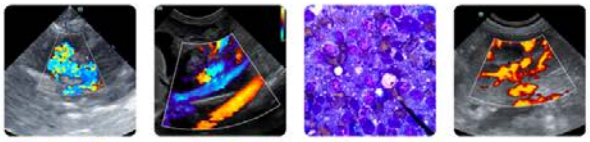


PATIENT

Sally Paterson Aichele

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

10 Years

WEIGHT

47 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Beth Mehaffey

INVOICE

74652

DATE

4/21/26

PRESENTING CLINICAL SIGNS

Hx: Sedated with butorphanol. Presenting for intermittent hematochezia that resolves with metronidazole and reoccurs when discontinued. Hx of IVDD, degenerative changes of the spine and OA. More recent fecal and urinary incontinence. Recent UTI cleared with course of Baytril. AUS performed 7/31/24 and small splenic nodule as well as enlarged adrenal (L) with hyperechoic foci. LDDST performed 8/12/24 and NOT consistent with Cushing's at that time. Chronic meds: Gabapentin, Librela, low dose carprofen PRN, currently on metronidazole, probiotics.

Diagnostics: 2/21/26 Bloodwork: HCT 39.6%, fecal NOS, 4dx neg x4, chem unremarkable. UA - USG 1.016, rods, inc WBC. Treated with baytril.

Thoracic and abd rads: No obvious metastatic disease, increased VHS but no heart murmur, widening of the gastroduodenal angle, multifocal IVDD and degenerative changes to the spine. No discernable cause for hematochezia. Reviewed by radiologist.

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. The left renal pelvis is mildly dilated, measuring approximately 0.30 cm. Right pelvic dilation is not noted. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measures 6.22 cm. Right kidney measures 5.39 cm.

Adrenal Glands

The left adrenal gland is diffusely enlarged and hyperechoic. The cranial pole has an irregular capsular margin suggestive of possible capsular escape. Visible phrenic vasculature is unremarkable, though definitive blood flow is not established in the phrenic vein. Left adrenal measures 3.95 cm in length x 0.51 cm at the caudal pole and 0.89 cm at the cranial pole.

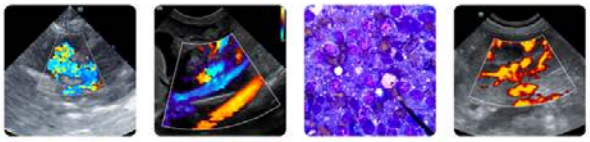
The right adrenal gland is more normal in size, shape and position. The cranial pole measures slightly enlarged but is subjectively normal in size for this patient. Right adrenal measures 4.3 cm in length x 0.90 cm at the caudal pole and 1.67 cm at the cranial pole.

Spleen

The spleen is subjectively prominent. parenchyma is diffusely slightly mottled. No specific nodules are seen on today's scan. No specific masses visualized.

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.



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The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing debris present. There is no surrounding free fluid or signs of active inflammation.

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.

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 visible pancreas was observed to be largely isoechoic to surrounding omental fat.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

- Left adrenomegaly.
- Slightly mottled spleen.
- Aging renal changes with mild left pyelectasia.
- Normal colon.
- Gallbladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Colon is ultrasonographically normal with no signs of mural disease. Colonic wall is of normal thickness with no cause of described clinical signs. GI panel (TLI/PL/cobalamin/folate/cortisol), fecal pathogen PCR, and empiric broad spectrum deworming and treatment with probiotics should be considered. An easily digestible GI diet with consideration for addition of extra fiber could be considered. If initial treatments are unsuccessful, treatment for dietary sensitivity/allergy could be considered which includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, and continued GI support as needed. Colonoscopy may reveal pathology not visible on ultrasound.

Splenic changes are a common benign age related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. No significant disruption of architecture noted to suggest significant pathology. Fine needle aspirate could be considered to further characterize parenchymal changes if clinically indicated, especially if any weight loss is noted or for baseline cytological assessment.

Renal changes are likely age related degeneration. Correlate clinical significance with semi-annual blood work/urinalysis findings and clinical signs. The very mild left pyelectasia may indicate pyelonephritis, though given the patient's reported minimally concentrated urine, this may be simply indicating polyuria.

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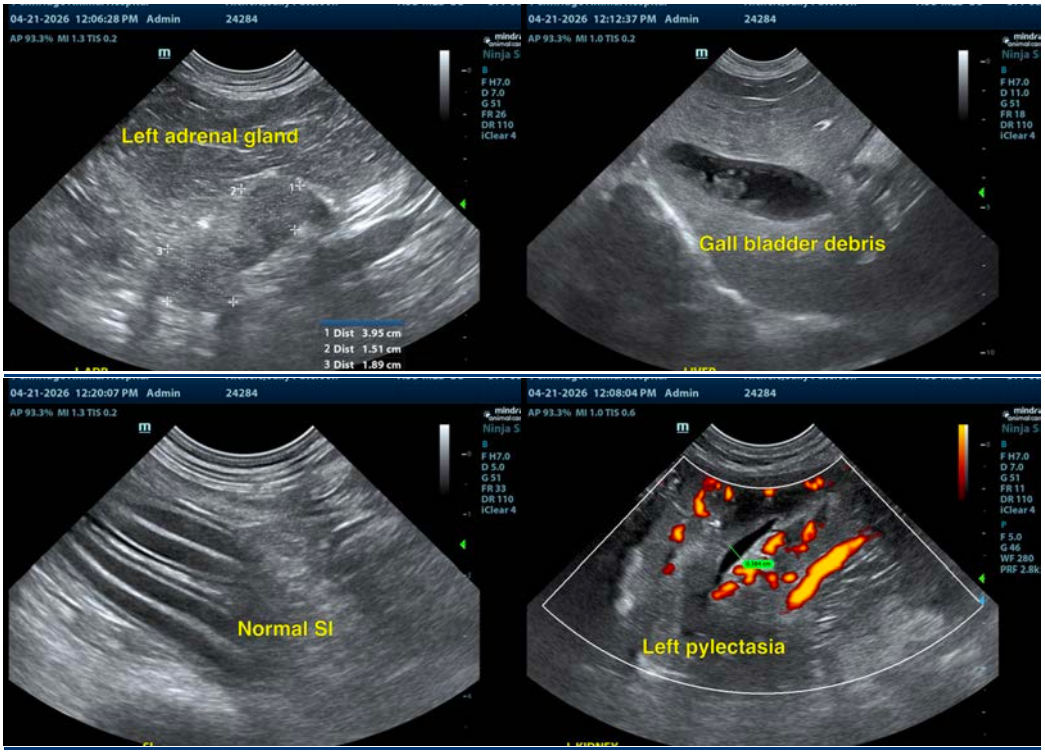
Left adrenal gland enlargement is most consistent with adrenal mass which may be malignant or benign. It appears subjectively resectable. Pre-surgical abdominal CT for surgical planning and thoracic CT for metastasis screen is recommended. Differentials owing to sonographic architecture and clinical history include carcinoma, 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 likely incidental to reported GI signs.

Gall bladder debris is likely an incidental finding and is often subclinical and often does not warrant specific treatment or further investigation. Correlate clinical significance with bloodwork findings and clinical signs. Serial imaging for monitoring could be considered especially if liver enzymes subsequently become elevated. If otherwise clinically indicated, investigation for endocrinopathy such as hyperadrenocorticism or hypothyroidism could be considered as an underlying cause predisposing to gall bladder debris accumulation.



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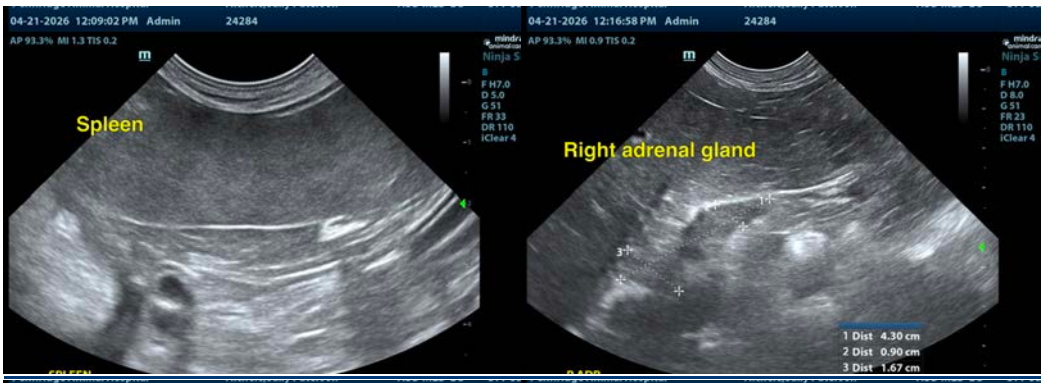

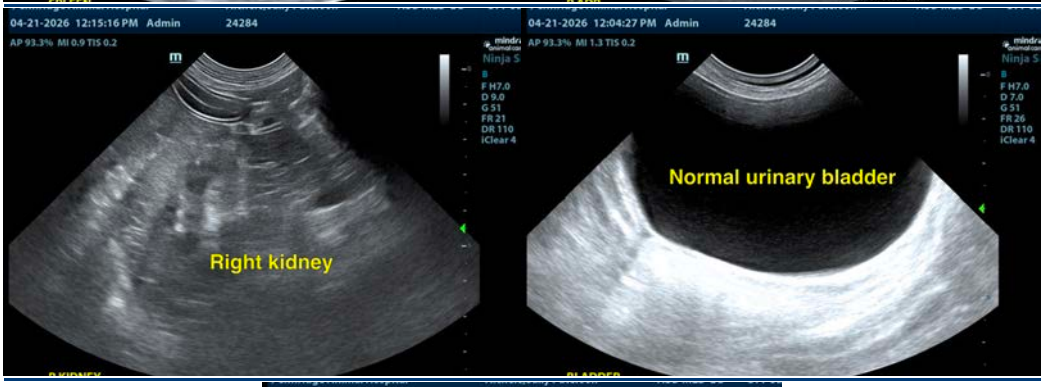

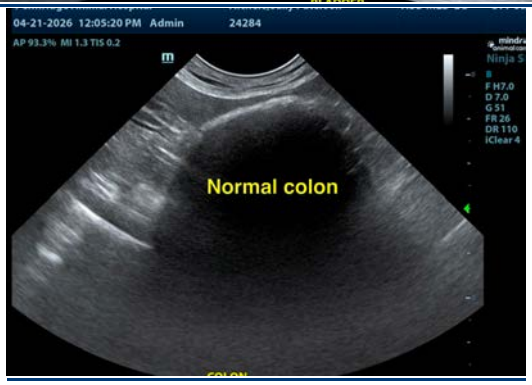

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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