PATIENT

Squid Tindall

SPECIES

Canine

BREED

English Setter

SEX

Spayed Female

AGE

11 Years 5 Months

WEIGHT

52.7 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Chloe Lowe CVT

HOSPITAL NAME

Newton Veterinary Hospital

REFERRING VET

Dr. Hipkin

INVOICE

16315

DATE

05/18/26

PRESENTING CLINICAL SIGNS

Suspected pancreatitis and gastric outflow obstruction. Painful cranial, abdomen, abdomen pendulous (gastric distention with mineral opaque foreign objects after 12 hours fast) carprofen(chronically), gabapentin, Clavamox.

BUN 48.3, phos 5.2, chol 424, Alt 165, Alp 2082, CPLi abnormal, neu 17.31, Wbc 19.34

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. Pinpoint areas of cortical mineralization. The left kidney measured 6.13 cm in length. The right kidney measured 5.78 cm in length.

Adrenal Glands

The left 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. The left adrenal gland measured 1.6 cm in length and 0.45 cm at the caudal pole and 0.47 cm at the cranial pole.

The right adrenal gland is diffusely enlarged and heterogeneous, consistent with effacement with mass. The right adrenal gland measured 3.67 cm in length and 1.63 cm at the caudal pole and 2.41 cm at the cranial pole.

Spleen

The spleen is subjectively normal in size with a generally smooth homogenous parenchyma. There are a few hypoechoic nodules noted within the spleen, the largest of which measures 0.5 cm x 0.7 cm.

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 appears to be distended with gas and material, causing complete acoustic dropout, most consistent with foreign material.

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

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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

Pancreatic tissue is not definitively visualized, likely due to gas shadowing from stomach. The area around the pancreas does not have significant inflammation visible.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

The right auricle and pericardium were unremarkable. No obvious pathology. If cardiac function evaluation is desired a full echocardiogram is warranted.

ULTRASONOGRAPHIC FINDINGS

- Shadowing material in the stomach most consistent with gastric foreign material.
- Right adrenal mass.
- Aging renal changes.
- Multiple small splenic nodules.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Hard shadowing in stomach likely represents non-food material. This shadowing could be a trichobezoar, foreign material, accumulation of plant debris, etc. Endoscopic visualization and retrieval should be considered. Abdominal exploratory surgery with plan for gastrostomy is an alternative.

Right 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, 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.

Splenic nodules are small but has the ultrasonographic features concerning for a mass. They may represent neoplasia with a primary differential being early hemangiosarcoma or may be a benign growth such as a hemangioma or hematoma. FNA is recommended. Consideration for splenectomy is reasonable given the aggressive nature and rapid progression of hemangiosarcoma, though the nodules do not overtly have the appearance of aggressive neoplasia. Repeat ultrasound evaluation

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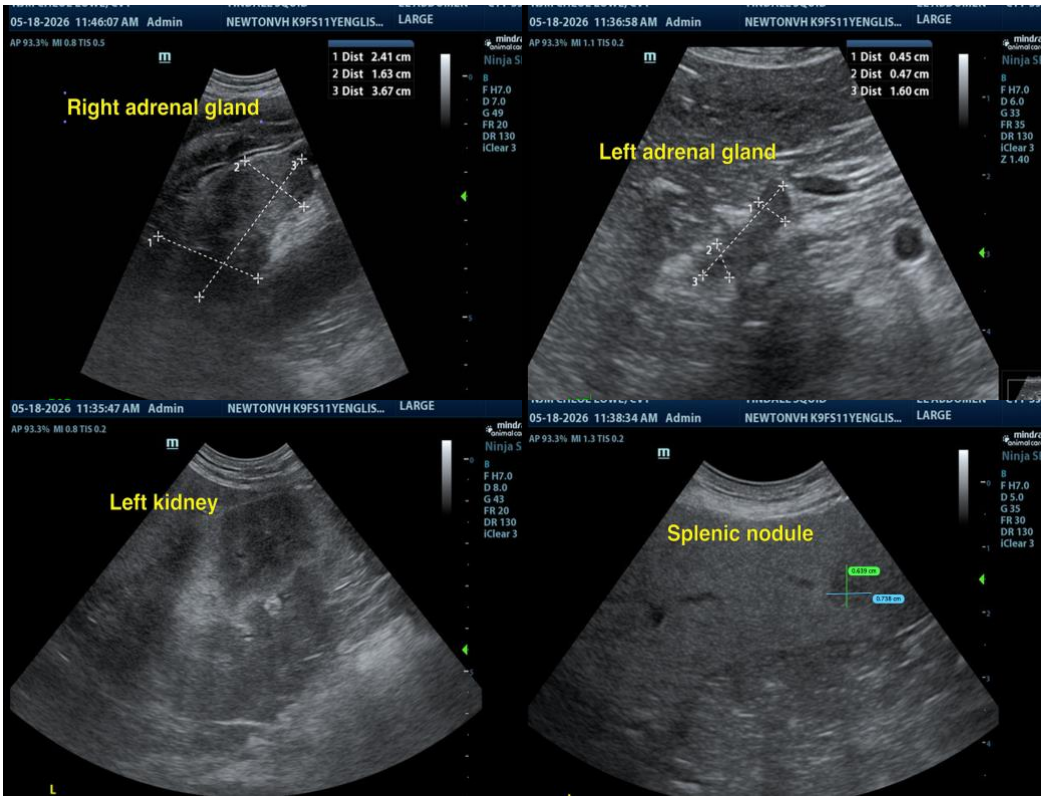
(every 2-3 months) for progression or resolution could alternatively be considered, though this increases the chances of spread if malignant neoplasia is the underlying cause.



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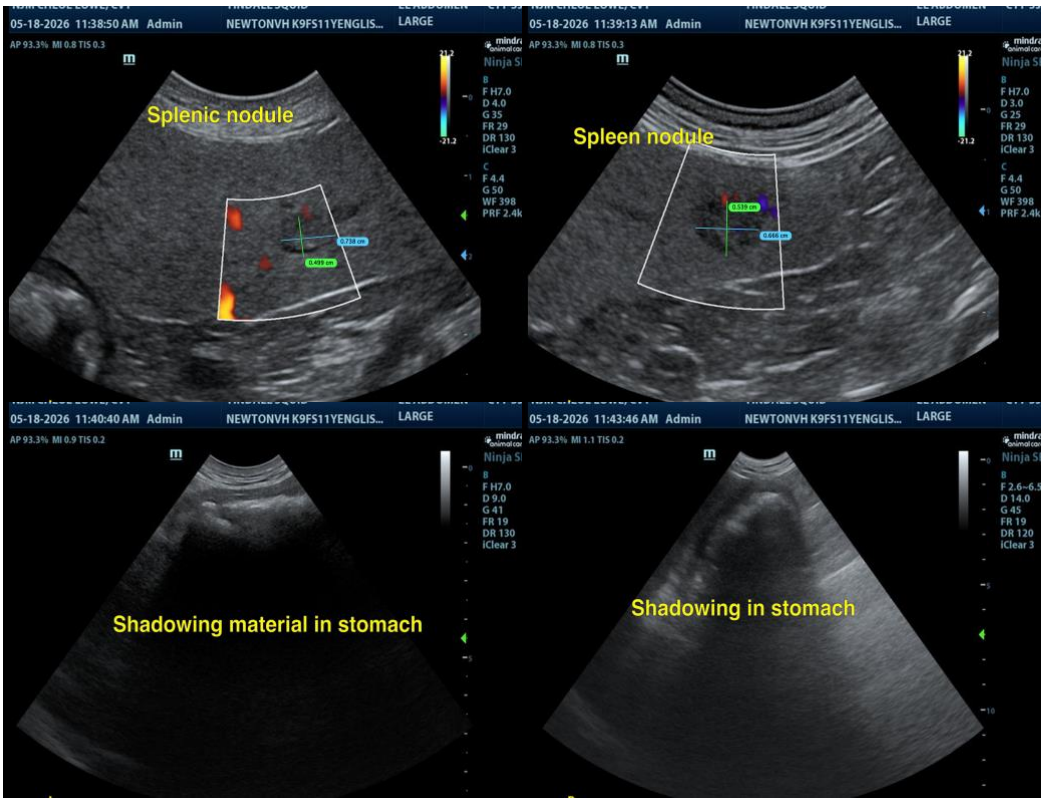

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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