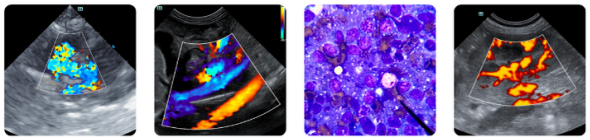

PATIENT

Lucy Dawidowski

SPECIES

Canine

BREED

Labradoodle

SEX

Spayed Female

AGE

8 years 6 months

WEIGHT

10.7

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Dr. Mariusz Chmielinski

HOSPITAL NAME

Apex Veterinary Services Ltd.

REFERRING VET

Alpine 24/7 – ER Doctor

INVOICE

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DATE

1/21/2026

PRESENTING CLINICAL SIGNS

- Acute onset vomiting starting Tuesday ~03:00.
- Initially ~6 episodes; progressed to multiple episodes throughout the day.
- Vomitus initially contained saliva, kibble, and plastic/string-like material.
- Progressed to watery, “dirty water” vomitus with no food.
- Anorexic, still drinking water.
- No bowel movements for ~48 hours.

Abnormal PE/Chem/CBC/UA Results: Mentation: Depressed, dull, Temperature: 37.4 °C, Heart Rate: 124 bpm (regular, pulse = HR), Respiratory Rate: 32/min, eupneic, Blood Pressure: 112/56 mmHg (MAP 69), Mucous Membranes: Pink, dry/tacky, CRT: <2 sec ,Hydration: ~9% DeH2O • Abdomen: Mildly distended, mild tenderness on palpation, gas appreciated CBC • HCT 72.3% / Hgb 271 g/L / RBC ↑ • WBC 14.47 ×10⁹/L (WNL–mild inflammatory pattern) Mild monocytosis, Suspected bands • Platelets: 402 ×10⁹/L (normal) Chemistry (partial) • Sodium 136 mmol/L (↓) • Chloride 97 mmol/L (↓) • Potassium WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (5.37 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.54 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

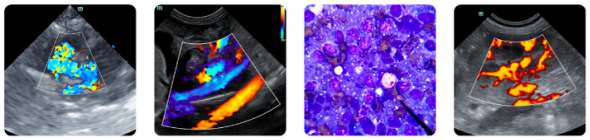
Adrenal Glands

The left adrenal gland is normal in size measuring 0.56 cm at the cranial pole and 0.56 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is large in size, and irregular in appearance measuring 0.95 cm at the cranial pole and 0.76 cm at the caudal pole. It is observed in its normal position between the right kidney and the caudal vena cava. It is abnormal in appearance in that there’s a hyperechoic nodule/mass effect at the cranial pole measuring 0.92 cm x 2.16 cm. No evidence of vascular invasion is visualized.

Spleen

The spleen is subjectively normal in size (1.05 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.



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Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. Hard shadowing ingesta is concerning for possible gastric foreign material. There's the appearance of linear material passing through the pyloro-duodenal junction into the duodenum.

Some of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Generally, wall thickness is normal to mildly increased. The duodenum measures 0.31 cm, the jejunum measures 0.29 cm. There are numerous focal lesions visualized within the small intestine. The duodenum appears thickened approximately and has a somewhat corrugated/bunched material with the appearance of hyperechoic linear material extending from the pyloroduodenal junction into the proximal duodenum, where focal linear material is shadowing along with some fluid. Distally, in the small bowel, there are section of jejunum which appear to have significant plication and intraluminal material (sometimes evident as linear material) and a partially obstructive pattern. In these areas, the bowel appears thickened and hypoechoic with reduced detailed wall layering. Most consistent with severe enteritis and edema. Findings are concerning for obstructive/partially obstructive linear foreign material.

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

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis in the left limb.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no significant lymphadenopathy. A jejunal lymph node is visualized measuring 0.3 cm. The omentum is hyperechoic around some of the areas of suspected obstruction/focal enteritis.

PRIMARY FINDINGS

- Pancreatic changes consistent with mild pancreatitis in the left limb.
- Focal, hard shadowing material visualized within the stomach, as well as suspected linear material passing from the stomach into the proximal duodenum, and more distal jejunal lesions

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involving plication and a partially obstructive pattern, as well as severe enteritis. Findings are concerning for partially obstructive linear foreign material.

- Hyperechoic nodule/mass effect at the cranial pole of the right adrenal. Possible differentials include an adenoma, carcinoma, pheochromocytoma, other.

SECONDARY FINDINGS

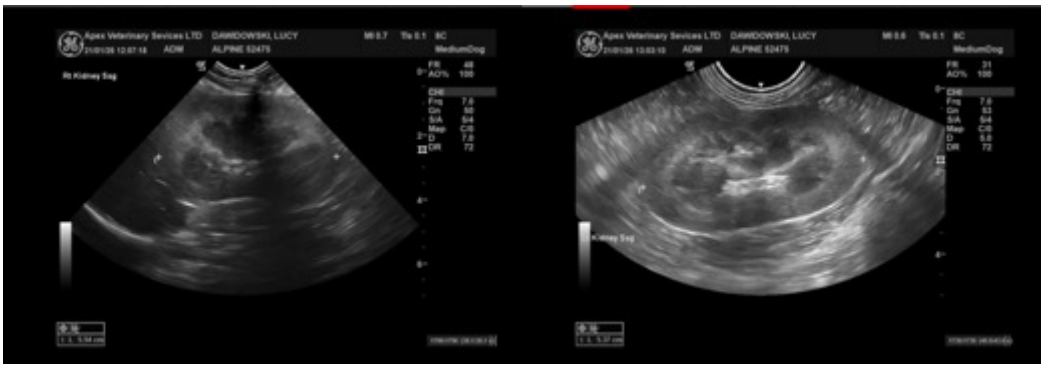
- Suspended echogenic debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There's focal hard shadowing material visualized within the stomach and the appearance of hyperechoic linear material which appears to be extending through the pyloroduodenal junction into a dilated, corrugated duodenum. Additionally, in the more distal jejunum there are areas exhibiting significant plication and intraluminal foreign material with partially obstructive pattern. Correlate findings with clinical assessment and radiographs. Based on these findings I would strongly consider an explore to evaluate for linear obstructions +/- biopsies of the GI tract.

There's a hyperechoic nodule/mass effect visualized at the cranial pole of the right adrenal. If symptoms consistent with Cushing's disease are present, consider adrenal function testing once the patient has recovered from this episode. Additionally, consider a blood pressure evaluation. If hypertension is present, consider measuring catecholamine levels looking for a possible pheochromocytoma. While there's no overt evidence of vascular invasion visualized, a contrast CT scan would be ideal prior to considering surgical removal.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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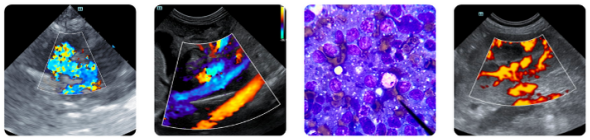

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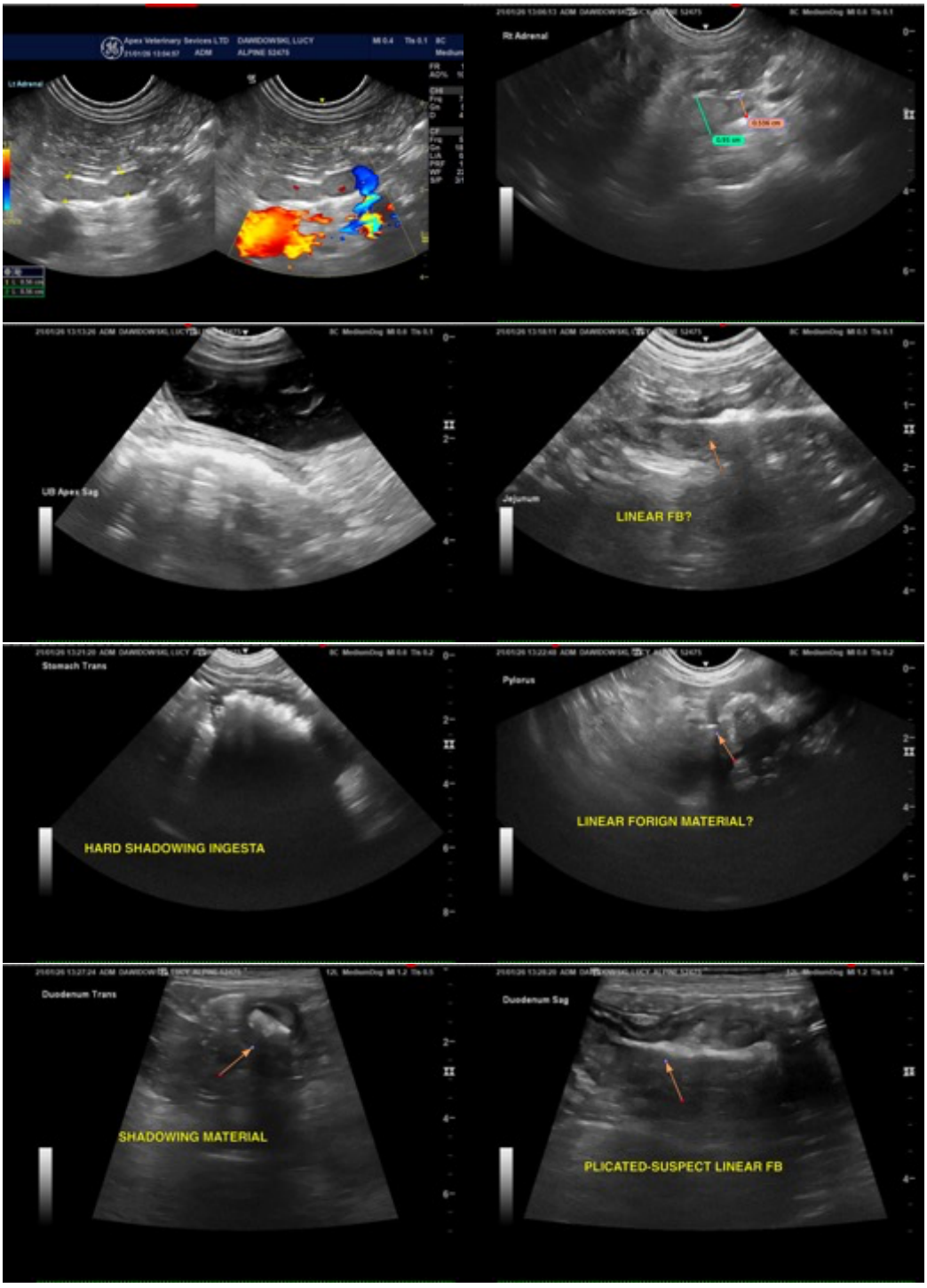

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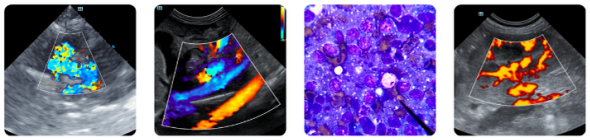

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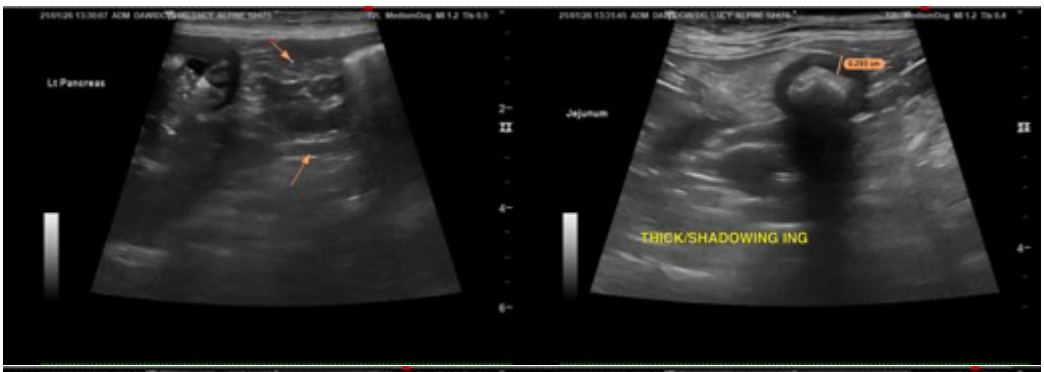

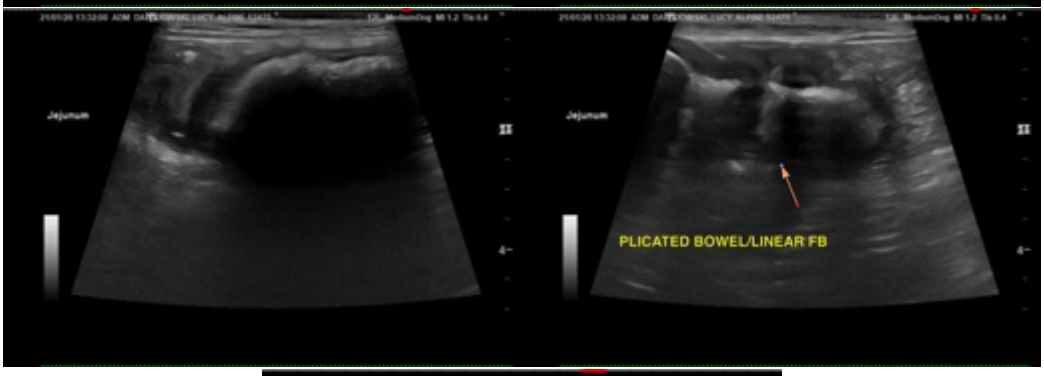

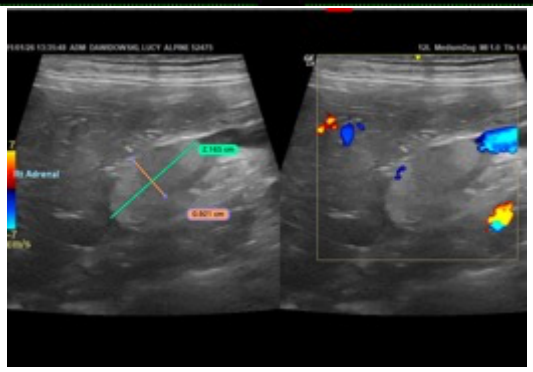

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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