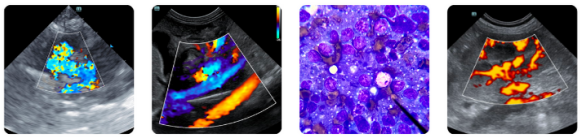


DATE

1/30/2026

PATIENT

Winnie Giordano

SPECIES

Canine

BREED

Golden

SEX

Spayed Female

AGE

7 years

WEIGHT

96 lbs

INTERPRETED BY

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

HOSPITAL NAME

Banfield Abingdon

REFERRING VET

Dr. Simpson

INVOICE

11215

PRESENTING CLINICAL SIGNS

Patient History: Winnie 7Y8M FS Golden Retriever presents for vomiting/diarrhea/not eating concerns. O states hasn't been wanting to eat. Tried 3 different types of prescription food, P did not eat. O states ate chicken and rice this morning. Ate wet food when given entyce1 hour before meal, but then wouldn't take it again. O doesn't notice increase in appetite after giving entyce. Yesterday ate around 15 hydrolyzed treats. Three bloody stools Sunday. No other bowel movements since Sunday. Drinking lots of water. P has been shedding a lot more for a few months Has had proviable multiple times in past seems to clear everything up.

Current Medications: Metronidazole 500mg Tablet: Give 2 tablets every 12 hours for 7 days; started today
Labwork Results: Labwork not attached, reported as: cpl – normal, superchem/cbc – wnl, platelet smear - adequate clumping, t4 – wnl.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: IV Torb and Midazolam.

Stat Report: Not requested.

Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. 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 cystic calculi.

The left kidney has a normal shape and size (6.64 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 (7.11 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 large in size measuring 0.71 cm at the cranial pole and 0.83 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 measuring 1.59 cm at the cranial pole and 1.14 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (2.35 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.

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 contains minimal luminal contents. 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 layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased (jejunum measures 0.39 cm). Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Visualized peristalsis appears appropriate. There is a large segment of bowel which is severely thickened with complete loss of wall layering and is surrounded by severely reactive mesentery. This section of bowel measures approximately 4.0 cm in diameter. The bowel wall measures 1.96 cm. Findings are consistent with an extensive bowel mass lesion.

. 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 normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity revealed scant free fluid. There's occasional prominent mesenteric lymph nodes, and a cranial abdominal lymph node is visualized measuring 1.67 cm x 1.71 cm. The omentum is severely hyperechoic around the abnormal bowel.

ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenomegaly. The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.
- Extensive segment of suspected small intestine with severe wall thickening and loss of layering.

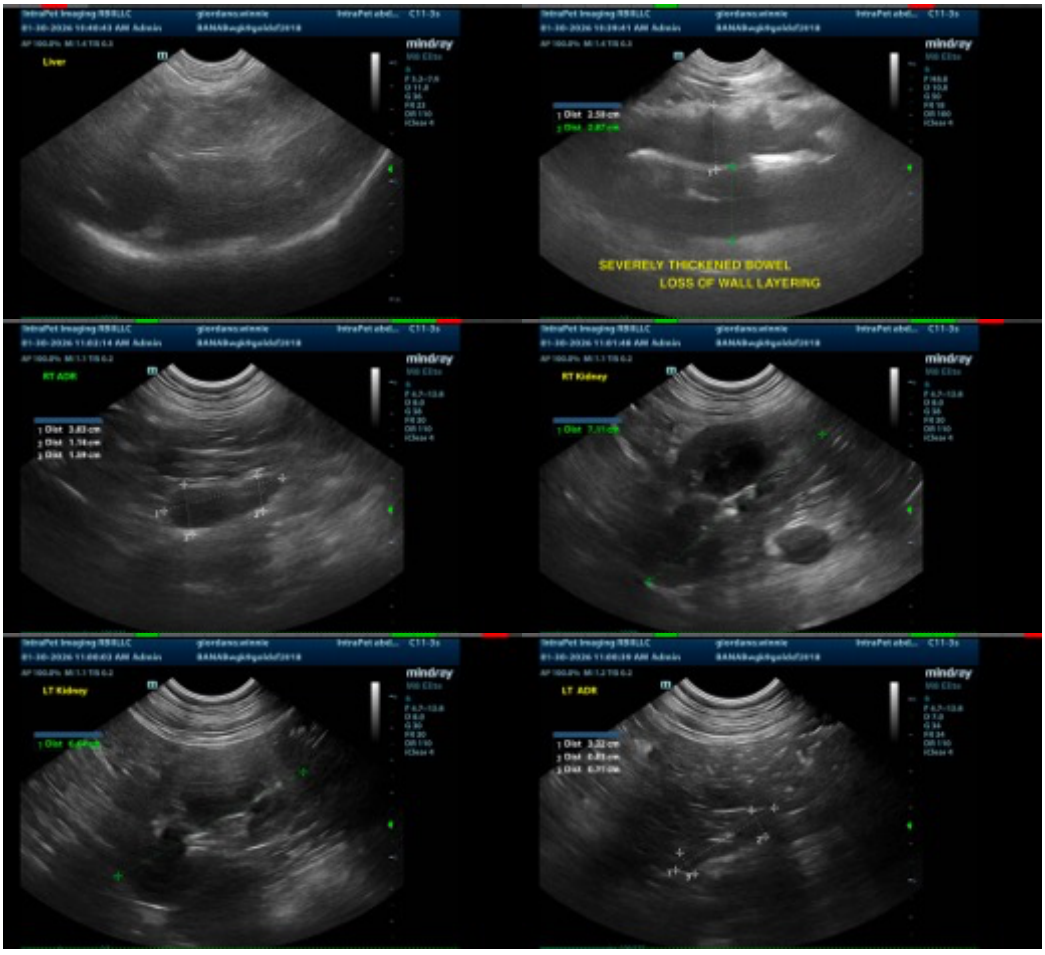
Findings are most concerning for infiltrative neoplasia (round cell neoplasia, carcinoma, other.)

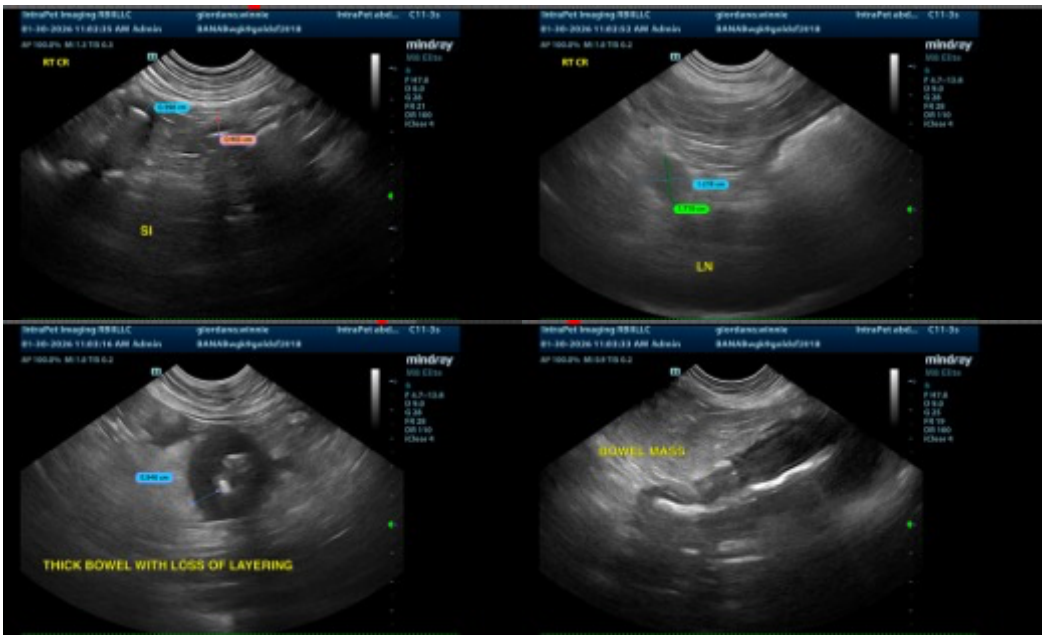
- Scant free fluid, highly reactive mesentery, and cranial abdominal lymphadenopathy. Findings are most consistent with reactive lymph nodes/mesentery. Metastatic lymph nodes cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There's a large segment of bowel (small intestine with severe wall thickening and complete loss of layering) creating bowel mass effect with severe surrounding inflammation. Consider a fine needle aspirate of this bowel mass for cytologic evaluation. If a diagnosis can be obtained, recommended consultation with veterinary oncologist regarding the best treatment options and prognosis. If a diagnosis cannot be obtained, surgical biopsies may be the next step. I am concerned that this lesion may not be surgically removable due to the extent of bowel involved. If surgical excision is considered, consider a contrast CT scan to better assess the extent and degree of bowel involvement.

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





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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