



PATIENT

Lulu Conklin

SPECIES

Canine

BREED

Shih Tzu

SEX

Spayed Female

AGE

12 Years

WEIGHT

15.8 lbs

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons),
DACVECC

IMAGING PERFORMED BY

Meghan Morse, LVT,
CVT

HOSPITAL NAME

Newton Veterinary
Hospital

REFERRING VET

Dr. Wyman

INVOICE

73002

DATE

1/7/26

PRESENTING CLINICAL SIGNS

Hx of increased LEZ and regurgitation daily. No current meds

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 have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measures 3.89 cm. Right kidney measures 3.84 cm.

Adrenal Glands

The adrenal glands are bilaterally prominent and measure enlarged. Echogenicity, especially of the left adrenal gland, is somewhat heterogeneous, with more significant enlargement of the caudal pole of the left adrenal gland. Visible phrenic vasculature is unremarkable. Left measures 1.84 cm in length x 0.72 cm at the cranial pole and 1.13 cm at the caudal pole. Right measures 2.09 cm in length x 0.74 cm at the cranial pole and 0.59 cm at the caudal pole.

Spleen

The spleen had hyperechoic pinpoint foci throughout consistent with hyperechoic stippling suggestive of dystrophic mineralization. It had a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. There were no specific masses or nodules seen.

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 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.

Sections of colon are visualized with fluid fecal material consistent with diarrhea. There is no observed focal or generalized colon wall thickening or loss of layering.



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Pancreas

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In the right limb of the pancreas there is a hypoechoic to somewhat heterogeneous nodule measuring 1.1 cm x 1.1 cm. Remainder of pancreatic parenchyma is normal.

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Lymph Nodes

Canine

No clinically significant lymphadenopathy or abnormalities noted.

BREED

Free Abdomen

Shih Tzu

No masses or free fluid were noted.

SEX

ULTRASONOGRAPHIC FINDINGS

Spayed Female

- Pancreatic nodule.
- Degenerative renal changes with nephrocalcinosis.
- Bilateral adrenomegaly with more significant enlargement of the caudal pole of the left adrenal gland.
- Hyperechoic stippling throughout the spleen.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The clinical significance of the pancreatic nodule is uncertain. It is possible that this represents a peripancreatic enlarged lymph node, though this is less strongly suspected based on ultrasonographic appearance. Unfortunately, it is in an area that would be very difficult or impossible to access via FNA, given surrounding GI tract, and surgical biopsy may be required to further investigate. Abdominal CT could be considered prior to pursuing surgery to further visualize the area. Alternatively, serial monitoring with ultrasound in 1-3 months is not unreasonable pending progression of clinical signs and overall patient stability. If surgery is pursued, GI and liver biopsies could also be considered, given the reported elevated liver values and GI signs.

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CVT

Bilateral adrenomegaly is most consistent with pituitary dependent hyperadrenocorticism. The reason for the more significant enlargement of the caudal pole of the left adrenal gland is uncertain. A developing adrenal mass is possible. Serial monitoring with ultrasound is recommended. Adrenal gland function testing should be considered.

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Splenic parenchymal changes are most consistent with dystrophic mineralization which is commonly seen with hyperadrenocorticism or other causes of mineral imbalance. Splenic aspirate could be considered if clinically warranted.

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The liver parenchyma appears normal and there is no ultrasonographic explanation for the elevated liver enzymes in this patient. There is no significant disruption of architecture noted to suggest significant pathology. Low grade inflammatory hepatopathy/reactive hepatopathy is a likely cause of LE elevations. Fine needle aspirate is recommended and bile acid profile to assess liver function. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol if bilirubin elevated or gall bladder sludge) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued.

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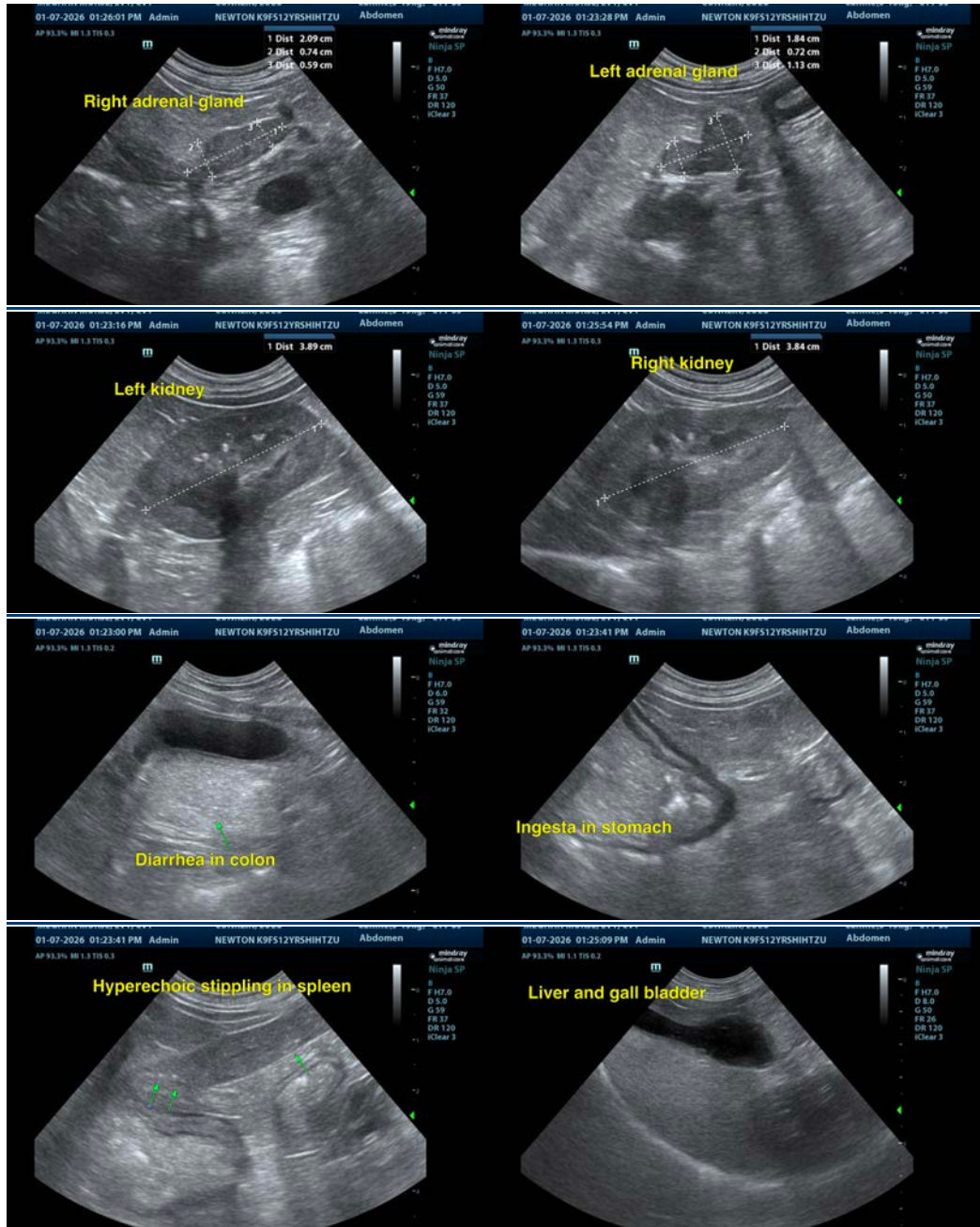
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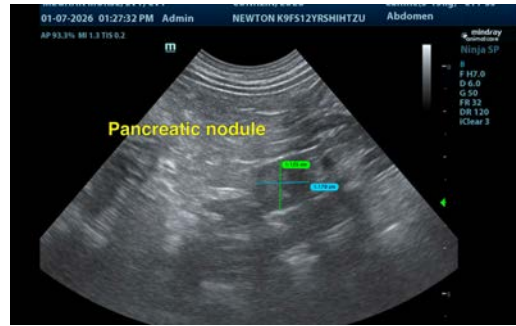
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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