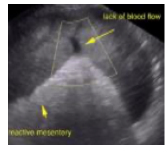
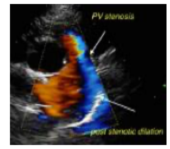
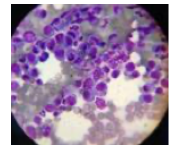
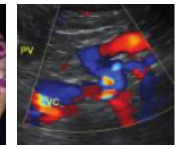





PATIENT

Ziva Kerschbaum

SPECIES

Canine

BREED

Belgian Terveuren

SEX

Female, spayed

AGE

14 Yrs.

WEIGHT

18.8 kg.

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Dr. McDaniel

INVOICE

13808

DATE

8/10/22

PRESENTING CLINICAL SIGNS

History: iva started vomiting green bile within the last 3 months. For the last month she has been vomiting once daily. On Saturday (4 days ago) her vomit was dark, had blood in it and a slight coffee ground appearance. Her feces that day was also very dark, but normal consistency for her. Her stool on Sunday was also darker than normal. She had reduced appetite on Saturday and only ate half her normal amount. She has not eaten a meal since then and has not taken any treats in the last 2 days. Per owner, Ziva had a barium study done and they were told she had an abnormality where the small intestine goes into the large intestine. Per owner, Ziva's sister died of stomach cancer in December last year, which is becoming more prevalanet according to their breeder. The sister also had similar symptoms to what Ziva is having now. She will have periods of heavy panting, lip licking and drooling. Omeprazole, Metoclopramide and Ondensetron didn't help.
Abnormal PE/Chem/CBC/UA Results: EENT: Clear OU/AU; ecchymotic lesions on upper gums bilaterally near k9 (worse on left side) Rectal: melena, no evidence of lymphadenopathy, anal sacs empty RBC - 5.49 (5.65-8.87) HCT - 36.0 (37.3-61.7) Retic- 118 (10.0-110.0) WBC - 17.87 (5.05-16.76) NEU- 14.88 (2.95-11.64) Mono- 1.38 (0.16-1.12) PLT - 21 (148-484) MPV - 19.2 (8.7-13.2) K- 3.1 (3.5-5.8)

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 is normal.

The left kidney is normal size (5.96 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 (5.58 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

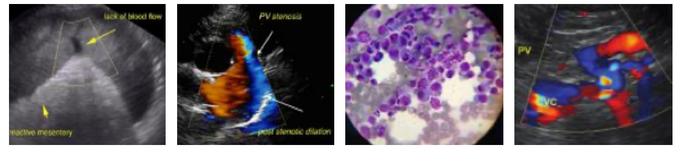
The left adrenal gland is normal size (0.74 cm at cranial pole) (0.68 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.90 cm at cranial pole) (0.75 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.

Spleen

The spleen is normal in size (1.57 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. A few small hypoechoic nodules are visualized. Splenic vasculature is normal.

Liver



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The liver is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen with minor changes consistent with age-related remodeling. A few ill-defined hypoechoic areas are seen. In addition, a 1.75 x 0.96 cm cyst is observed on the left side. 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 moderate amount of aggregated echogenic partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The wall in the region of the fundus/greater curvature is thickened (up to 1.43 cm) and irregular with a loss of the normal layering pattern. The mesentery effacing the serosal surface in this region is hyperechoic. The remaining gastric wall is normal in thickness with retention of the normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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. A 4.19 cm hyperechoic cystic lymph node is observed at the aortic trifurcation. In addition, a 1-2 prominent cranial abdominal lymph nodes are seen. The largest node measures 2.5 cm in length and is rounded/hypoechoic.

Other

A 2.33 x 0.82 cm hypoechoic nodule is observed caudal to the right adrenal gland.

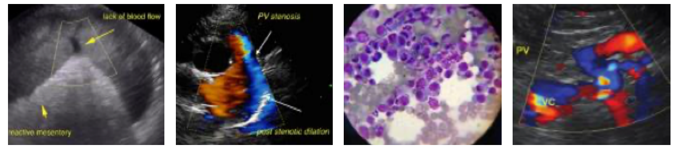
ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gastric wall changes are concerning for infiltrative neoplasia. Top differentials include lymphoma and adenocarcinoma with a lower possibility of a severe inflammatory process. Regional peritonitis is present.
- The abdominal lymphadenopathy could be consistent with lymphoid hyperplasia, reactive lymphadenitis or infiltrative neoplasia.

Secondary Findings:

- Minor bilateral age-related renal changes.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).



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- The hepatic parenchymal changes are most consistent with benign age-related process (i.e., regenerative nodular hyperplasia and/or vacuolar hepatopathy). Inflammatory disease and infiltrative neoplasia are considered less likely. However, correlation with the patient's liver values is recommended.
- The gallbladder changes could be consistent with cholestasis, fasting or a developing mucocele.
- The origin of the nodule in the right mid-abdomen is unclear. It may represent a prominent lymph node, a mesenteric nodule, other.
- Age-related pancreatic remodeling/fibrosis. Concurrent mild pancreatitis is also possible, particularly if the patient exhibits pain on cranial abdominal palpation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- If accessible, a fine needle aspirate of the thickened gastric wall is recommended (if clotting status is appropriate). If the area is not accessible or if cytology results are inconclusive, endoscopic or surgical biopsies may be necessary to get a definitive diagnosis.




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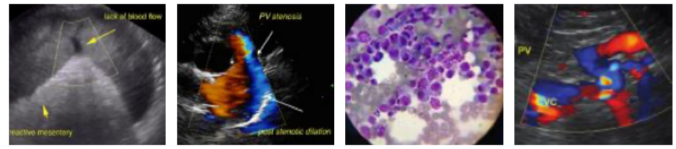

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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