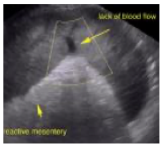
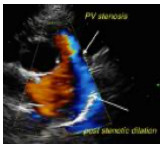
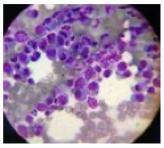
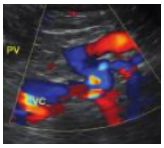
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Bella Pauline

SPECIES
Canine

BREED
Lab Mix

SEX
Spayed Female

AGE
13 years

WEIGHT
45 lbs

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

IMAGING PERFORMED BY
Dr. Reyes

HOSPITAL NAME
Mobile Vet Ultrasound

REFERRING VET
Dr. Beltran

INVOICE
11257

DATE
7.22.22

PRESENTING CLINICAL SIGNS

History: Pet presented to urgent vet on 07/07 for vomiting blood. On PE the only finding was pain on palparían of cranial abdomen. Dog is doing well at home besides episodes of vomiting blood. Currently taking Sucralfate. Urgent vet also sent home Panacur and gave Cerenia injection on 07/07. Pet continues to have episodes of hematemesis
Abnormal PE/Chem/CBC/UA Results: Hct: 35.9 Hgb: 12.6 SDMA: 16 Cpl: normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The **left kidney** is normal size (5.87 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. Renal vasculature is normal.

The **right kidney** is normal size (6.45 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. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.46 cm at cranial pole) (0.53 cm at caudal pole); 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 (0.77 cm at cranial pole) (0.40 cm at caudal pole) (2.49 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 (1.36 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 isoechoic relative to the spleen and heterogenous in appearance, with one-two small, ill-defined hypoechoic nodules/areas. 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. A small amount of aggregated, echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen is** mildly distended with ingesta. In the region of the fundus a focal wall thickening measuring 1.33 cm in width, is visualized. The mesentery effacing the serosal surface of the stomach is

hyperechoic. There is questionable retention of the normal layering pattern within this section. The remaining fundic wall appears normal in thickness. As the wall extends towards the pyloric antrum, the wall again, becomes thickened (up to 1.05 cm) with questionable retention of the normal layering pattern. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. The colonic wall is 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.

Free Abdomen

The **peritoneal cavity** is normal. There is no evidence of inflammation or effusion. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Focal gastric wall thickenings. Differentials include neoplasia (i.e., round cell tumor, adenocarcinoma) versus multifocal inflammatory disease versus hypertrophy versus other.

Secondary Findings

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely. However, correlation with the patient's liver values is recommended.

- Bilateral, chronic, age-related renal changes

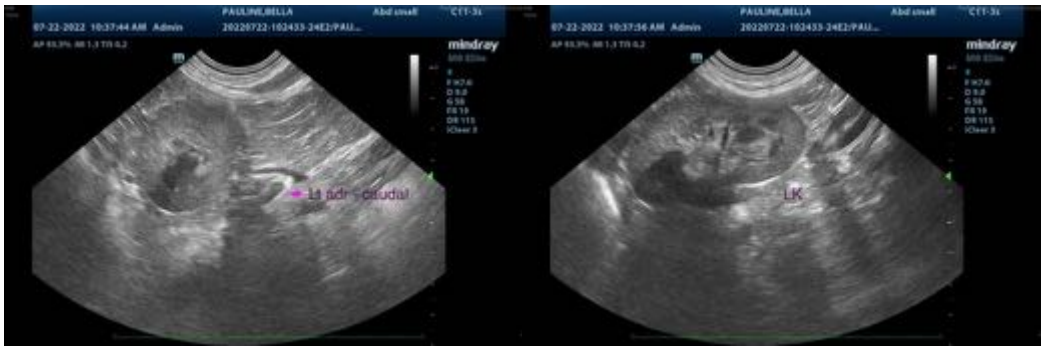
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

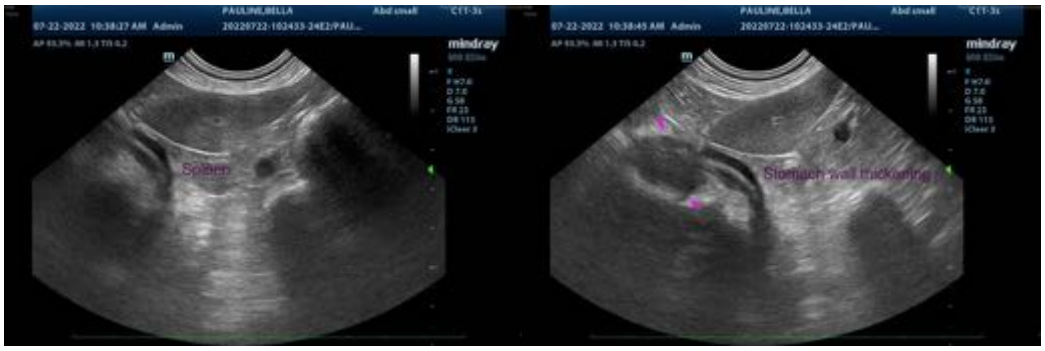
Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

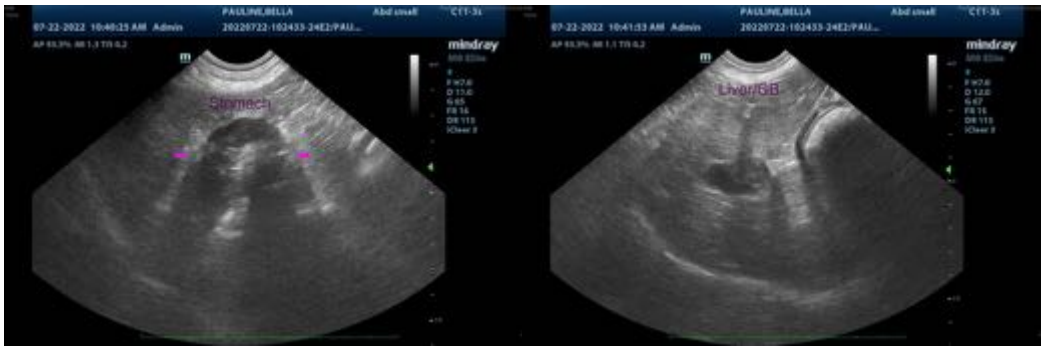
If accessible, ultrasound-guided fine-needle aspiration of the focal gastric wall thickenings is recommended. A 25-gauge needle should be used. If the area is inaccessible or if cytology results are inconclusive, endoscopic or surgical biopsies are recommended to get a definitive diagnosis. If biopsies are not to be pursued at this time, continue empirical treatment for gastric ulceration (i.e., sucralfate, proton pump inhibitor) is recommended for at least 10-14 days.

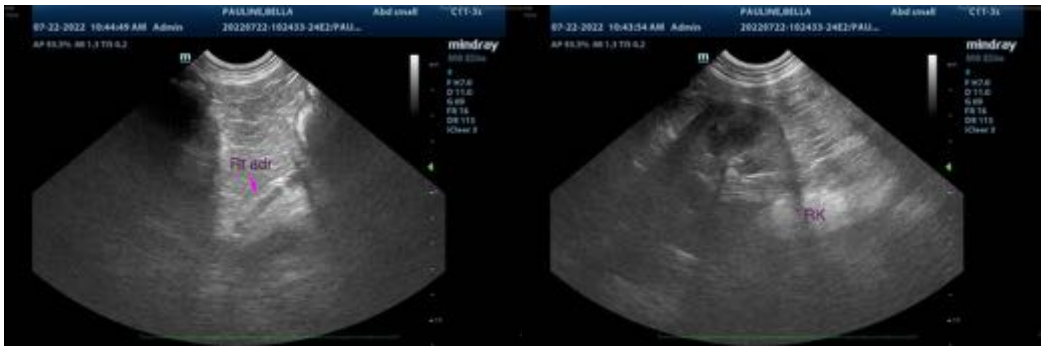
Also consider empirical treatment for helicobacter:

a. Amoxicillin: 10-22 mg/kg PO q 12 hours x 14-21 days
b. Metronidazole: 10-15 mg/kg PO q 12 hours for 14-21 days
c. Omeprazole: 0.7 mg/kg PO q 24 hours for 14-21 days
d. (+/- the addition of Bismuth subsalicylate: 3.85 mg/kg PO q 6-8 hours x 14-21 days)









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)
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