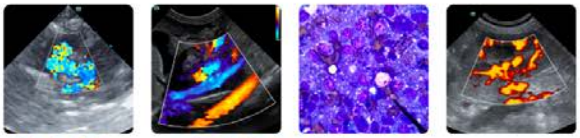


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Astra Barrett

SPECIES

Canine

BREED

Bully x

SEX

Spayed Female

AGE

10 Years

WEIGHT

28.2 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Westoak Animal Hospital

REFERRING VET

Dr. Kohlmaier

INVOICE

72290

DATE

1/20/26

PRESENTING CLINICAL SIGNS

History of pancreatitis and is currently experiencing a decreased appetite.

Fever of unknown origin.

Primary Question to Be Answered in This Exam - Why has appetite decreased?

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. Left measures 7.47 cm. Right measures 6.95 cm.

Adrenal Glands

In the area of the left adrenal gland there is an ovoid heterogeneous mass measuring 3.4 cm x 2.6 cm.

The right adrenal gland is not distinctly visualized.

Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a 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 age 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.

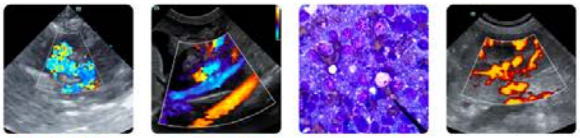
Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains a small amount of ingesta. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

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. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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.



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Pancreas

The area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Left adrenal mass.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No cause of reported fever was identified on abdominal ultrasound. Additional diagnostics to be considered include current chem/lytes/CBC, urinalysis and culture, thoracic radiographs (to assess for occult pneumonia), infectious disease testing (FUO PCR, regionally appropriate fungal and leptospirosis testing, etc - results may be confounded by prior or concurrent antibiotic administration), orthopedic radiographs (to assess for osteolytic lesions or sources of pain). More invasive diagnostics may include joint taps with fluid analysis, cytology and culture, CSF tap and fluid analysis. Fever cases can be frustrating as an underlying cause is not found in up to 50% of cases despite extensive work-up. Empiric treatment with broad spectrum antibiotic medications, other supportive care as clinically indicated and careful monitoring for clinical decline is not unreasonable. Some cases are steroid responsive - use of the lowest dose possible for the shortest treatment course possible is recommended.

The adrenal gland mass is not a likely cause of reported GI signs or fever, but this cannot be completely ruled out.

Left adrenal gland enlargement is most consistent with adrenal mass which may be malignant or benign. It appears subjectively resectable with capsular expansion without obvious capsular escape or vascular invasion. Right adrenal gland was not definitively visualized in this study and another attempt to visualize the adrenal under heavy sedation could be considered to further investigate the possibility of bilateral disease, which may change the diagnostic/treatment approach. If adrenal glands are bilaterally enlarged, pituitary dependent hyperadrenocorticism is most likely. A urine cortisol creatinine ratio could be used as a screening test. Low dose dexamethasone suppression test may be of use to non-invasively further investigate this possibility as it has the potential to both diagnose hyperadrenocorticism and differentiate between adrenal and pituitary dependent disease. Abdominal CT may be of use for further evaluation of the glands and is recommended along with thoracic CT for metastasis if surgical removal is pursued. Differentials owing to sonographic architecture and clinical history include carcinoma, pheochromocytoma, adenoma, hyperplasia, cortisol secreting tumor, myelolipoma less likely. I recommend urine catecholamine screen (available through Marshfield labs) for pheochromocytoma detection if surgical removal is pursued as pre-surgical treatment of pheochromocytoma is essential. It is possible to have both cortisol and catecholamine secretion from the same adrenal tumor so presence of hypercortisolemia does not obviate the need for presurgical urine metanephrine screening.

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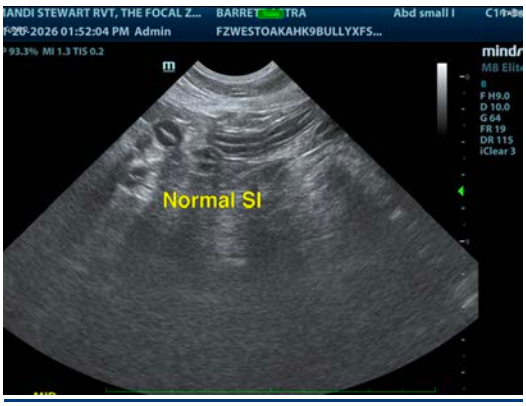

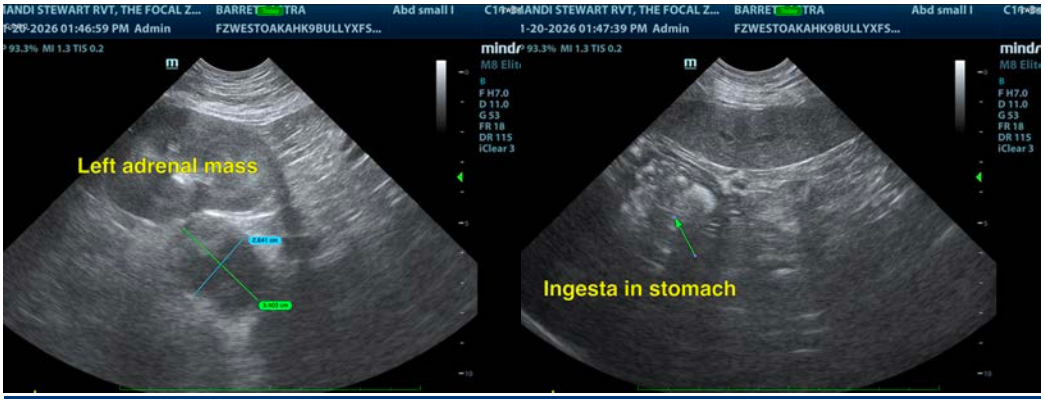

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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