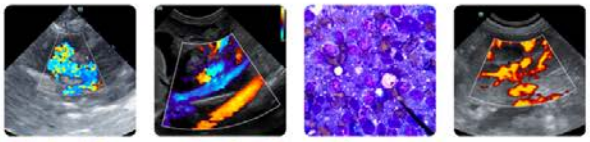


PATIENT

Quinn Curl

SPECIES

Canine

BREED

Boston Terrier

SEX

Intact Female

AGE

9.9 Years

WEIGHT

15.5 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Jen Heller

INVOICE

75091

DATE

5/12/26

PRESENTING CLINICAL SIGNS

Hx: Patient was sedated with butorphanol. 2 month history of a rectal prolapse. Originally it started out mild and would occasionally mildly prolapse and was easy to replace at home by owner. Started to have more inflammation and becoming a larger prolapse with the prolapsed tissue looking somewhat irregular. Patient was sedated on 4/17 and a purse string was placed. After the purse string was removed a week later, the prolapse continued to reoccur and worsen. Another purse string was put in on 5/6 . Plan is to have an abdominal ultrasound to see if a possible colonic mass or other underlying cause of the prolapse is found. If nothing is found, plan for owner to proceed with a spay and colopexy. Current Medications: Metronidazole 75mg PO BID. had been on a course of prednisone, course if finished. owner occasionally gives miralax. Current Diet: raw diet

Abnormal PE/Chem/CBC/UA Results: 4/3/26 - Negative fecal 3/11 and 4/8 - abdominal radiographs show possible obstruction/thickening in colon (mass?), stool is noted and then stops at a suspect soft tissue opacity.

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 kidney measures 4.18 cm. Right kidney measures 4.74 cm. Hyperechoic, shadowing foci present in renal parenchyma and calyces bilaterally, consistent with nephrocalcinosis.

Adrenal Glands

The cranial pole of the left adrenal gland is significantly enlarged with a somewhat irregular capsule and a hypoechoic nodule noted within the parenchyma. The caudal pole has more normal appearance and size. Left measures 2.79 cm in length x 0.54 cm at the caudal pole and 1.05 cm at the cranial pole.

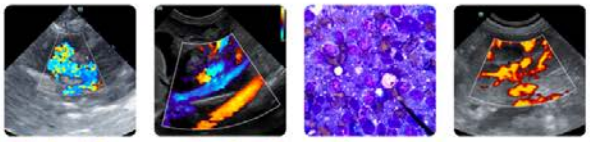
The right adrenal gland is slightly small in size with normal shape, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Right measures 2.16 cm in length x 0.42 cm at the caudal pole and 0.38 cm at the cranial pole.

Spleen

The spleen had a generally smooth homogeneous parenchyma and a smooth capsule with a solitary hyperechoic nodule visualized most consistent with benign myelolipoma. There was 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.



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Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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.

In the distal colon there is significant thickening of colonic tissue, suspected to represent a distal colonic intussusception. The remainder of the visible colonic wall is of normal thickness with normal wall 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.

There is a spherical structure with a anechoic contents in the area of the left ovary measuring approximately 1.0 cm x 1.3 cm, suspected to represent a left ovarian cyst.

ULTRASONOGRAPHIC FINDINGS

- Distal colonic thickening – most consistent with colonic intussusception.
- Developing left adrenal mass.
- Mild nephrocalcinosis.
- Gallbladder debris.
- Cyst in the area of the left ovary.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mass effect noted on abdominal radiographs is suspected to represent a colonic intussusception, which likely intermittently resolves with colonic prolapse. An underlying cause is not identified. There is no ultrasonographically apparent mass noted on ultrasound. An intrapelvic mass cannot be completely ruled out. Consultation with a veterinary surgeon could be considered to discuss further options. Plan for ovariohysterectomy and colopexy may be reasonable.

The cystic structure in the area of the left ovary is suspected to represent an ovarian cyst.

Left adrenal gland cranial pole changes are most consistent with an early 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, pheochromocytoma, adenoma, hyperplasia, cortisol secreting tumor,

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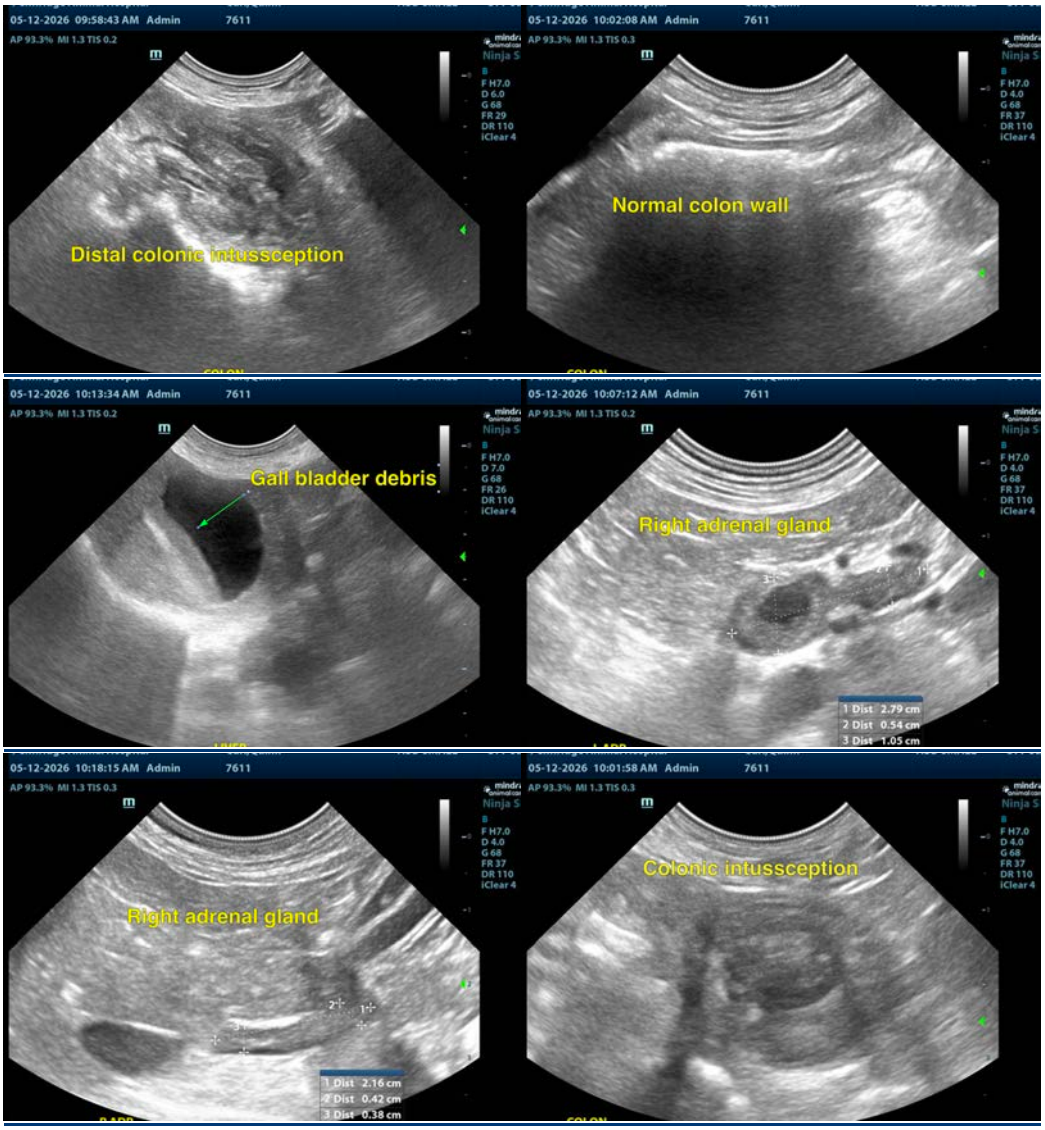
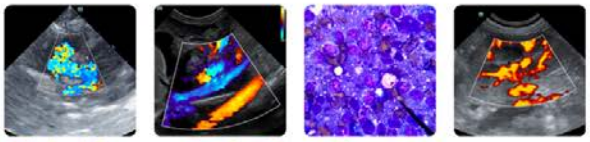
myelolipoma less likely. Adrenal gland function testing (ACTH stimulation test and/or LDDST and urine metanephrine screen) should be considered to further evaluate functionality. I recommend urine catecholamine screen for pheochromocytoma detection if surgical removal is pursued as pre-surgical treatment 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. Serial ultrasound in evaluations (every 2-3 months) for progression could alternatively be considered. This is likely incidental to rectal prolapse.





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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