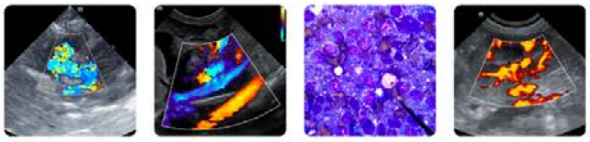


PATIENT

Heidi Kelley

SPECIES

Canine

BREED

German Shorthair Pointer

SEX

Spayed Female

AGE

10 Years

WEIGHT

66 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Julia Bakker, DVM

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Bruce McLaughlin, DVM

INVOICE

71551

DATE

11/4/25

PRESENTING CLINICAL SIGNS

Patient presents for vomiting and melena. Symptoms improved with cerenia and metronidazole but within a few days patient became ataxic, has nystagmus, increased respiratory rate, soft tissue swelling of the right stifle and edema of the inguinal area. Labwork shows >30k leukocytosis and radiographs show cardiomegaly and hepatomegaly. Patient has declined rapidly this week.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended. Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 7.19 cm. Right kidney measured 6.94 cm.

Adrenal Glands

The right adrenal gland is unable to be visualized in these images.

The left adrenal gland is enlarged, measuring 1.4 cm at the cranial pole and 0.87 cm at the caudal pole, with moderately heterogeneous parenchymal changes. Swollen capsular expansion is noted, as is suspicious vascular invasion into the phrenicoabdominal vein and the vena cava, with the intraluminal density in the vena cava measuring approximately 3.8 cm x 21. Cm in size.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

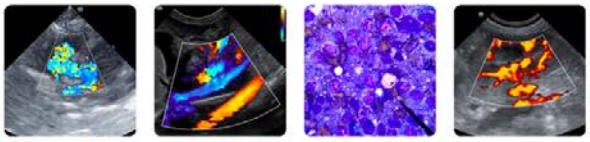
Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

In the mid left abdomen there is a loop of bowel that in some images is labeled “small bowel” and in other images I labeled “colon”(?) because I can’t definitively determine whether it is colon or small bowel in



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that area, but several intraluminal hypoechoic densities measuring approximately 0.60 cm thick are noted within the wall of the bowel. The remaining visible small intestines and colon are normal in wall thickness and layering, and are empty.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation. *See other.

Other

There is no visible free peritoneal effusion noted in these images.

There is no definitively identifiable lymphadenopathy. However, adjacent to the bowel loop described above, there is an ill-defined, amorphous, approximately 1.8 cm x 2.8 cm mixed area characterized by an anechoic center and a hypoechoic wall or surrounding tissue of unidentifiable origin. This structure could represent fluid versus a lymph node versus pancreatic changes versus other.

PRIMARY FINDINGS

- The left adrenal mass is concerning for neoplastic disease such as an adenocarcinoma, pheochromocytoma, other, given the concern for vascular invasion. A benign process with thrombi can't be ruled out but is considered less likely. This finding should be interpreted in combination with hormone testing, advanced imaging such as a contrast CT scan, etc.
- The bowel wall changes described above are similarly concerning for infiltrative neoplasia, given the focal loss of layering in the areas. A benign inflammatory process, however, can't be ruled out without tissue sampling. The relation of these two changes, if any, is unknown.
- Mildly heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- An unidentifiable ill-defined density in the left abdomen adjacent to the bowel described above again could represent a benign inflammatory change, fluid, reactive lymph node, although a neoplastic density, nodule, lymph node can't be ruled out.

SECONDARY FINDINGS

- Age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's reported cardiomegaly, clinical history, etc., an echocardiogram is recommended if not recently evaluated, as is a blood pressure.

Given the pathologic changes described above, especially the concern for vascular invasion from a left adrenal tumor, and the inability to definitively identify the pathology in the GI tract in the left abdomen, if possible, advanced imaging such as an abdominal contrast CT scan is recommended.

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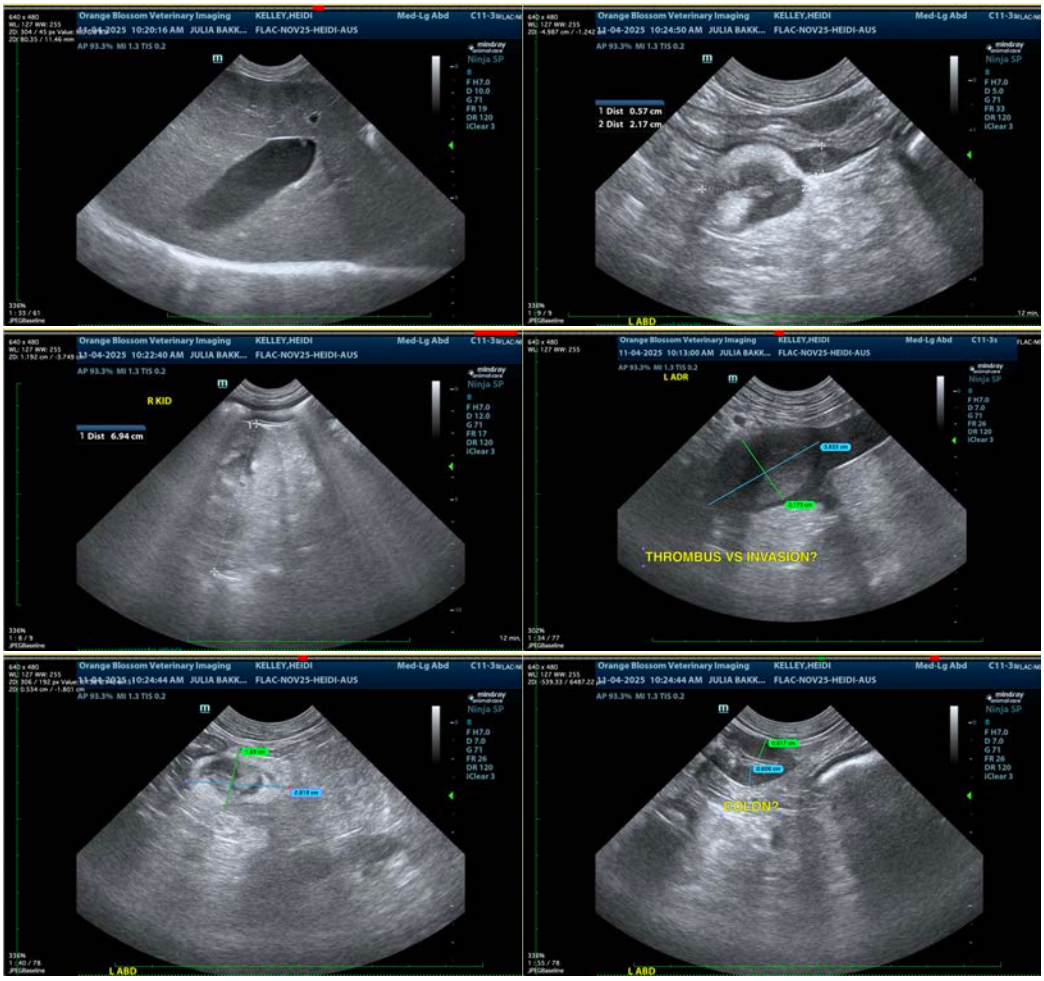
In the meantime, a low-dose Dexamethasone suppression test could be considered, as could a routine fecal/giardia exam.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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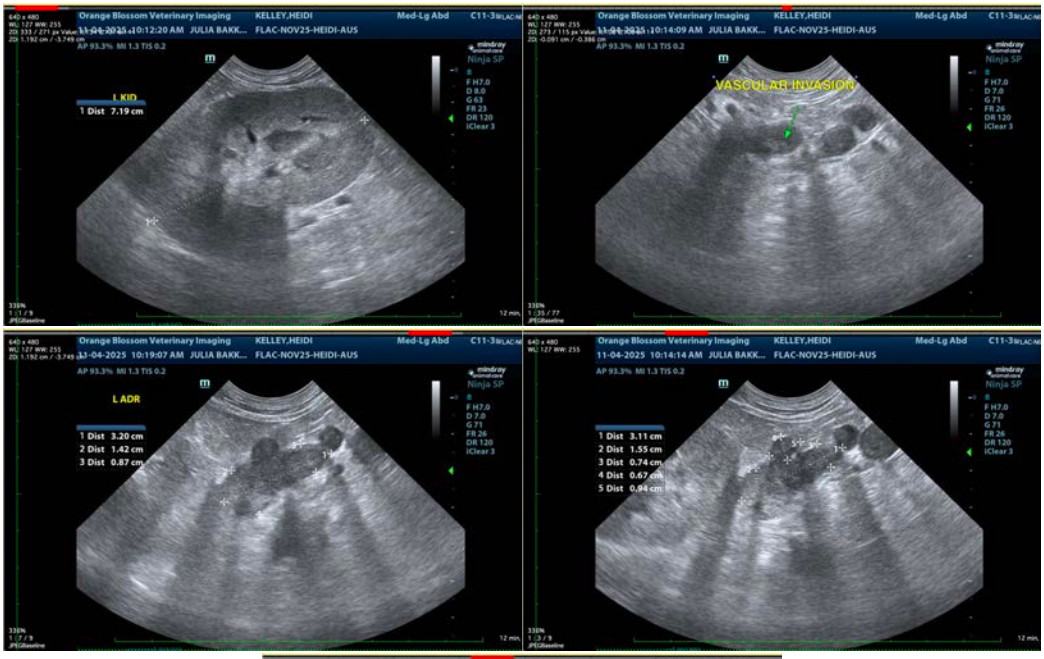

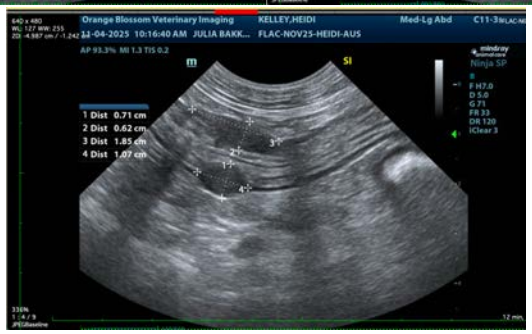

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com