PATIENT

Charlie Walker

SPECIES

Canine

BREED

Shi-Poo

SEX

Neutered Male

AGE

15 Years

WEIGHT

4.8 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Wellington Animal Hospital

REFERRING VET

Dr. Dennis

INVOICE

13105

DATE

01/12/26

PRESENTING CLINICAL SIGNS

Anal gland tumor found in Nov In Dec developed acute vomiting/diarrhea, blood work suggested mild pancreatitis Resolved with supportive care but then returned this week (diarrhea and decreased appetite) Current Medications Metronidazole 10mg/kg

Abnormal PE/Chem/CBC/UA Results: Lab work attached Consistent hypercalcemia with elevated renal values r/o secondary to anal gland tumor Primary Question to Be Answered in This Exam Concerned about spread of suspected cancer from anal glands to other organs contributing to GI issue

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is nearly completely empty with diffusely thickened walls, likely secondary to pseudohypertrophy. Within the lumen, there are multiple shadowing cystoliths visible with the largest measuring 0.57 cm in diameter.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. The right kidney measured 3.5 cm in length. The left kidney measured 3.2 cm in length.

Adrenal Glands

Adrenal glands are visualized and measured on still images only. Resolution is inadequate to assess glandular detail or confirm measurement. The left adrenal gland measured 1.48 cm in length and 0.64 cm at the cranial pole and 0.50 cm at the caudal pole. The right adrenal gland measured 1.16 cm in length and 0.91 cm at the cranial pole and 0.54 cm at the caudal pole.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

ULTRASONOGRAPHIC FINDINGS

- Nephrocalcinosis.
- Multiple cystoliths.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There's no obvious intra-abdominal spread of reported anal gland tumor. Hypercalcemia is likely hypercalcemia malignancy related to anal gland tumor. Hypercalcemia is a likely cause of the GI signs, acute kidney injury, nephroliths, and cystoliths. Anal gland tumor removal should be considered. Cystotomy with plan for stone removal should be considered when hypercalcemia and AKI have resolve.

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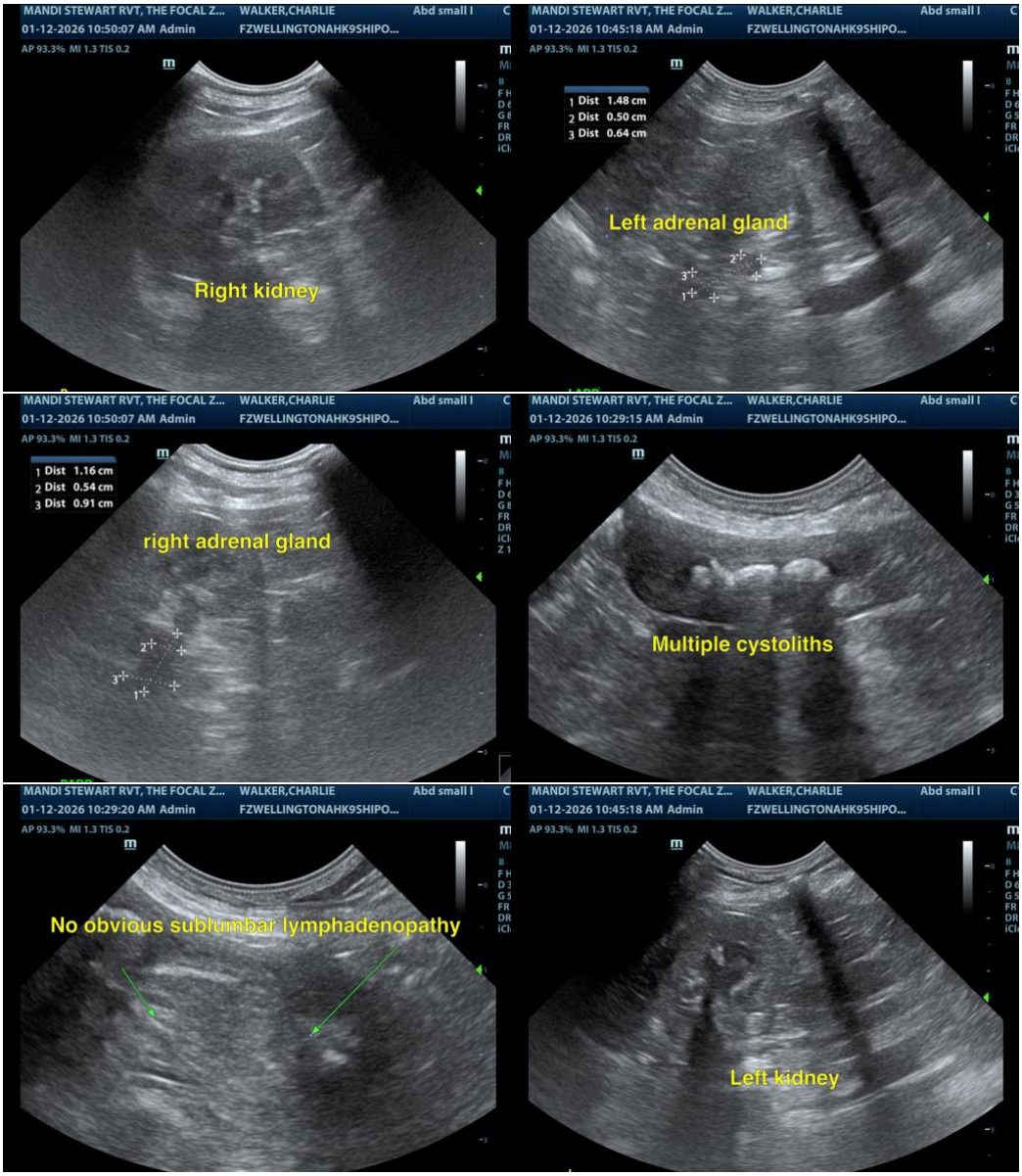

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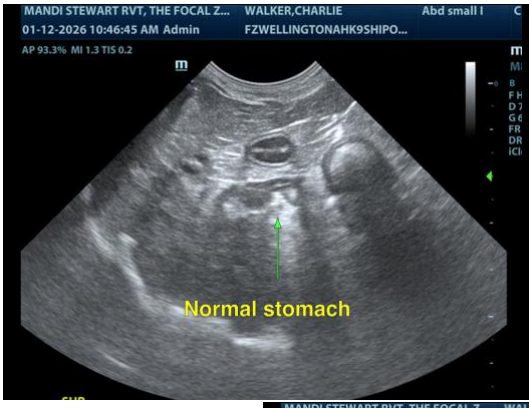

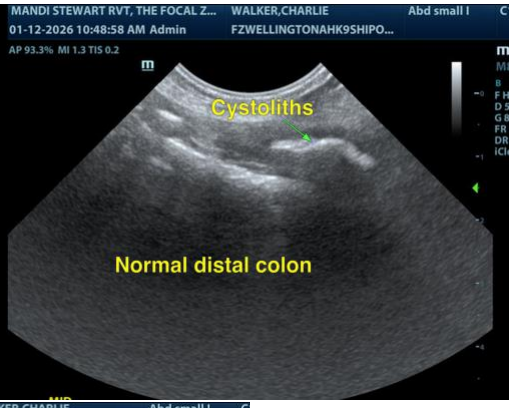

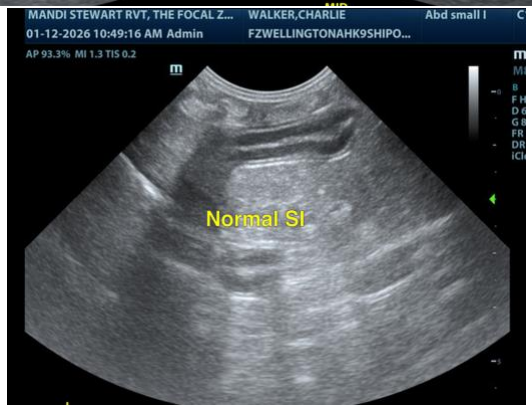

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com