



## PATIENT

Fred Bremer

## SPECIES

Canine

## BREED

Husky Mix

## SEX

Neutered Male

## AGE

15 Years

## WEIGHT

61 pounds

## INTERPRETED BY

R. McKenzie Daniel,  
DVM, DABVP (Canine  
/ Feline Practice)

## IMAGING PERFORMED BY

Dr. Beth Coe

## HOSPITAL NAME

Riverside Animal Clinic

## REFERRING VET

Dr. Beth Coe

## INVOICE

13985

## DATE

02/27/26

## PRESENTING CLINICAL SIGNS

- Presented for 1-2 day history of repeated vomiting and lethargy/inappetence. Got into garbage 2 days ago, and owner noted aluminum foil debris possibly eaten, as well as a missing washcloth. Vomited food 3x yesterday morning, then vomited bile once. Drinking increased amounts of water, and vomiting water. No vomit when water withheld last night, but vomited water again this morning. Not eating since yesterday morning.
- Patient's diet hasn't changed. He does not take any medications.
- Owner noted a similar "episode" 3 months ago but was self-limiting and patient normal after ~3 days.

Abnormal PE/Chem/CBC/UA Results: Quiet and panting on presentation. Mucous membranes tacky, and pink in color. Cardiothoracic auscultation difficult d/t panting, but no obvious murmur or dyspnea. Pulse ~150bpm. Abdomen soft, but possible discomfort as patient stopped panting during palpation. GI sounds quiet to absent. Euthermic. CBC: Mild leukocytosis/Neutrophilia (18K). Hemoconcentration (RBC 9.75M/uL, HCT 55%). PLT WRI. Chem: Mild Azotemia (SDMA 28/BUN 49/Crea1.7). Hyperproteinemia (8.5)/Globulin (5.1). Mild elevation ALT (196), ALKP (213), Chol (377). Mild hypochloremia (105) - suspect GI loss vs sequestration/ileus. PL WRI. Abdominal Radiographs: ST density/fluid filling pylorus on left lateral image. Poor serosal detail/mass effect? mid-ventral abdomen/jejunum. Feces/gas desc colon. Fluid SI non-distended.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.4 cm in length. The right kidney measured 5.5 cm in length.

### Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.70 cm width in the caudal pole. The right adrenal gland measured 0.59 cm width in the caudal pole.

### Spleen

The spleen presented overall normal in size with primarily homogenous parenchyma and mild medial capsule asymmetrical contour. A solitary visualized small yet mild capsule distorting nonhomogenous hypoechoic cranial splenic mass was present measuring 2.1 cm in diameter.

### Liver & Gallbladder



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The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mild nonuniform and hypoechoic to the spleen with a mild coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with mild nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

### ***Gastrointestinal***

The stomach was mildly distended with retained fluid and nonspecific hypoechoic echo in the gastric body. Shadowing ingesta or content was present at the level of the pyloric outflow.

The small intestine presented overall intact wall layering and normal wall layer ratio. Primarily empty intestinal lumen. A segmental of small intestine, likely consistent with upper small intestine i.e. duodenum or upper duodenum contained a mild amount of hyperechoic to shadowing content. No overt intestinal obstructive pattern to the level of the colon.

Normal visible colon wall layers were present with apparent formed feces in lumen.

### ***Pancreas***

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

### ***Free Abdomen***

No overt lymphadenopathy or peritoneal effusion was present.

## **ULTRASONOGRAPHIC FINDINGS**

- Small yet expansive splenic mass.
- Retained gastric fluid with shadowing pyloric content and nonspecific hyperechoic lumen echo.
- Segmental intestinal shadowing content- suspect duodenum or upper duodenum.
- Mild hepatic parenchymal remodeling.
- Mild gallbladder debris (non-mucocele).
- Age-related renal/adrenal changes.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The splenic mass is nonspecific with considerations including hyperplasia, hematopoiesis, granuloma, splenitis, or neoplasia (sarcoma, round cell neoplasia, other).

The gastric and segmental intestinal shadowing content and hyperechoic gastric lumen echo are highly suggestive of foreign material in conjunction with the patient's clinical signs and history.

No obvious sonographic evidence of additional neoplastic or major organ metastatic criteria. Assuming no pathology on three view chest radiographs, laparotomy with gross inspection on the gastrointestinal tract with expectation toward probable gastrotomy and enterotomy with concurrent splenectomy is recommended.



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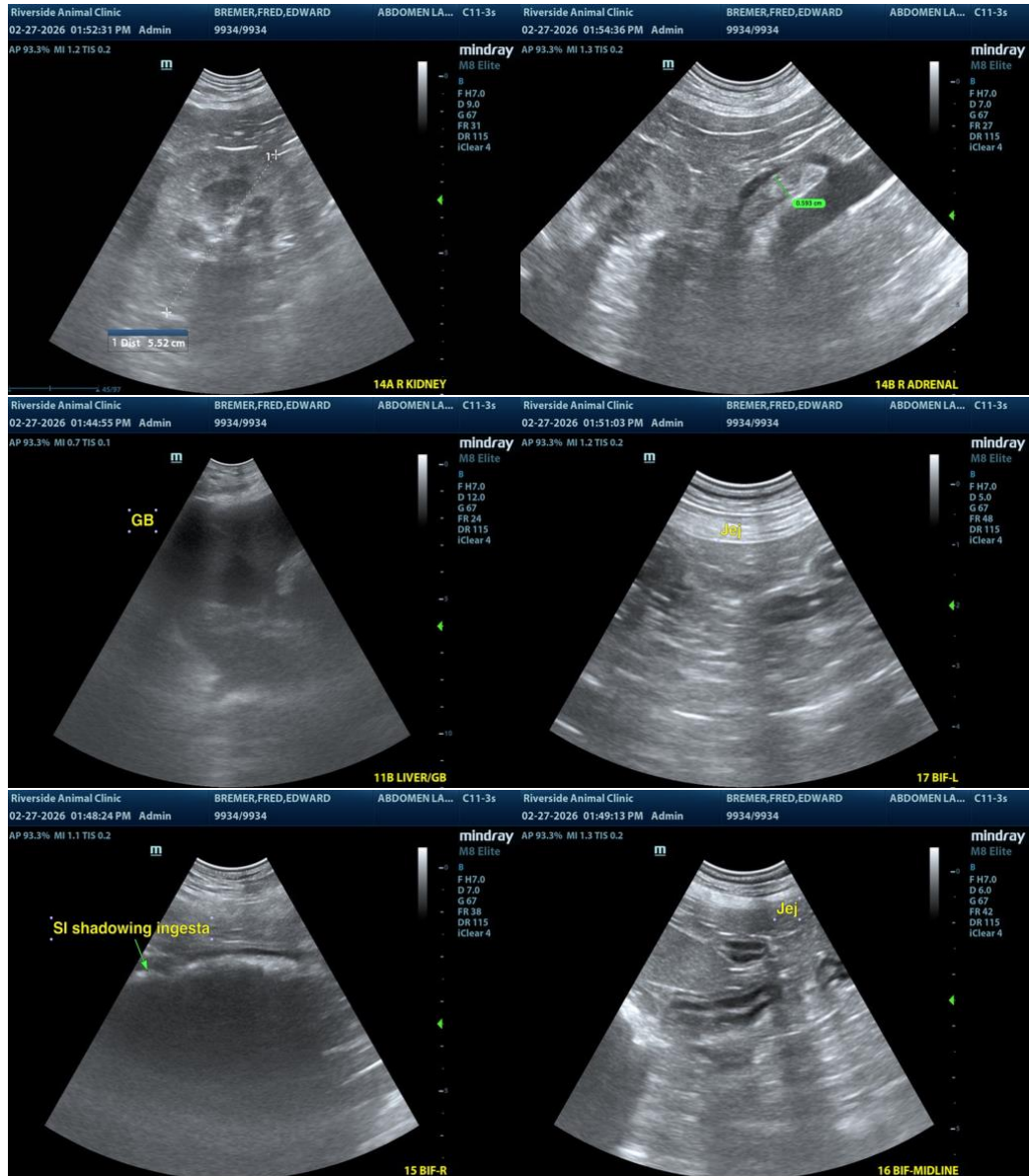
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Hepatic biopsies at time of surgery given elevated liver values could be considered if normal clotting status. If available, gastric endoscopy could be considered for further assessment of the gastric content as a more conservative approach.





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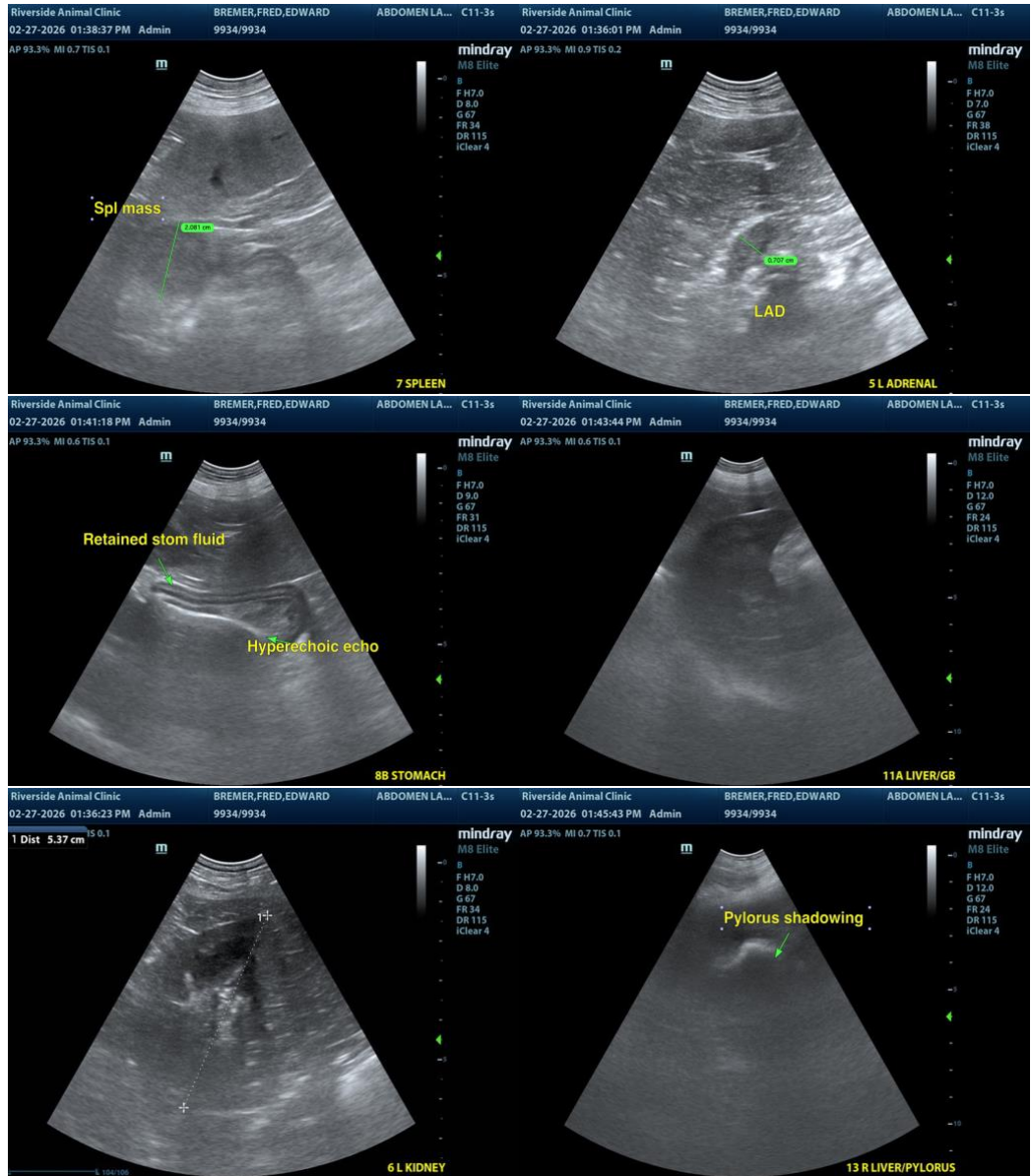
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

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