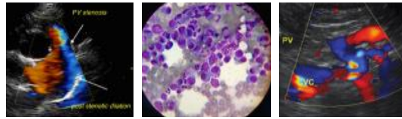
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

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DATE

4/1/2022

PATIENT

Paris Henderson

SPECIES

Canine

BREED

Ragdoll

SEX

Spayed Female

AGE

11/19/2008

WEIGHT

13 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Ann Sinclair

INVOICE

10650

PRESENTING CLINICAL SIGNS

Presented to Festival mid-Feb for weight loss, not eating well, seeming to have a difficult time eating. Not much seen on oral exam, treated with convenia, buprenorphine. Did better for a little while then presented 3/9/22 for difficulty eating and shaking her head. She was treated with Elura which did not really help. She was seen at AEH 1 week later for the same reason and was sedated for thorough oral examination. Nothing was found. I saw her on Tuesday for the same thing. I sedated her and did an oral examination as well as dental radiographs. Nothing was found. Did x-rays of her chest and abdomen and her gastric axis appears shifted as well as perhaps there might be a thickening of the pyloric portion of the stomach wall? The mediastinum also appears wider on the lateral with less detailed cranial border of the cardiac silhouette. Her ALKP was 128 on Tuesday so now concerned about the possibility of hepatic lipidosis (owner declined a feeding tube). When she got home from here after being treated with sq fluids, a cerenia injection, a dexSP injection and cyproheptadine, she ate 2 bowls of food, both wet and dry, with no issues. However, she tried to eat yesterday but couldn't/didn't and today she was treated with fluids, dex, cerenia and cypro and she has only eaten 1/2 can of food and attempted but not eaten anything else. I am not sure if there is something going on with her stomach that is causing her anorexia issues.

Current Medications: Dex SP SQ on 3/29 and 3/31, Cerenia 6.5mg on 3/29 and 3/31, Cyproheptadine.
Lab Results: ALKP 128, Alb 2.2.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone is normal

The left kidney is normal size (4.25 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (4.29 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The region of the adrenal glands is evaluated. No obvious pathology is observed.

Spleen

The spleen is normal in size (0.91 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 enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is not distended. The majority of the gastric wall is severely thickened (up to 1.30 cm) and hypoechoic, with a complete loss of the normal layering pattern. The mesentery effacing the serosal surface is hyperechoic. The pyloric outflow tract appears 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 colonic wall is normal

Pancreas

The left limb is visible, with slightly irregular peripheral contours. The parenchyma is subtly hypoechoic relative to surrounding omental fat and mottled in appearance, with 1-2 small, hypoechoic nodules. The pancreatic duct is not overtly dilated. Surrounding mesentery is hyperechoic.

Free Abdomen

There is no evidence of free fluid. Several enlarged, rounded, hypoechoiclymph nodes are observed in the cranial abdomen, the largest measuring 1.87 cm in length.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or chamber enlargement.

The caudal vena cava is subjectively dilated (0.85 cm in diameter).

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gastric wall changes are most consistent with infiltrative neoplasia (i.e., lymphoma, adenocarcinoma) with a lower possibility of a severe inflammatory process. Regional peritonitis is present. The adjacent lymphadenopathy could be consistent with infiltrative neoplasia, lymphadenitis, or lymphoid hyperplasia.

- The pancreatic changes are suggestive of chronic +/- active pancreatitis with age-related remodeling. The small pancreatic nodules likely represent benign nodular hyperplasia.

- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.

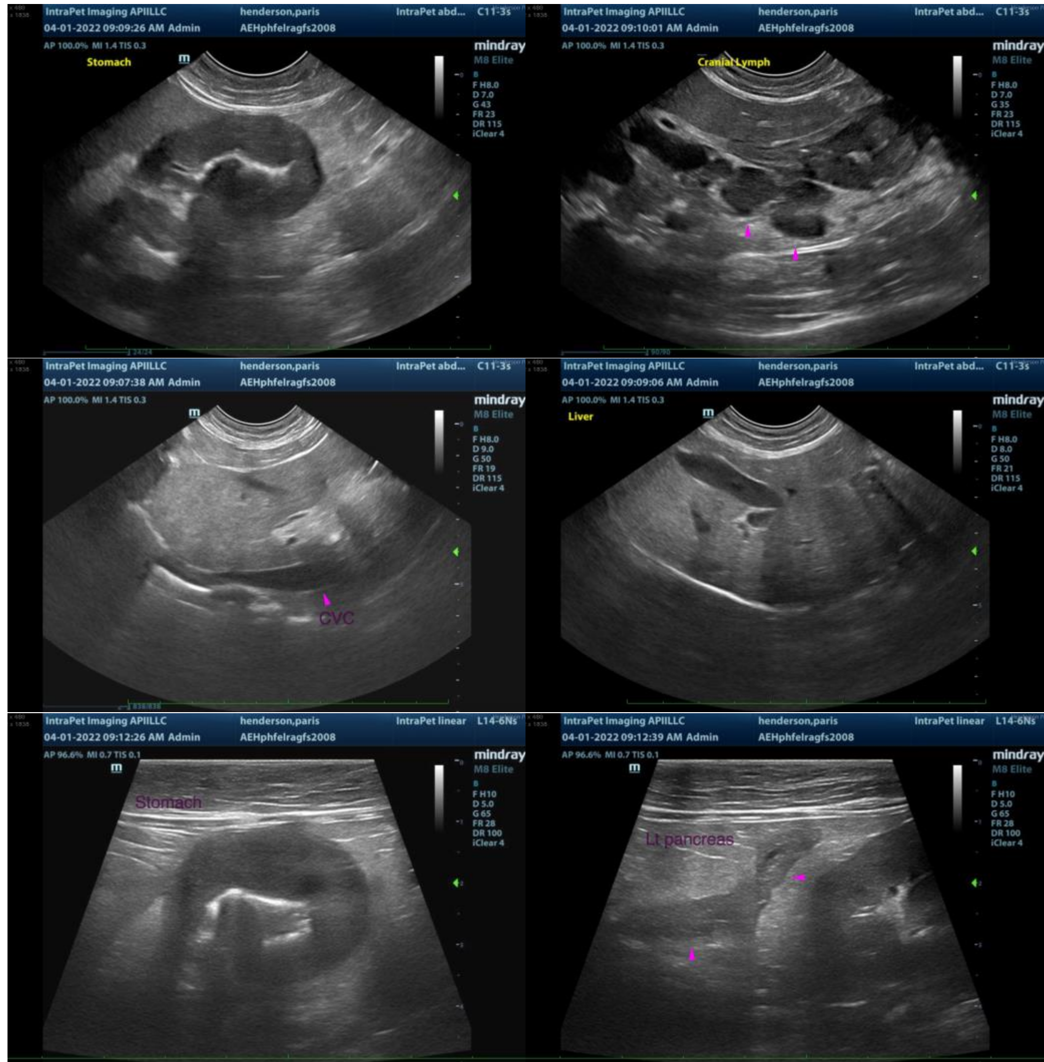
Secondary Findings

- Bilateral, minor age-related renal changes

- The significance of the mildly dilated caudal vena is unclear. It may be secondary to a mild increase in hydrostatic pressure, proximal obstruction (i.e., intraluminal or extraluminal), other

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- A fine-needle aspirate of the gastric wall is recommended if clotting status is appropriate. If cytology results are inconclusive, endoscopic or surgical gastric wall biopsies may be necessary to get a definitive diagnosis. If surgery is pursued, biopsies of the abdominal lymph nodes should also be obtained.
- Also consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI.



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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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