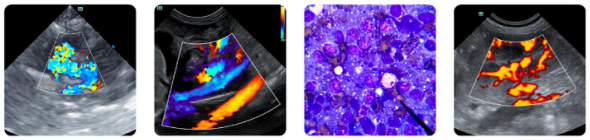


PATIENT

Bradie Wade

SPECIES

Canine

BREED

Nova Scotia Duck Retriever

SEX

FS

AGE

11 years

WEIGHT

31 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jesmine Palacios

HOSPITAL NAME

River's Edge Pet Medical Center

REFERRING VET

Dr. Shelby Young

INVOICE

11283

DATE

2/12/2026

PRESENTING CLINICAL SIGNS

- Lethargy, soft stools, low grade fever for 24hrs.
- Dehydrated 10% on exam on 2/11.
- Pt was hospitalized for diarrhea and ADR in 9/2025, no AUS performed at that time.

Abnormal PE/Chem/CBC/UA Results: See attached labs: -mild hypochromic, microcytic nonregenerative anemia; mild neutrophilia with a left shift; mild monocytosis; mild thrombocytosis -Mild hypokalemia; mild hypochloridemia -Pancreatic lipase: WNL -Resting cortisol : WNL See attached rads: Large cavitated intra-abdominal mass.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a moderate amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (5.14 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (5.22 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (1.0 cm at cranial pole and 0.37 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.36 cm at cranial pole and 0.44 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

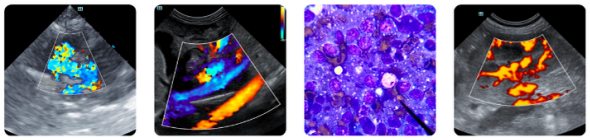
Spleen

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

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. 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.



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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 to cranial abdomen, there is an approximately 7.2 cm x 5.6 cm heterogenous, hypoechoic bowel mass that I believe does not incorporate the ileocecal colic junction but sits directly adjacent to it. With involvement unable to be definitively ruled out. The lumen of the bowel mass is a bright, echogenic intraluminal hard shadowing density. Some of the bowel, I assume, cranial to the mass, is mildly fluid distended with more normal appearing empty bowel beyond the mass. indicating at least partial obstruction likely caused by the mass. The remaining small bowel is normal in thickness and layering.

The colon wall is normal, but the colon is diffusely, mildly distended with soft stool.

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.

Free Abdomen

There is a trace amount of anechoic free fluid present in these images.

There is mild lymphadenopathy adjacent to the mass or incorporated into the mass, can't be ruled out given the irregular, almost lobulated appearance of the mass in some views.

Assessment of heart base images is included when/if a splenic nodule/mass is present (as a complimentary add on). They are also assessed when a specific request is made for assessment of a limited second cavity (heart base and/or thorax) for an additional charge. Images of the heart (and/or) thorax were not assessed for this study. Please contact us if you would like a second cavity.

ULTRASONOGRAPHIC FINDINGS

- The suspect small bowel mass is most concerning for infiltrative neoplasia such as round cell neoplasia, i.e. lymphoma versus carcinoma versus other. A benign process can't be ruled out but is considered less likely.
- Trace Free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- A moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

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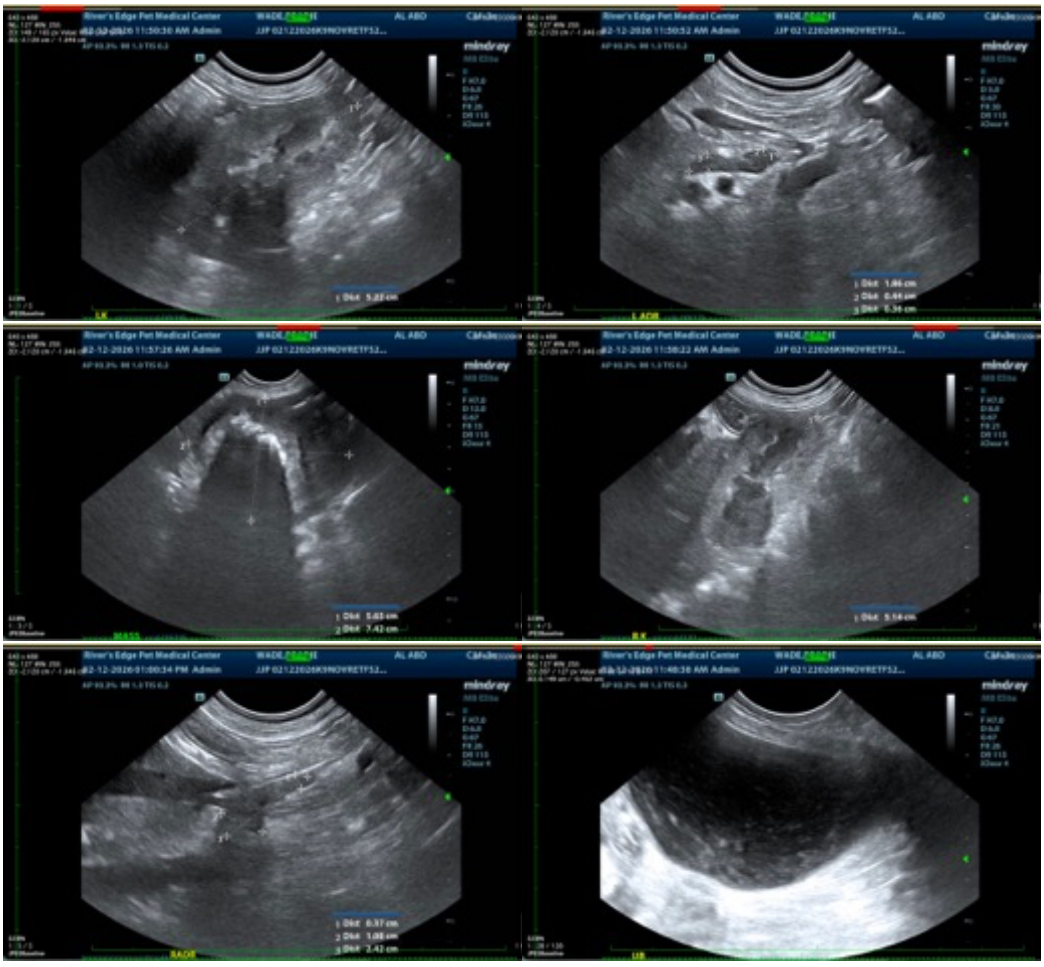
Fine needle aspirates of the bowel mass are recommended if patient's coagulation status is appropriate.

Pending results of cytology or if a cytologic diagnosis is unable to be obtained, or if patient is believed clinically to be fully obstructed and/or septic, ultimately, an exploratory laparotomy for planned resection and anastomosis of the mass may be warranted. If pursued, consultation with a veterinary surgeon is recommended.

In the meantime, to further help guide medical management, following mass removal, etc., Additional gastrointestinal diagnostics to get pending could include:

- 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.



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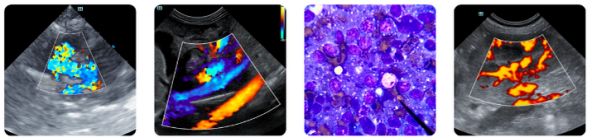

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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