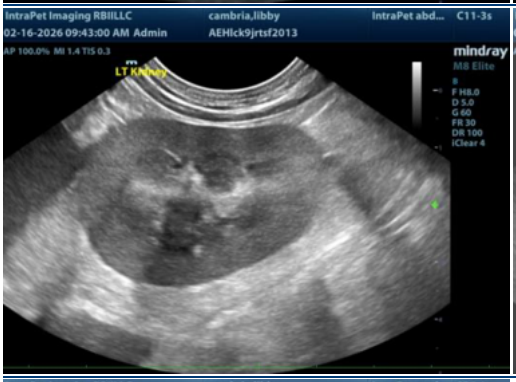
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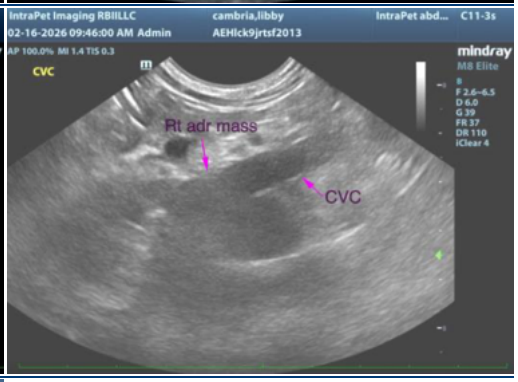
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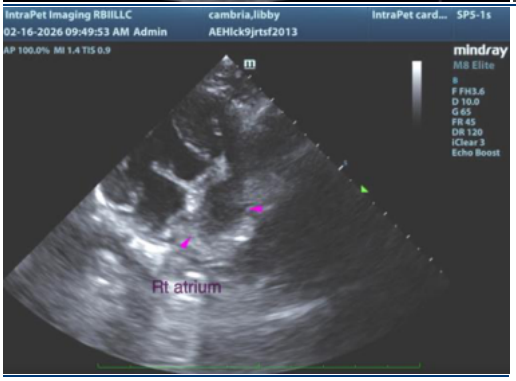
CVC
Rt adr mass
CVC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mindray
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Rt atrium

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine) info@SonoPath.com