



**PATIENT**

Magnum Albright

**SPECIES**

Canine

**BREED**

American Bulldog

**SEX**

Intact Male

**AGE**

10 Years

**WEIGHT**

34.4 kg

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Erin Wicks

**HOSPITAL NAME**

Shores VEC

**REFERRING VET**

Dr. Miller

**INVOICE**

16512

**DATE**

7/25/22

**PRESENTING CLINICAL SIGNS**

History: Presented at our hospital for difficulty walking and decreased appetite. While owner was on vacation, family was watching P. During that time, P became lethargic and started eating less than normal. When owner got back, P was still lethargic and not eating well; owners states only eating about half of normal amount. States that P is having difficulty walking and getting up things like stairs and on furniture. P also vomited once this morning and is having softer stool, but not diarrhea. Previous Health Concerns: None Current Medications: None Appetite/When did they eat last: decreased appetite; last ate around 10 pm

Abnormal PE/Chem/CBC/UA Results: Abdominal: tender- full on palpation Genitourinary: 2 testicles palpable; perirectal hyperplasia; mild prostatomegaly- smooth/ symmetrical Musculoskeletal: TL discomfort Rad- lack of detail ventral abdomen; dorsally displaced colon; caudally displaced small bowel; splenic mass concerns; effusion highly likely. EPOC- Hct 33 % (L) Pre-surg- NSF

**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 largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some minor 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 right kidney measured 6.4 cm.

**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. The left adrenal gland measured 2.44 cm x 0.61 cm at the cranial pole and 0.64 cm at the caudal pole.

**Spleen**

A mixed hypoechoic **splenic mass** was present with significant disruption of architecture, deriving from the caudal pole. Free fluid around the mass would suggest hemorrhage or paraneoplastic effusion. Some heterogeneous omentum was noted around the spleen, which may represent regional omental spread.

**Liver**

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some mild 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



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past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable. No overt evidence of metastatic disease.

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**Gastrointestinal**

The **gastrointestinal tract** presented considerable gastric artifact due to the presence of ingesta. This did not permit thorough evaluation of portions of the gastric and upper intestinal structure. No overt abnormality was seen in the visualized tissue, however. This is consistent with a post-prandial presentation within a few hours of mealtime. If the prandial temporal interval does not fit the case history, and the patient presents a history of post-prandial vomiting, this could indicate a delayed upper gastrointestinal outflow due to primary or secondary pyloric hypertrophy, upper GI infiltrative disease, motor deficits, or a non-visualized foreign body. A prudent approach would be to rescan this patient at 24 hour NPO status to further review the non-visible regions if stomach primarily as well as assess any delayed outflow issue.

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**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.

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**Free Abdomen**

**Free fluid** was noted in the abdomen.

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- Ruptured splenic mass, potential omental spread
- Full stomach
- Age-related renal and hepatic changes

**ULTRASONOGRAPHIC FINDINGS**

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**IMAGING PERFORMED BY**

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Three-view chest radiographs and immediate exploratory surgery indicated. However, spread into the regional omentum may be an issue. The mass may be histopathologically benign, as it is a solitary mass with rupture and the omental changes may represent blood clots. Echocardiogram is ideal to ensure no metastatic disease of the right auricle or pericardium. Hemangiosarcoma is a strong potential. Histopathologically benign yet functionally malignant hematoma or degenerative process possible.

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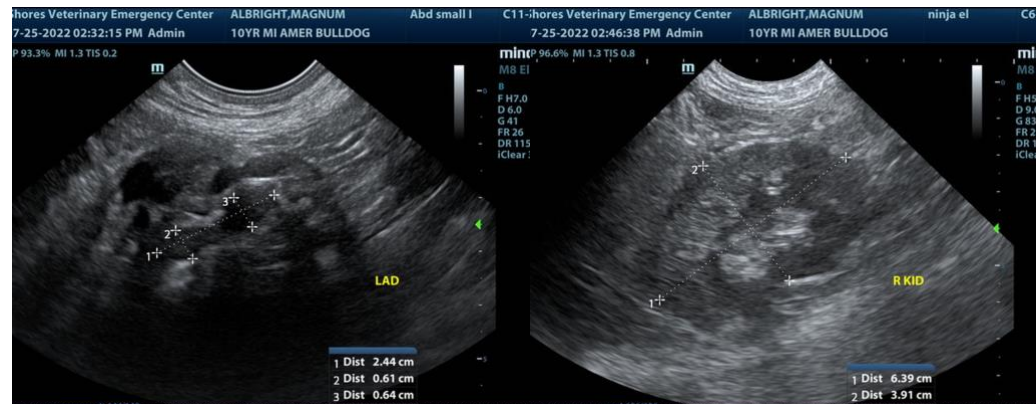
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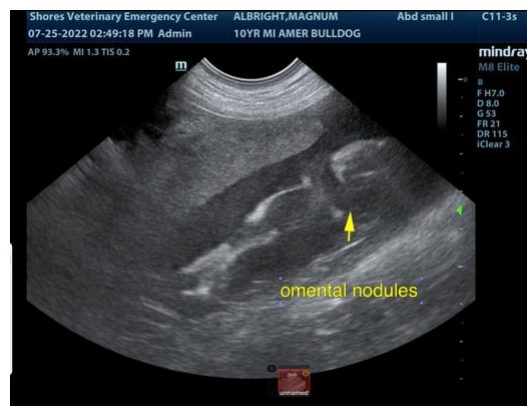
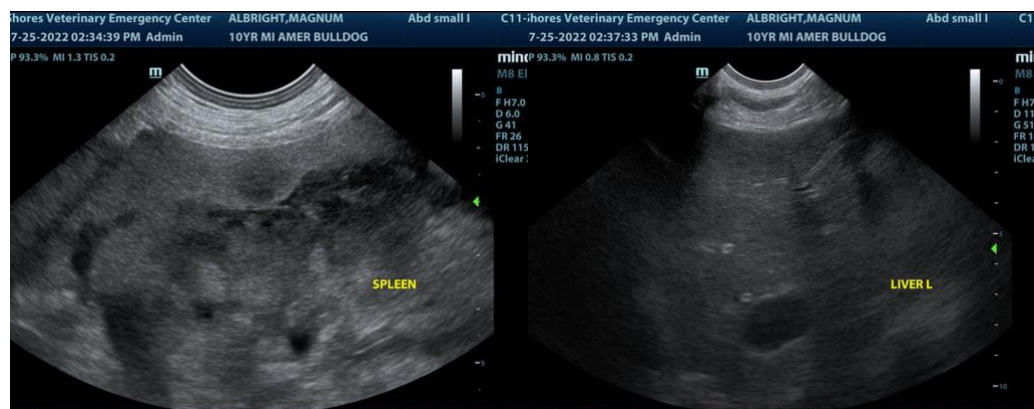
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**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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  
info@SonoPath.com