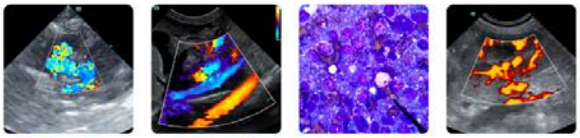


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Lenny Velazquez

SPECIES

Canine

BREED

Boston Terrier

SEX

Neutered Male

AGE

13 Years

WEIGHT

10.8 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Animal Hospital of Kitchener/Waterloo

REFERRING VET

Dr. Akhliesh

INVOICE

72577

DATE

12/15/25

PRESENTING CLINICAL SIGNS

Findings: Pain on abdominal Palpation Has had previous abdominal mass removal surgery. Low grade spindle cell sarcoma in Nov 2023 Primary Question to Be Answered in This Exam Why is abdomen painful

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder lumen volume is small, and walls are diffusely thickened most consistent with pseudohypertrophy. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal focal 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 5.34 cm. Right measures 5.35 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized. Both were subjectively prominent. No specific masses or nodules seen. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Left measures 1.81 cm in length x 0.68 cm at the caudal pole and 0.41 cm at the cranial pole. Right measures 2.82 cm in length x 0.66 cm at the caudal pole and 1.39 cm at the cranial pole.

Spleen

A small portion of the spleen was visualized. It was overtly normal with normal echotexture and no masses or nodules seen.

Liver

The liver is enlarged with rounded hepatic margins. Parenchyma is generally smooth and homogeneous and slightly hyperechoic. There are no specific masses or nodules seen.

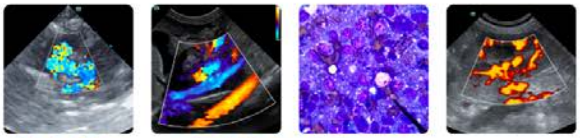
Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains 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 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.



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

PATIENT

Lenny Velazquez

SPECIES

Canine

BREED

Boston Terrier

SEX

Neutered Male

AGE

13 Years

WEIGHT

10.8 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Animal Hospital of Kitchener/Waterloo

REFERRING VET

Dr. Akhliesh

INVOICE

72577

DATE

12/15/25

Pancreas

The left limb and body of the pancreas is enlarged and hypoechoic with surrounding hyperechoic mesentery. No fluid accumulations visualized. No mass effect consistent with pancreatic neoplasia visualized.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

There is a moderate to large volume of anechoic fluid visible, especially around the liver and in the left abdomen.

ULTRASONOGRAPHIC FINDINGS

- Moderate to large volume abdominal effusion.
- Pancreatitis.
- Hepatomegaly with rounding of liver lobes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Pancreatic changes are most consistent with pancreatitis, and this is a likely cause of reported abdominal pain. The prognosis of acute pancreatitis is largely dependent on the severity of clinical signs and response to treatment. Mortality is reported as high as 25% and secondary organ dysfunction and systemic inflammatory response syndrome can occur as inflammation progresses. Ultrasonographically, pancreatic inflammation is relatively severe in this patient. Ultimately the need for hospitalization for treatment is based on the patient's cardiovascular stability, pain and appetite. Hydration and enteral nutrition are key factors in positive outcomes and if these cannot be achieved on an outpatient basis, hospitalization for 24 hour care is strongly recommended.

Treatment for pancreatitis is entirely supportive and involves fluid support, GI support - anti-nausea (ondansetron, cerenia 2mg/kg PO SID), appetite stimulation (mirtazapine, elura), analgesia (buprenorphine, gabapentin) and enteral nutrition as needed (syringe feeding, NG tube placement, etc). Panoquel could be considered if available and deemed clinically warranted. Antibiotics are generally not warranted for acute pancreatitis as it is usually sterile, however given the severity of inflammation. I would use antibiotics (ex unasyn +/- fluoroquinolone) in this case. Intravenous antibiotics are preferred to ensure absorption and decrease GI side effects of oral antibiotics which can lower appetite compromising treatment and recovery. Anti-inflammatory steroids may be tried in an attempt to reduce inflammation if traditional supportive care is inadequate. Serial imaging is indicated to monitor response to treatment.

Abdominocentesis with plan for fluid analysis and cytology is recommended. While severe pancreatic inflammation can cause abdominal effusion, the amount of abdominal effusion present in this patient is more than I would expect from an inflammatory peritonitis, even if severe. Evaluation for other causes of abdominal effusion such as right-sided congestive heart failure or a pericardial effusion is recommended. If not performed, thoracic radiographs are recommended to further assess.

Bilateral adrenomegaly is of uncertain clinical significance. It may represent pituitary dependent hyperadrenocorticism. This is not the likely cause of current clinical signs, and adrenal gland function

PATIENT

Lenny Velazquez

SPECIES

Canine

BREED

Boston Terrier

SEX

Neutered Male

AGE

13 Years

WEIGHT

10.8 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Animal Hospital of Kitchener/Waterloo

REFERRING VET

Dr. Akhliesh

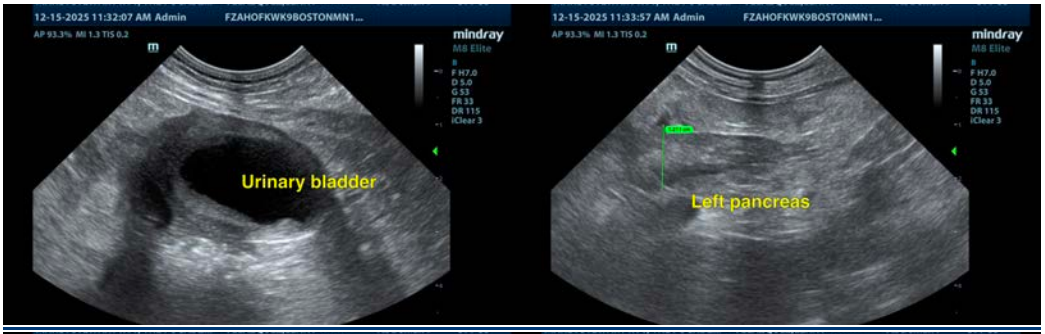
INVOICE

72577

DATE

12/15/25

testing should be done if there is clinical concern for adrenal gland disease when patient has recovered from this acute episode for at least 2-3 weeks.



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