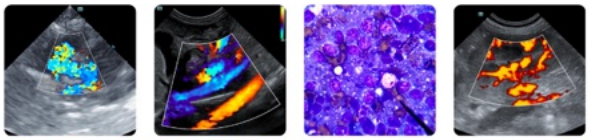


PATIENT

Lucy Goetz

SPECIES

Canine

BREED

Labrador

SEX

Spayed female

AGE

11 years

WEIGHT

80 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Brian Klug

HOSPITAL NAME

Sondel Family VC

REFERRING VET

Dr. Elana Frankenthal

INVOICE

75306

DATE

5/11/26

PRESENTING CLINICAL SIGNS

History: vomiting multiple times per week overnight - usually between midnight and 3/4am since end of January. o has tried feeding late evening snack, trialed omeprazole, and trialed Hill's z/d low fat and none of the above have helped.
Bloodwork, including GI panel all normal. No diarrhea

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is moderately distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. No calculi are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic change.

The left kidney is normal in shape and size, measuring 5.97×3.37 cm, with a cortical thickness of 0.55 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 6.22×3.53 cm, with a cortical thickness of 0.60 cm in the sagittal plane. Both kidneys demonstrate cortical echogenicity similar to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

Both adrenal glands demonstrate normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane are as follows: the left adrenal gland measures 0.37 cm at the cranial pole and 0.45 cm at the caudal pole. A small focal mineralization is present at the cranial pole of the left adrenal gland. The right adrenal gland is partially visualized and measures 0.41 cm.

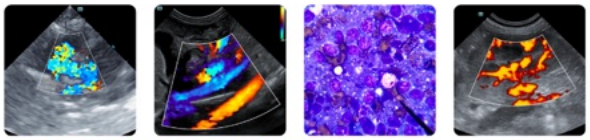
Spleen

Splenic thickness is 1.99cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively increased in size, with rounded edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal Tract

The stomach is empty, containing a small amount of fluid and gas. A focal region of marked gastric wall thickening is identified, measuring up to 1.84 cm, with loss of normal wall layering/stratification. The remaining gastric wall measures approximately 3.28 mm in thickness with preserved wall layering. The duodenum measures 4.02 mm in thickness. The jejunum measures 3.9 mm in thickness, with preserved wall layering. The colon measures 1.06-1.85 mm in thickness with normal luminal contents.

Pancreas

The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No abdominal effusion or evidence of peritonitis is identified. Cranial mesenteric and ileocecal lymph nodes are not confidently visualized; however, a markedly enlarged rounded hypoechoic lymph node measuring 1.32×1.92 cm is identified adjacent to the stomach, associated with marked surrounding hyperechogenicity/reactivity of the perigastric and perinodal fat.

An additional rounded nodular structure measuring 2.45×2.23 cm is identified adjacent to the gastric lesion and closely associated with the adjacent hepatic parenchyma. Due to its location and the available imaging planes, it cannot be confidently determined whether this structure represents: a focal hepatic parenchymal lesion/nodule, a markedly enlarged lymph node, or direct extension from the adjacent gastric lesion.

PRIMARY FINDINGS

- Focal severe gastric wall thickening (up to 1.84 cm) with loss of mural layering.
- Enlarged rounded hypoechoic perigastric lymph node.
- Rounded hypoechoic lesion closely associated with the liver or region or the lesser curvature/hepatogastric area.
- Marked surrounding perigastric/perinodal fat reactivity.

SECONDARY FINDINGS

- Subjetive hepatomegaly.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study demonstrates a focal region of severe gastric mural thickening with complete loss of normal wall layering, accompanied by a markedly enlarged hypoechoic perigastric lymph node and prominent surrounding inflammatory/reactive mesenteric fat change. Collectively, these findings are highly concerning for a clinically significant infiltrative gastric process.

The primary differential diagnosis is gastric neoplasia, particularly gastric adenocarcinoma, given the focal asymmetric transmural thickening, loss of mural stratification, associated regional lymphadenopathy, and marked perigastric fat reactivity. Other infiltrative neoplastic processes such as

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lymphoma or less likely leiomyosarcoma remain possible.

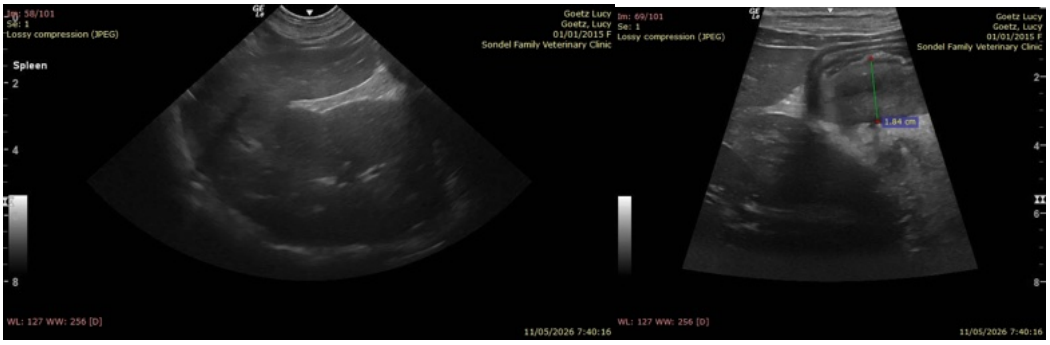
An additional rounded nodular structure adjacent to the gastric lesion and hepatic parenchyma further increases concern for regional metastatic or infiltrative extension. Although the exact origin of this structure cannot be confidently determined sonographically, possibilities include metastatic or reactive hepatic or gastric lymphadenopathy, focal hepatic involvement, or direct extension associated with the gastric lesion.

Overall, the ultrasonographic findings are strongly suspicious for a focal infiltrative gastric neoplasm with regional lymph node involvement.

Recommendations

- Endoscopic evaluation with gastric biopsies is strongly recommended, if clinically feasible.
- Alternatively, given the focal transmural appearance and concern for infiltrative disease extending beyond the mucosa, a surgical full-thickness biopsy may provide a higher diagnostic yield than superficial endoscopic sampling alone.
- Fine-needle aspiration of the hypoechoic nodular area.
- Thoracic imaging is recommended for staging if neoplasia is confirmed or strongly suspected clinically.
- The apparent hepatomegaly should be interpreted in conjunction with liver enzyme levels and overall laboratory findings.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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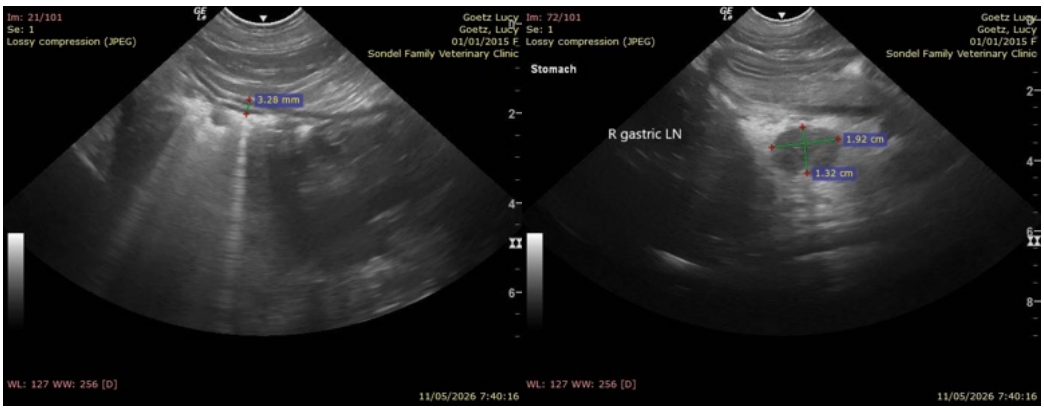

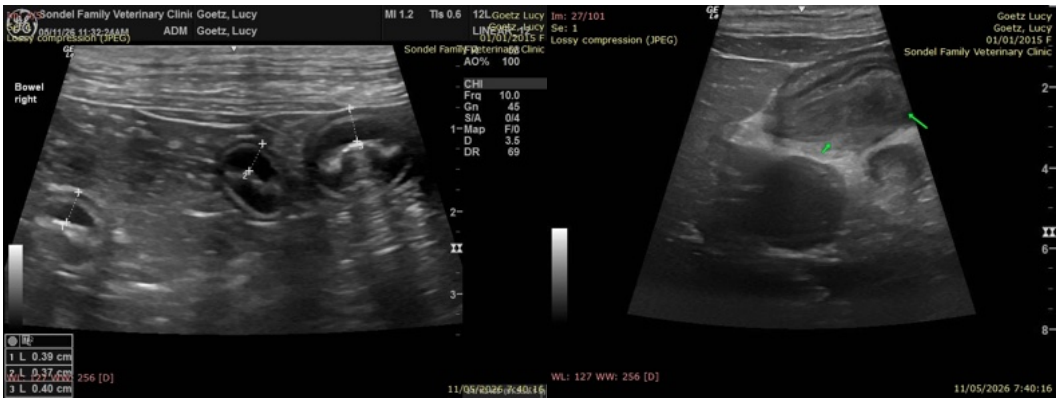

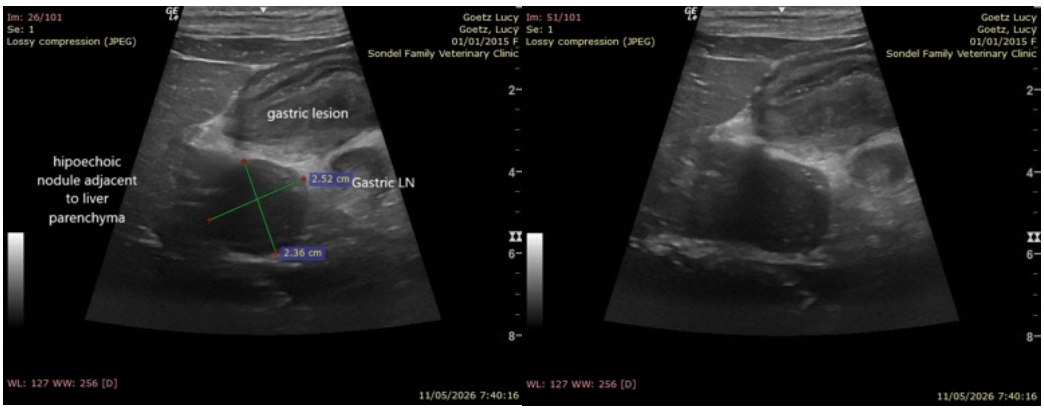

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com