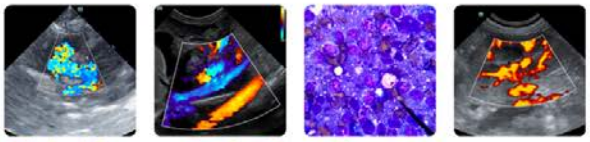


PATIENT

Brick Lupinacci

SPECIES

Canine

BREED

Golden Retriever

SEX

Intact Male

AGE

9 Years

WEIGHT

31.2 kg

INTERPRETED BY

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Victoria Orlando

INVOICE

72450

DATE

1/24/26

PRESENTING CLINICAL SIGNS

Vomiting began yesterday around 12:30 PM; at least 9 episodes over approximately 12 hours. Material described as saliva and ingested grass; late episode around 11:45 PM contained flecks of blood. Marked grass ingestion reported; muzzle used to prevent further ingestion. Ate ~0.25 cup rice with chicken broth for dinner and vomited it. Owner reports little to no water intake in the past ~12 hours. Owner reports urination and defecation occurred; no diarrhea.

History of prior abdominal foreign body (end of a ram horn) requiring surgery at ~2–2.5 years old. Yesterday chewed apart part of a tennis ball; owner believes all pieces retrieved. Frequently ingests rabbit feces. 5-6% dehydrated. Uncomfortable upon cranial abdominal palpation. Rectal reveals mildly enlarged prostate (non-painful and smooth) along with hemorrhagic diarrhea

Abnormal PE/Chem/CBC/UA Results: EPOC: NSF PCV/TS: 48/6.8 Catalyst pancreatic lipase: 613 (H) Conclusions: 1. No evidence of small intestinal mechanical obstruction. Nonspecific gastroenteritis +/- acute pancreatitis (given mildly decreased peritoneal serosal detail within the cranial abdomen) may explain the reported gastrointestinal clinical signs. Rounded soft tissue opacity confluent with the ventral extremity of the spleen. This may represent presence of a splenic nodule, which may be benign (extramedullary hematopoiesis, nodular hyperplasia) or malignant (hemangiosarcoma, other sarcoma, round cell). Abdominal ultrasound by an experienced sonographer is recommended for further characterization. 3. Mild nonspecific hepatomegaly

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. There is a mild to moderate amount of suspended echogenic debris. There is a hyperechoic structure in the urinary bladder trigone that appears to be mobile and most consistent with additional bladder debris. However, it is possible this communicates with the urinary bladder mucosa, but this is not definitively visualized at this time. The ureteral papillae appear normal.

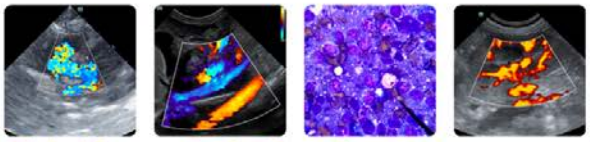
The prostate is enlarged and mildly to moderately hyperechoic with smooth and symmetrical borders.

The kidneys are normal in size and structure, with appropriate corticomedullary definition and cortex to medulla ratio. The cortices are uniform in texture with normal echogenic relationship to liver and spleen. The medullary structure differed distinctly from the cortex and no evidence of pyelectasis is present. The capsules are uniform without significant irregularities noted. Left kidney measures 6.9 cm. Right kidney measures 7.4 cm.

Adrenal Glands

The left adrenal gland is visualized and has normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left measures 0.63 cm at the caudal pole.

The right adrenal gland is not visualized.



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Spleen

The spleen measures 1.83 cm at the hilus. It is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented.

Liver

The liver is subjectively normal liver size, contour, and structure. Parenchymal echogenicity is naturally coarse and hypoechoic to the spleen. Vasculature is within normal limits with no evidence of congestion. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

Gastrointestinal

The stomach is mildly to moderately distended with echogenic ingesta. There is additional hyperechoic linear structures within the gastric lumen. This is most consistent with grass or other fibrous material. The small intestine is non-distended with no significant dilation, shadowing material, or evidence of small intestinal mechanical obstruction. The gastrointestinal walls are normal in thickness with maintenance of normal wall layering. The colon contains normal shadowing feces.

Pancreas

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.
- The enlarged, hyperechoic prostate is consistent with benign prostatic hypertrophy, especially given the patient's intact male status.
- The mild amount of gastric contents is not consistent with a mechanical pyloric outflow obstruction.
- The pancreas appears normal. However, this does not exclude an acute or active pancreatitis as an underlying cause for the clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Continued supportive care for acute gastroenteritis or suspected pancreatitis, as clinically indicated, is recommended.

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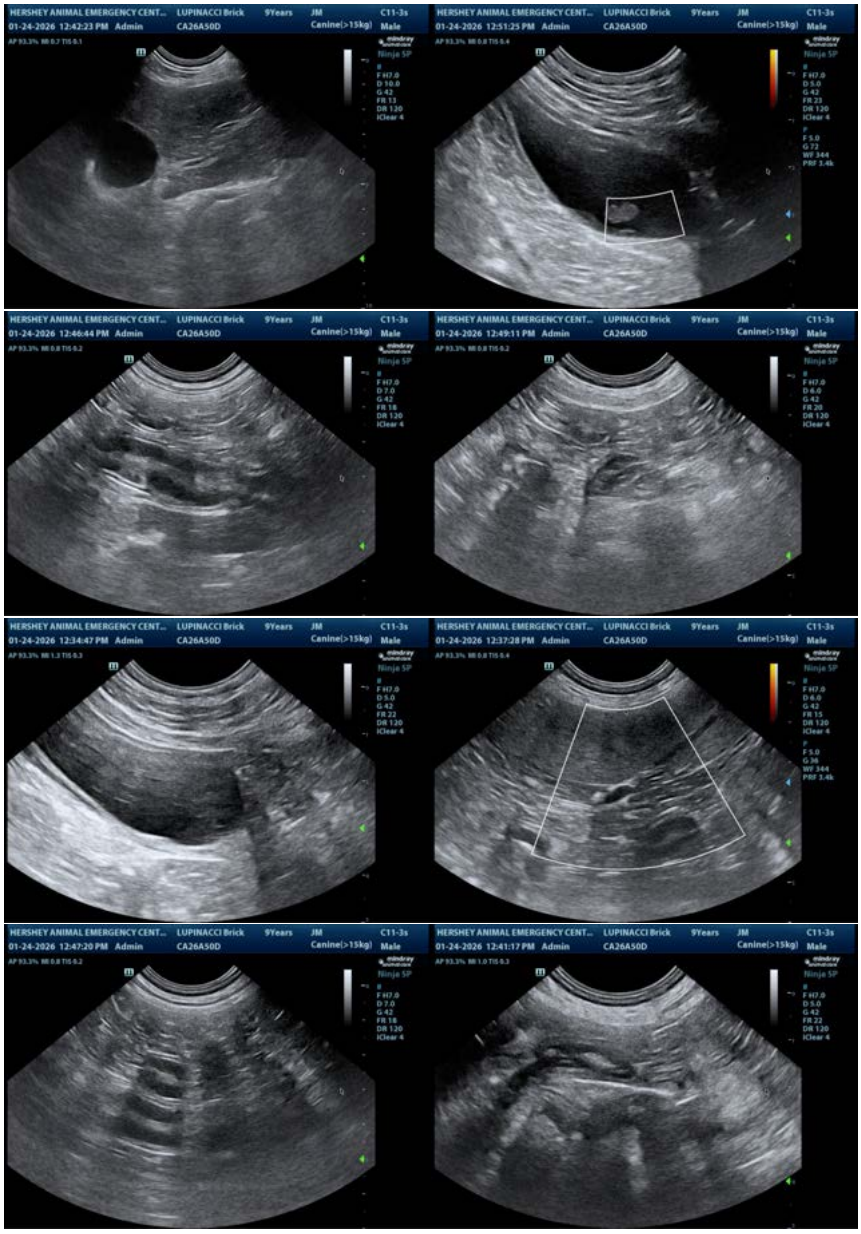
A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.



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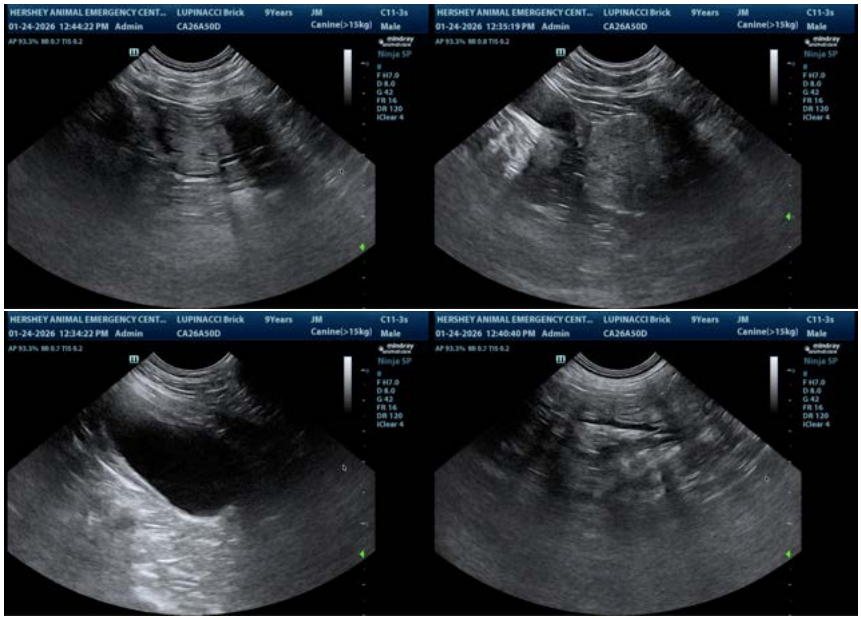

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com