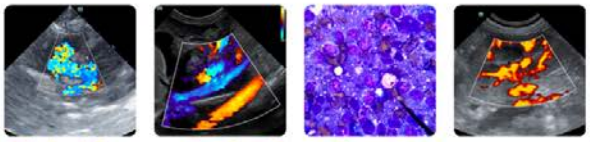


PATIENT

Chloe Carroll

SPECIES

Canine

BREED

Lab Retriever

SEX

Spayed Female

AGE

10 Years

WEIGHT

64.4 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Sheldon

HOSPITAL NAME

Advanced PetCare of Oakland

REFERRING VET

Dr. Langfelt

INVOICE

71785

DATE

11/13/25

PRESENTING CLINICAL SIGNS

Intermittent vomiting x6 months, usually food within 15 minutes of eating. Frequency increasing. Normal vomits a few times weekly. Grass eating behavior also increasing. Normal energy, normal appetite. Stage B1 DMVD with grade 2 murmur, managed by cardiology. On omeprazole daily x5-6 months but no significant difference in vomiting noted so it was discontinued. Started GI low fat diet and ondansetron 6 weeks ago and is having rare vomiting now but will have fecal incontinence a few times a day when nervous and excited. No diarrhea noted.

Abnormal PE/Chem/CBC/UA Results: Mild leukopenia (new) characterized by neutropenia, lymphopenia, eosinopenia. Mild/mod mixed hepatopathy (ALT 388, AST 80, ALP 454) - progressive. Radiographs of chest/abdomen: CONCLUSION: 1. There is no evidence of pyloric outflow or small intestinal mechanical obstruction. 2. Cranioventral thoracic summation of regional soft tissue structures (vasculature, cutaneous/subcutaneous nodule, etc.). A small pulmonary nodule (metastasis, granuloma, etc.) is considered somewhat less likely. 3. Equivocal left atrial enlargement. There is no evidence of left heart failure. 4. Left elbow and left stifle degenerative joint disease.

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 mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci present bilaterally in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measures 5.85 cm. Right kidney measures 6.2 cm.

Adrenal Glands

The right adrenal gland is visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Right measures 1.97 cm in length x 0.73 cm in thickness.

The left adrenal gland is significantly enlarged and efface with hyperechoic to slightly heterogeneous mass tissue. Visible phrenic vasculature is unremarkable. Left measures 3.57 cm in length x 1.08 cm at the caudal pole and 1.62 cm at the cranial pole.

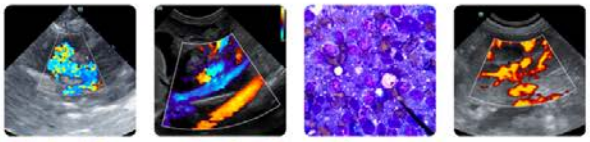
Spleen

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 irregular borders. The parenchyma is heterogenous with a coarse appearance. No specific nodules are visualized. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

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



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Gastrointestinal

The stomach contains minimal luminal contents. 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 gas throughout with no overt distention. 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 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 area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

ULTRASONOGRAPHIC FINDINGS

- Left adrenal mass.
- Aging renal changes with nephrocalcinosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no ultrasonographically evident cause of reported GI signs in this abdominal study. Pancreas and GI tract are within normal limits. Consideration for dietary indiscretion, infectious etiologies (bacterial, viral, parasitic), food sensitivity/allergy or mild inflammatory bowel disease is reasonable. While not sonographically evident, pancreatitis cannot be completely ruled out. Empiric treatment for GI signs including anti-nausea, appetite stimulant and fluid support as clinically indicated is warranted. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically. If signs are persistent or recurrent, additional diagnostics to be considered include baseline cortisol +/- ACTH stimulation test, GI panel (TLI/PLI/cobalamin/folate), fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes. Ultimately GI biopsy may be required for more definitive diagnosis if the patient is not responsive to medical treatment.

Bilious vomiting syndrome is a diagnosis of exclusion in dogs and describes a benign cause of intermittent vomiting of bile. Most frequently the vomiting is in the morning or after other extended period without being fed. Offering a small snack to interrupt up prolonged fast (example, before bed) is often effective at eliminating or significantly reducing symptoms. Antacids are often tried but are of no proven benefit.

The 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. Pre-surgical abdominal CT for surgical planning and thoracic CT for metastasis screen is recommended. Differentials owing to sonographic architecture and clinical history include carcinoma,

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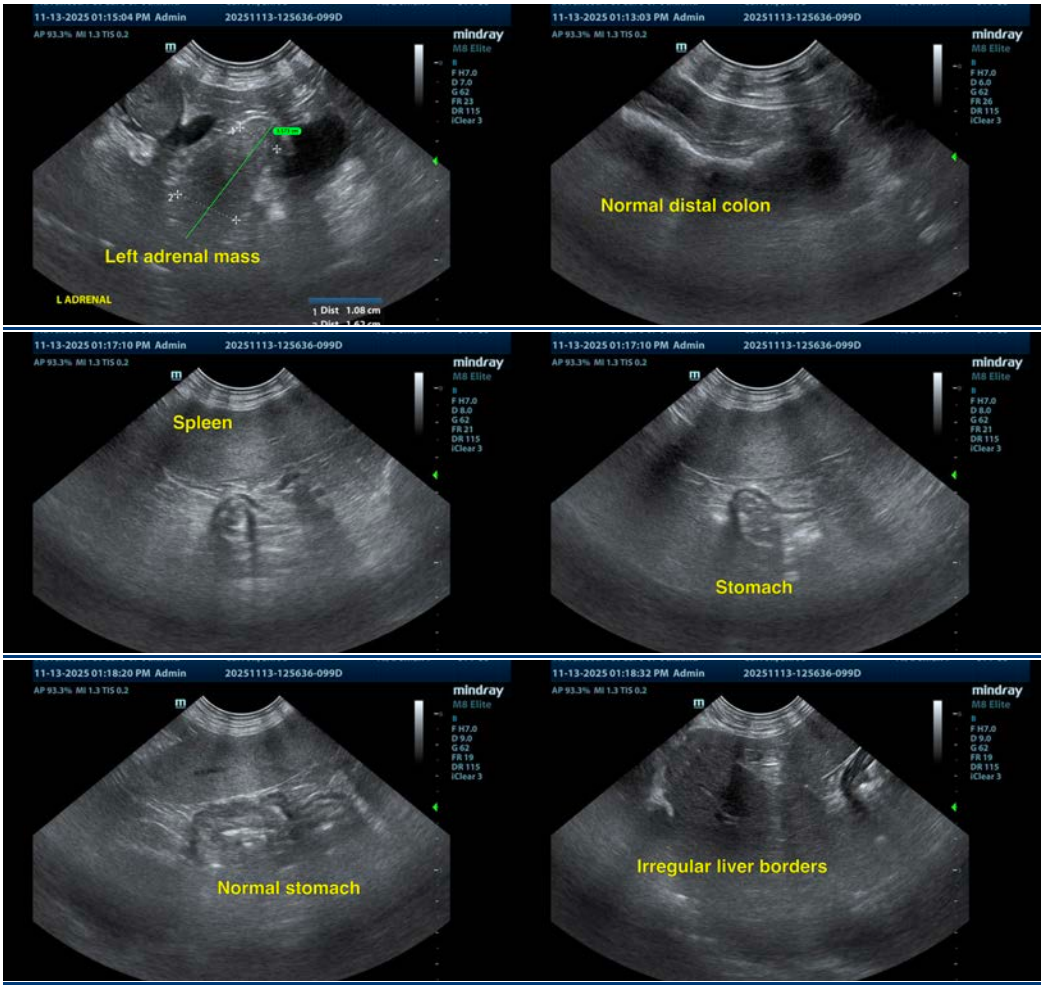
pheochromocytoma, adenoma, hyperplasia, cortisol secreting tumor, myelolipoma less likely. I recommend urine catecholamine screen for pheochromocytoma detection if surgical removal is pursued as pre-surgical treatment of pheochromocytoma is essential. It is possible to have both cortisol and catecholamine secretion from the same adrenal tumor so presence of hypercortisolemia does not obviate the need for presurgical urine metanephrine screening. This is an unlikely but possible cause of chronic vomiting.



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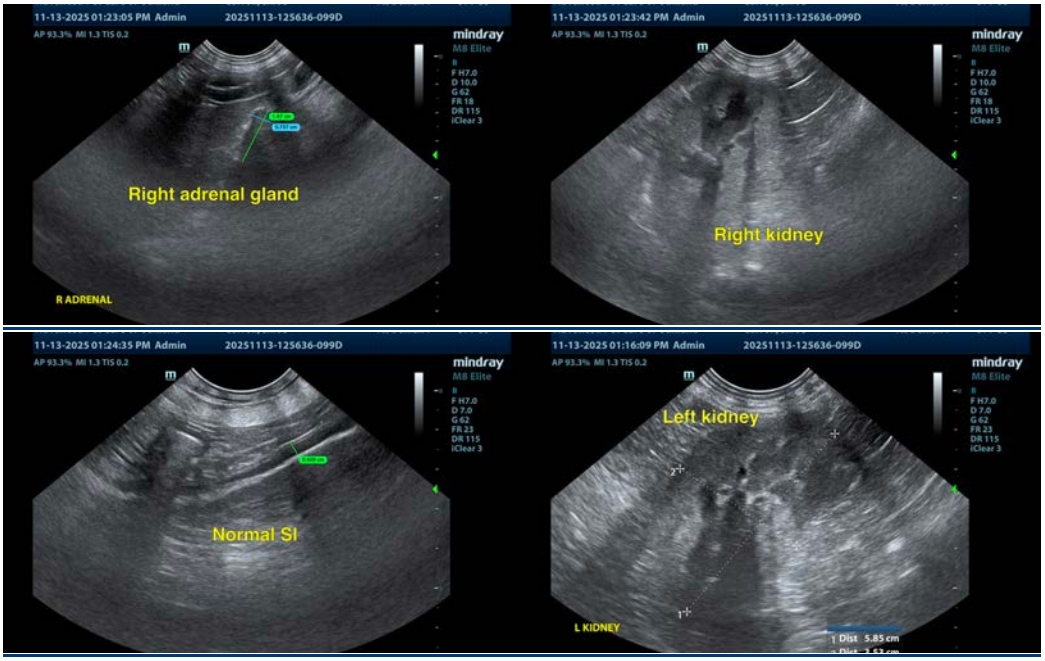

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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