



**PATIENT**

Buddha Griffin

**SPECIES**

Canine

**BREED**

French Bulldog

**SEX**

Neutered Male

**AGE**

6 Years

**WEIGHT**

10.5 kg

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Danielle Jaspar

**HOSPITAL NAME**

Orchard VC

**REFERRING VET**

Dr. Reilly

**INVOICE**

22451

**DATE**

5/10/23

**PRESENTING CLINICAL SIGNS**

History of ~ 3 weeks vomiting, anorexia, dark colored stools. Treated with Cerenia, omeprazole for possible ulcer Recheck, no improvements, ran full blood work, mild anemia, neutrophilia and low Alb. Abdominal radiographs and AUS preformed. Dx: neoplasia, IBD, ulcer, other

\*A large amount of images were excessively dark, obscuring some interpretation.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal. The pelvic urethra was imaged 1.0 cm beyond the cystourethral junction.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities.

**Adrenal Glands**

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient.

**Spleen**

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

**Liver**

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

**Gastrointestinal**

The **gastric** wall was mildly thickened with a minor amount of fluid filled lumen. A cranial abdominal gastrointestinal mass was noted, presumed to be jejunal. FNA is indicated. The mass is possibly resectable. However, I cannot completely rule out the potential of gastric mass, as the mass is superimposing upon the stomach, but appears to be associated with the small intestine. Slight regional lymphadenopathy was also noted yet length to width ratio was maintained.

**Pancreas**



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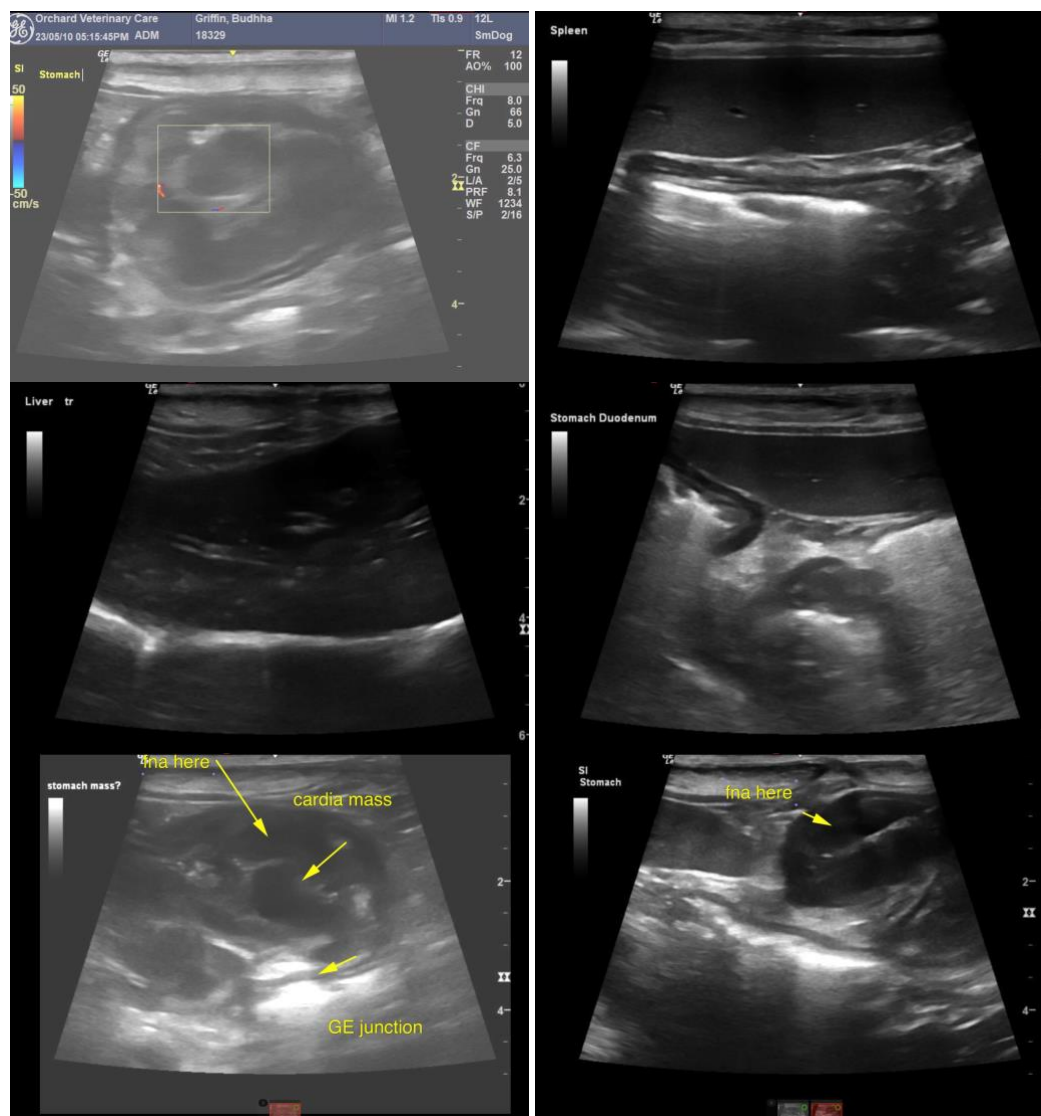
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

## ULTRASONOGRAPHIC FINDINGS

- Upper gastrointestinal mass, presumed to be jejunal
- Minor gastritis pattern
- Slight regional lymphadenopathy

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

FNA of the mass is indicated. Carcinoma, gastric lymphoma and granulomatous disease are all possible. GI protectant protocol is warranted. Exploratory surgery could be considered, however, full resection of the pathology may be difficult, depending on if the gastric wall is emerging neoplastic, as well as the primary mass. Chest radiographs are warranted to assess for metastatic disease.





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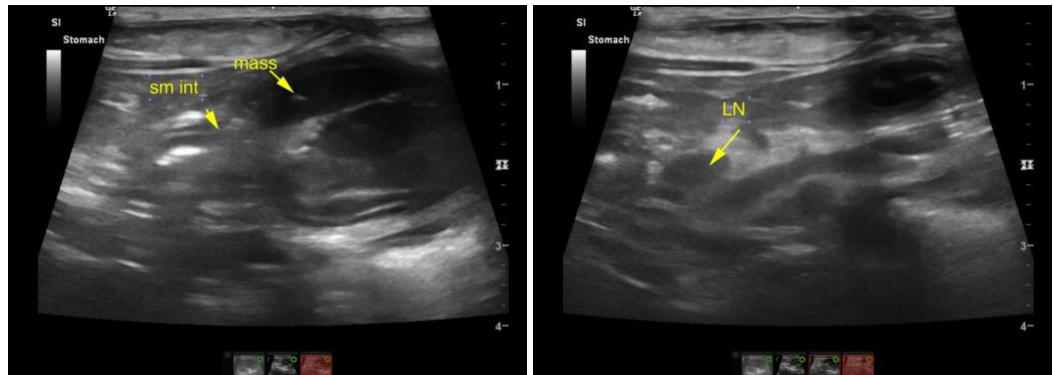
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Eric Lindquist**, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com  
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