Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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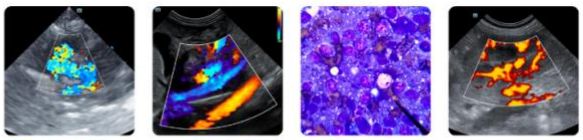

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Maddie Sarvis

SPECIES

Canine

BREED

Lab/Greyhound

SEX

Female Spayed

AGE

10/21/2017

WEIGHT

25.2

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Meadowlawn Conway

REFERRING VET

Dr. Heim/Dr. Hardee

INVOICE

22588

DATE

2-20-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Leukopenia (low white blood cell count). Low BUN and low liver enzymes (ALT, ALK PHOS, GGT) are concerning for underlying liver disease. Differentials include liver disease, intestinal disease, or neoplasia. The patient is clinically declining with significant weight loss. Patient is not eating and is also vomiting. Appetite did not improve with Entyce.

Abnormal lab-work values: Complete Blood Count (CBC) shows a white blood cell count of 4,100. Blood chemistry panel results show a BUN of 6, an albumin of 2.9, and a globulin of 3.8. The liver enzymes ALT, ALK PHOS, and GGT are all low. The total bilirubin is normal at 0.2. A fecal sample was collected and will be sent to an external lab for analysis to rule out parasites. Results are expected tomorrow. Owner declined at this time, other suggested lab tests including the GI Panel (send-out, includes TLI, PLI, Cobalamin) and radiographs.om

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (5.52 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.10 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.49 cm at cranial pole) (0.55 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.57 cm at cranial pole) (0.36 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.49 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of gravity-dependent, hyperechoic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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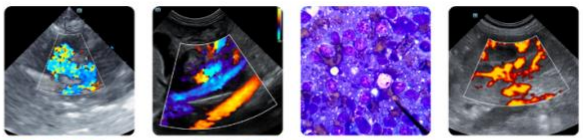

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Gastrointestinal
The gastric lumen is mildly fluid-distended. The gastric wall is normal to severely thickened (up to 1.63 cm). In the thickened portion, there is loss of the normal layering pattern. The mesentery effacing the serosal surface of the stomach is hyperechoic. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. The ileocecocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

Pancreas
The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph Nodes
An enlarged (1.03 x 0.77 cm) hypoechoic gastric lymph node is visualized.

Free Abdomen
There is no obvious evidence of free fluid.

Other
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

The gastric wall changes could be consistent with infiltrative neoplasia (i.e., lymphoma, adenocarcinoma). However, severe gastritis is also possible. Adjacent peritonitis is present. The enlarged gastric lymph node could be consistent with infiltrative neoplasia or reactive change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the subcostal location of the stomach, the stomach wall is not amenable for safe aspiration. Therefore, endoscopic or surgical gastric wall biopsies are recommended to get a definitive diagnosis. If surgical biopsies are pursued, the enlarged gastric lymph node should also be submitted for histopathology. If tissue sampling is not pursued at this time, consider empirical treatment for gastritis (i.e., proton pump inhibitor, sucralfate, antiemetics) with a recheck ultrasound in 2-3 weeks to assess for changes in gastric wall thickening.

- Three-view thoracic radiographs can also be considered to assess for pulmonary metastatic disease.

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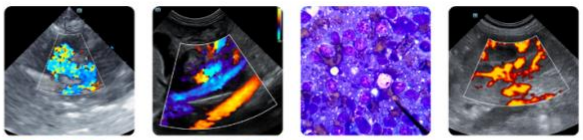

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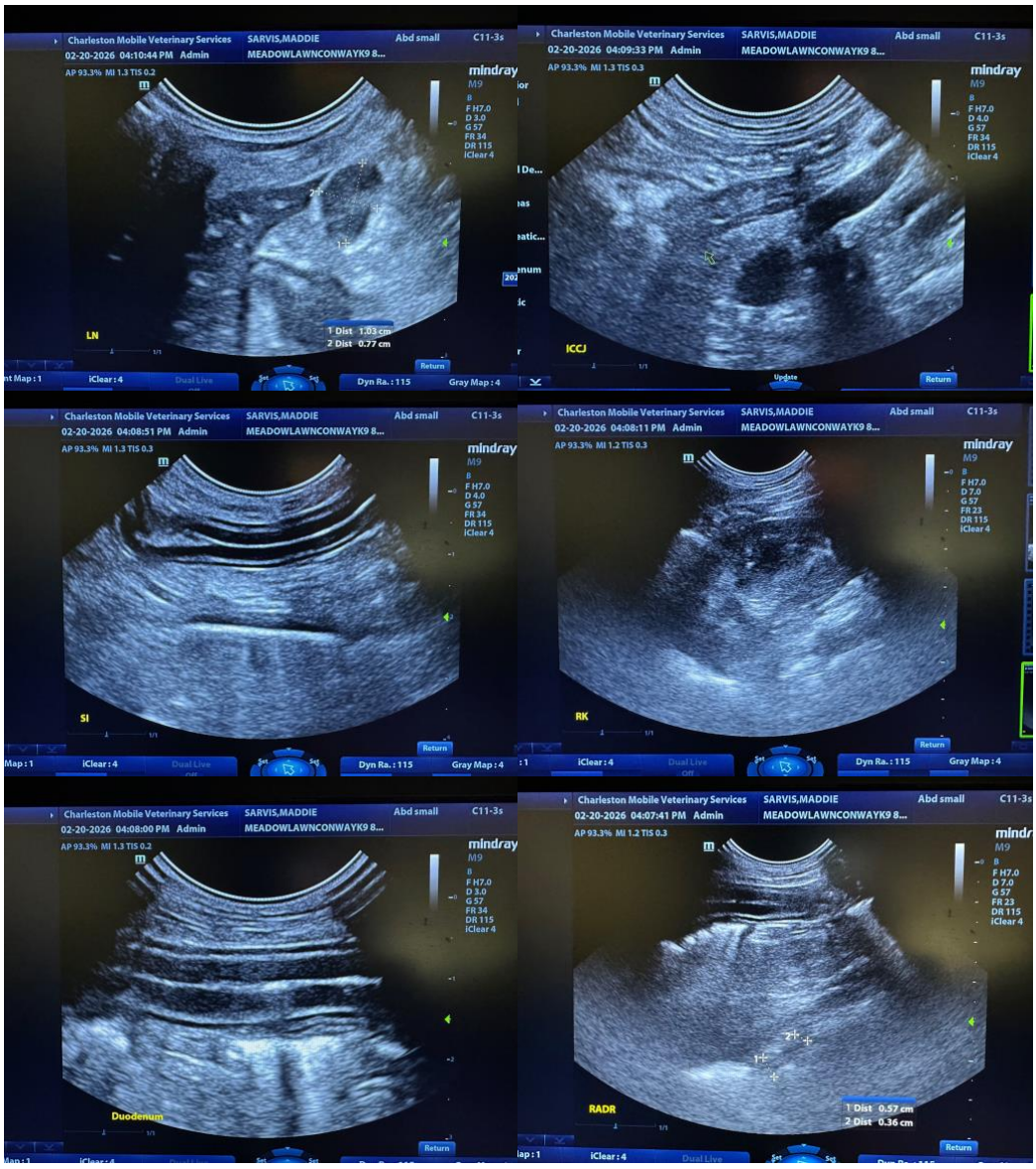

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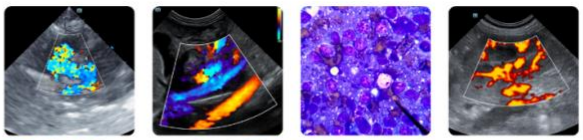

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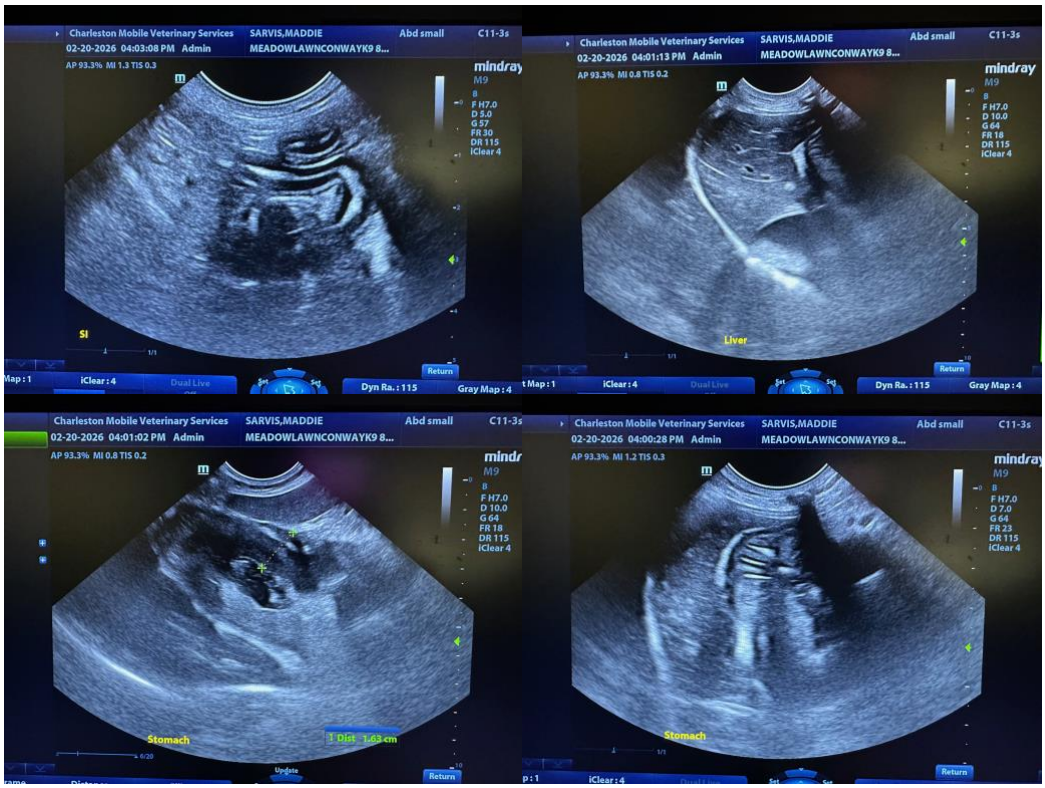

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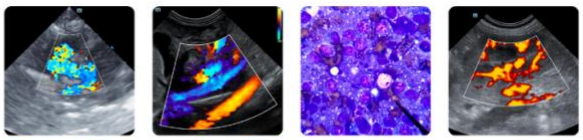

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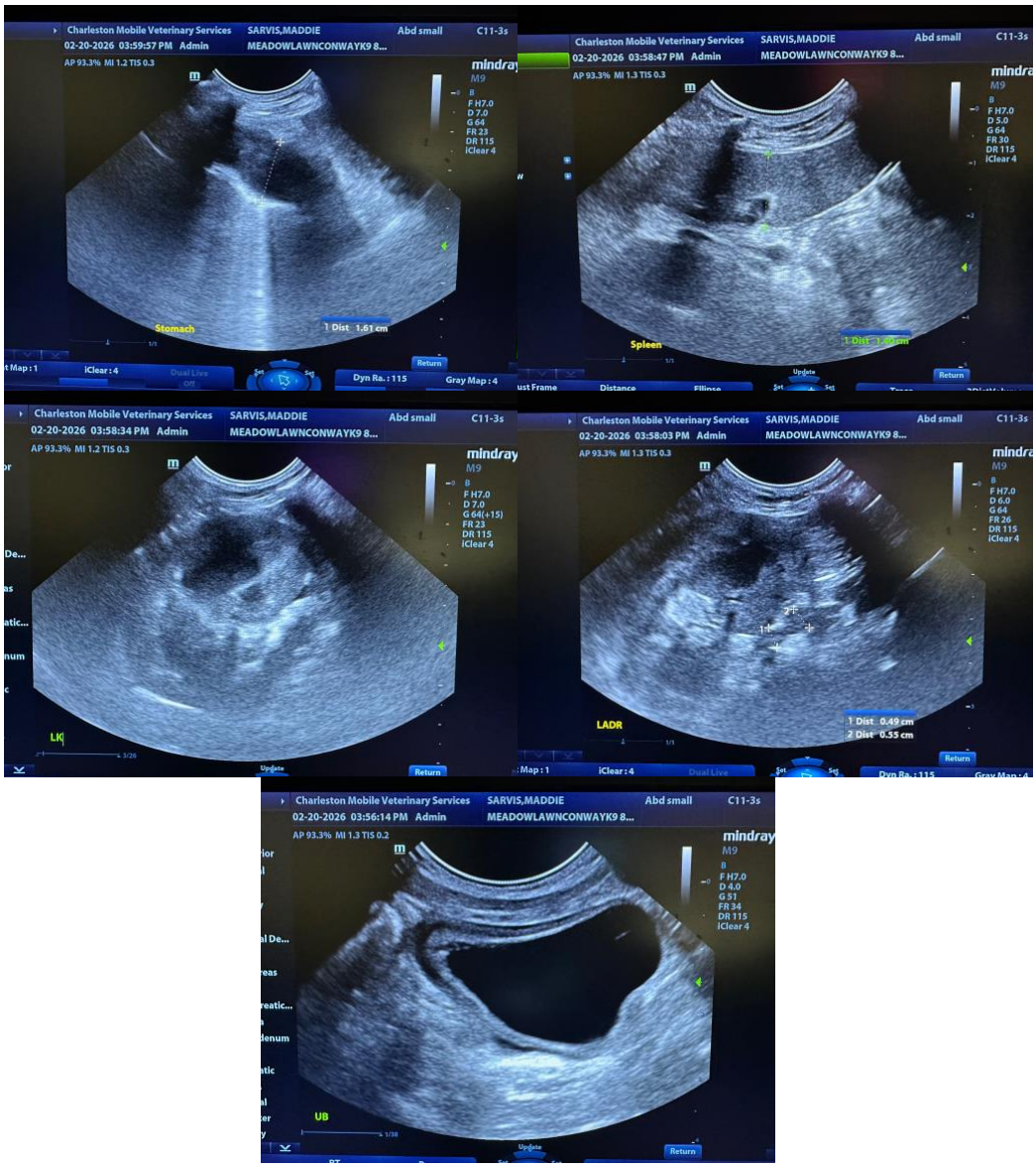

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com