



PATIENT

Loki Moretti

SPECIES

Canine

BREED

American Eskimo

SEX

Neutered Male

AGE

14 Years 6 Months

WEIGHT

13.5 kg

INTERPRETED BY

Eric Lindquist, DMV,
DABVP(CFM), Cert.
IVUSS

IMAGING PERFORMED BY

Renee Trionfetti VMD

HOSPITAL NAME

Blue Pear Wyomissing

REFERRING VET

Blue Pear Wyomissing
ER

INVOICE

16053

DATE

05/11/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate hematemesis, 1 day anorexia, possible FB. Transferred to ER from urgent care. Yesterday eating but V+. Not wanting to eat today at all. Anorexia (Inappetence) (r/o FB vs. pancreatitis vs. neoplasia vs. other), Vomiting, Regenerative Anemia (mild - r/o GI bleeding vs. other), Loose Tooth (suspect 206), Advanced Periodontitis, Ataxia (moderate, generalized) - historical per O r/o spinal injury > other. Medications: gaba, got cerenia at FFUC

Abnormal PE/Chem/CBC/UA Results: Firefly diagnostics: CBC: Hct 30% (L), retics 184k (H), WBC 21k (H), neut 17.8 (H), lymph 1k (L), mono 1.35k (H), plt 87k (L< but on inVue plt estimate > 150k) Chem 15: NSF (BG 105, creat 0.8, BUN 8, Na 152, Cl 110, K 4, alb 3, glob 3.9, ALT 38) Rads: chest fairly NSF for older dog, dilated bowel loops POCUS: no pleural/pericardial/peritoneal effusion appreciated; dilated bowel w/ some "sloshing" back and forth, shadowing object noted in intestines

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra to a depth of 3.0 cm 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 **residual prostate** measured 0.87 cm.

The **iliac trifurcation** was unremarkable.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some mild age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 4.71 cm in length. The right kidney measured 4.78 cm in length.

Adrenal Glands

The **right adrenal gland** was 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. The right adrenal gland measured 1.97 cm x 0.92 cm width at the cranial pole and 0.59 cm width at the caudal pole.

The **left adrenal gland** comprised a mass measuring 2.84 cm x 1.55 cm width at the caudal pole and 0.78 cm width at the cranial pole. The left adrenal gland was considerably vascular. No evidence of capsular escape or vascular invasion.

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



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congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some moderate age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable. Increased portal markings were noted.

Gastrointestinal

The **stomach** revealed an edematous pattern with mild mucosal remodeling and a 2.0 cm accumulation of luminal material consistent with foreign matter. This material was shadowing. The small intestine revealed areas of spasm. A portion of intestine was thickened with loss of mural detail with reactive mesentery. This portion of intestine appears to be resectable and extends for at least 7.0 cm to 8.0 cm in a tapering fashion.

Pancreas

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.

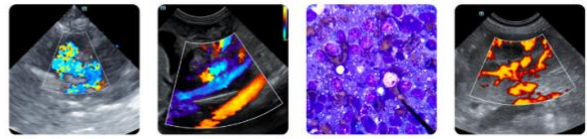
ULTRASONOGRAPHIC FINDINGS

- Left adrenal mass- considerably vascular. Adenocarcinoma or pheochromocytoma are primary concerns. Adenoma is possible yet less likely.
- Abnormal portion of intestine- carcinoma suspected, round cell neoplasia possible, non-neoplastic intestinal necrosis/enteritis possible, granulomas disease less likely, with concurrent foreign matter in the stomach.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Intraoperative ultrasound with resection and anastomosis, a portion of jejunum along with left adrenalectomy and gastrotomy would all be indicated in this patient. Intraoperative ultrasound is strongly recommended, or the surgeon can follow the reactive mesentery and resect approximately 3.0 cm to 5.0 cm on each side. The pattern appears to be stricturing and carcinoma is a strong potential. Liver biopsy is also indicated.

According to SonoPath research presented at ECVIM 2016 (Stockholm, Sweden), Advances in Small Animal Medicine and Surgery (May 2017), and EVDI 2017 (Verona, Italy), concurrent underlying chronic inflammatory neoplastic intestinal disease can often reside in PICA patients. Therefore, surgical biopsies are essential in this case regardless of the exploratory findings.



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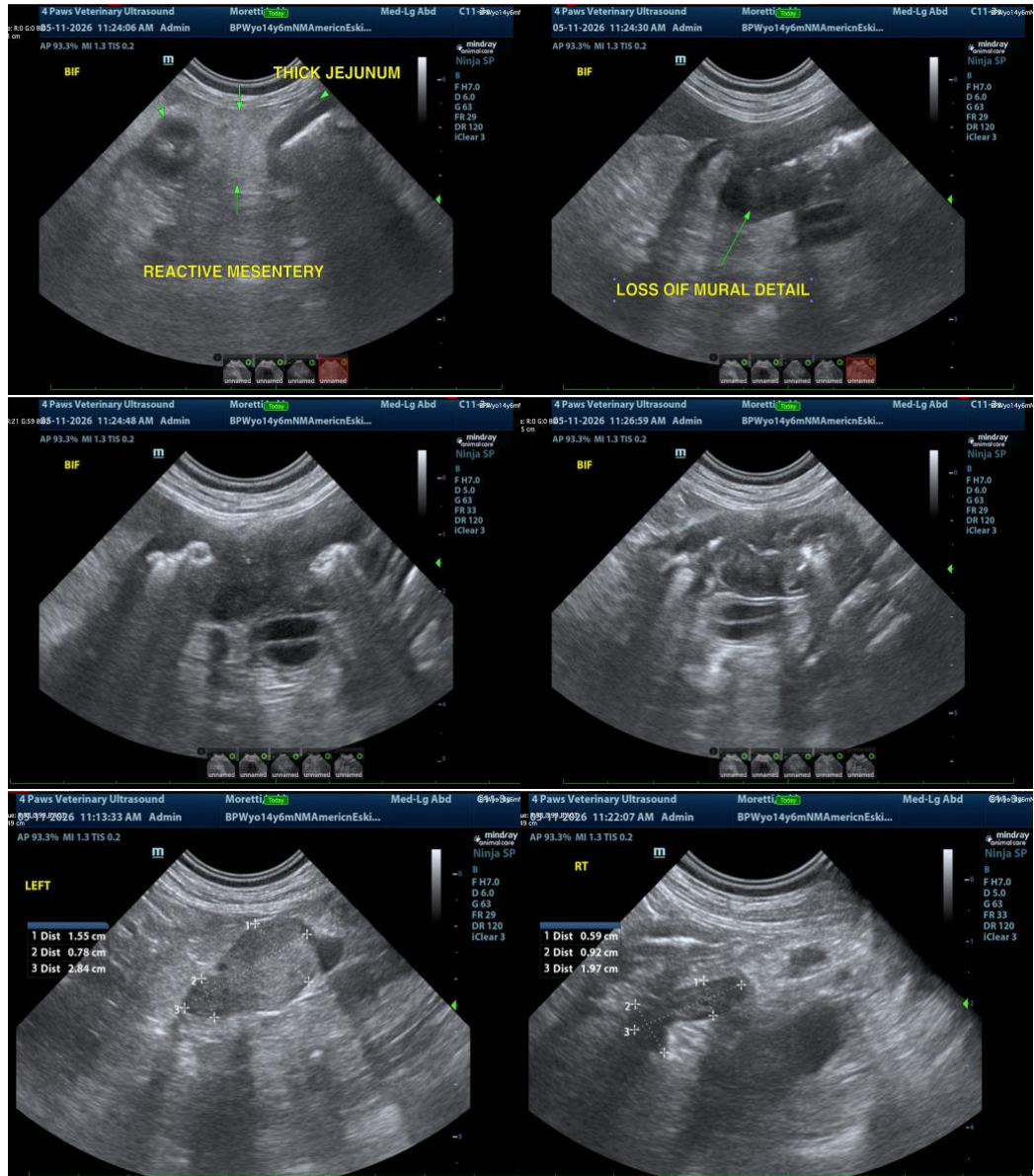
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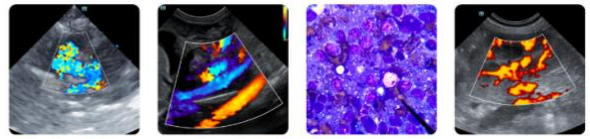
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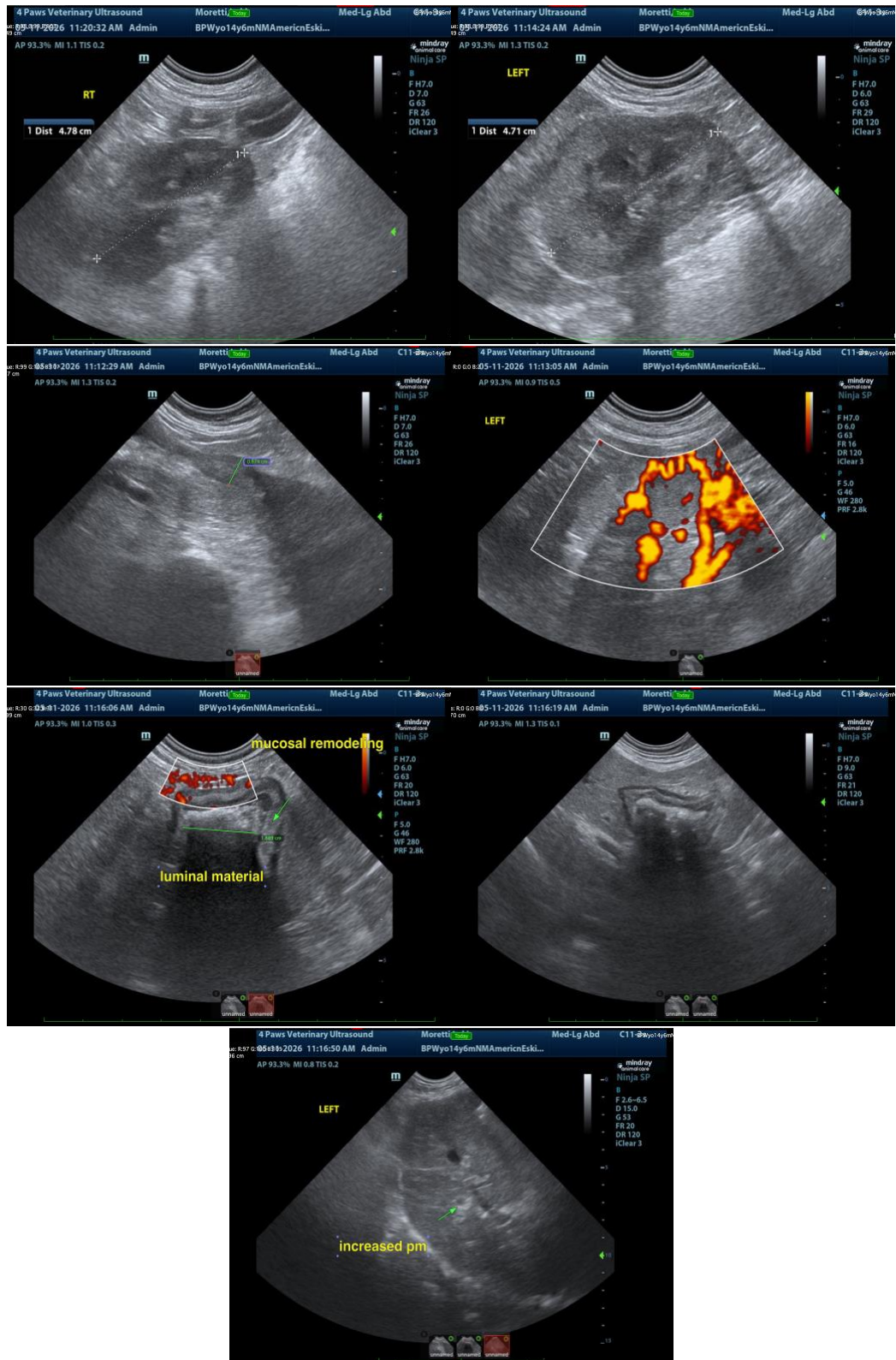
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS,

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