

**DATE PRESENTING CLINICAL SIGNS**

4/18/23

**PATIENT**

Ruby O'Connor

**SPECIES**

Canine

**BREED**

French Bulldog

**SEX**

Female, spayed

**AGE**

9/15/2012

**WEIGHT**

31.5 lbs.

**INTERPRETED BY**

Andrea Nicastro, DVM,  
 Diplomate ACVIM  
 (Small Animal Internal  
 Medicine)

**HOSPITAL NAME**

Animal Emergency  
 Hospital

**REFERRING VET**

Dr. Martinoli

**INVOICE**

14820

History of seizures, started about 1-2 years ago. Was on 250 mg regular Keppra BID, about 2 weeks ago she was having cluster seizures; increased to TID; then added Gabapentin at night only. Still having some breakthrough seizures so about a week ago changed to 500 mg ER. Also a week ago went to rDVM for regurgitation; they started metaclopramide and sucralfate, gave dose of Cerenia and SQ fluids. 2 days later was still regurgitating; returned to rDVM and had xrays; noted an abdominal mass and pneumonia (likely aspiration.) Added Clavamox 250 mg BID. Gradually seemed like she was getting better and started eating a little bit. This morning she did eat but then mid-day she vomited, then became extremely lethargic and was mainly just laying around.

Current Medications: Sucralfate, Keppra, Cerenia, Unasyn, Ondansetron, Buprenorphine.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: STAT requested.

Imaging Performed By: Rachel Brillhart, RDMS.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

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

The left kidney is normal size (5.00 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few small, non-obstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (5.43 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few small, non-obstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal size (0.84 cm at cranial pole) (0.62 cm at caudal pole) (2.60 cm in length); normal shape; 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 size (0.78 cm at cranial pole) (0.68 cm at caudal pole) (2.69 cm in length); normal shape; 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 (1.17 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 curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

### ***Gastrointestinal***

The gastric lumen is severely fluid distended. Within the fluid, a large amount of echogenic debris is observed. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. In the region of the pylorus, an approximately 2.3 cm round hypoechoic mass/structure is observed. The mass appears to be almost completely obstructing the pyloric outflow tract. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

### ***Pancreas***

The right limb of the pancreas is normal in size with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

### ***Free Abdomen***

There is no obvious evidence of free fluid. The abdominal lymph nodes are normal/not visible.

### ***Other***

Several ring down lesions are observed in the visualized portion of the thorax.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary Findings:**

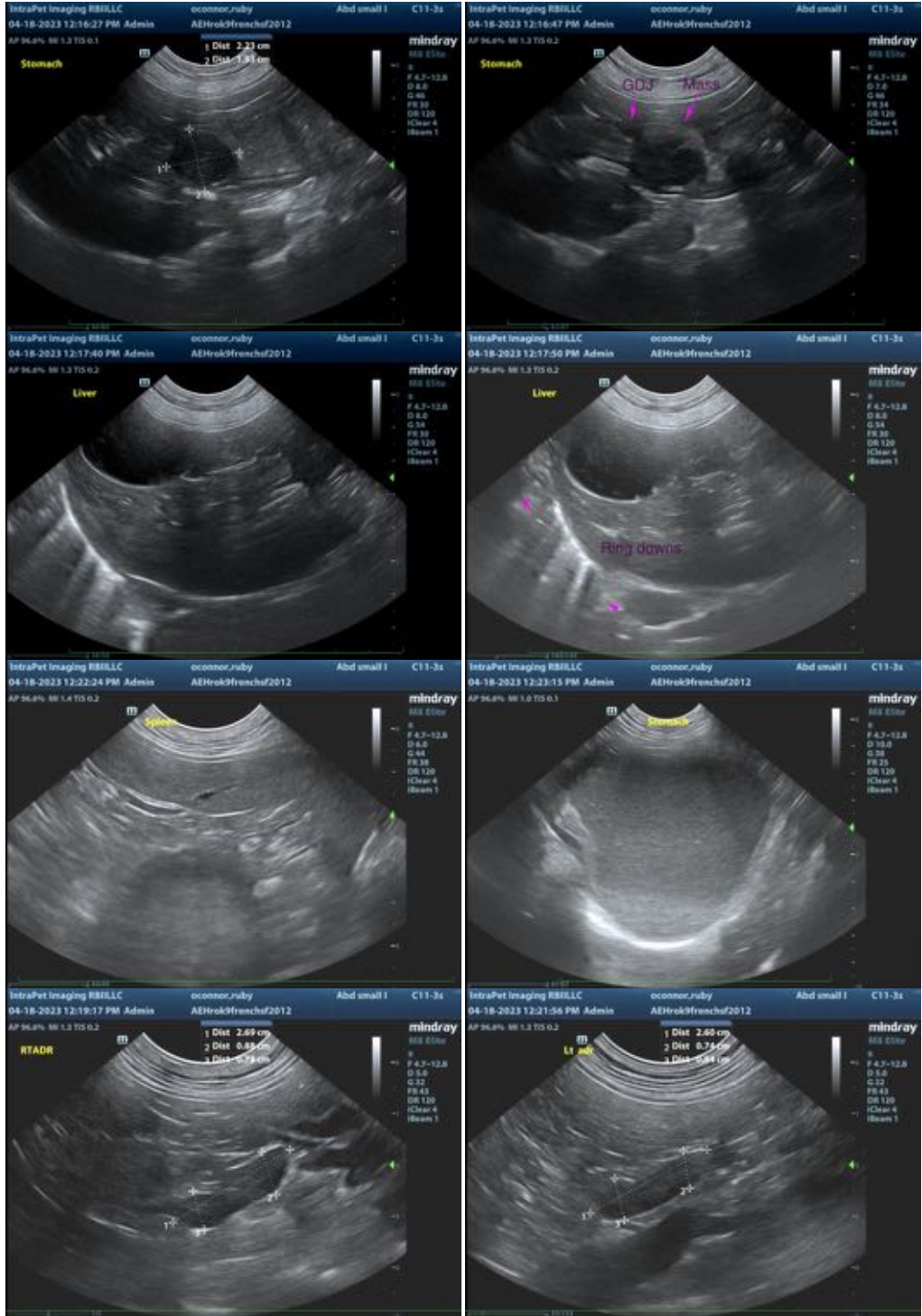
- Mass/structure in the pyloric antrum, causing almost complete obstruction of the pyloric outflow tract. Differentials include neoplasia (i.e., adenocarcinoma, lymphoma), polyp, granuloma, foreign body, other.

### **Secondary Findings:**

- Bilateral, chronic renal changes with non-obstructive nephrocalcinosis.
- Minor age-related pancreatic remodeling.
- The hepatic parenchymal changes are most consistent with benign age-related remodeling. However, correlation with the patient's clinical history is recommended.

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

Once the patient's pneumonia has stabilized, consider an upper GI endoscopy to biopsy the gastric lesion. Alternatively, an abdominal exploratory surgery can be considered to perform an excisional biopsy. If surgery is pursued, consider referral to a board certified surgeon due to the potential for a complicated surgical resection.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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