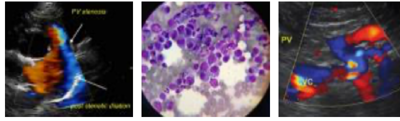


DATE
8/8/21

PATIENT
Rue-B Boettinger

SPECIES
Canine

BREED
French Bulldog

SEX
Female, spayed

AGE
2/8/2010

WEIGHT
17.5 lbs.

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

HOSPITAL NAME
Paradise Animal Hospital

REFERRING VET
Dr. Twardzik

INVOICE
11899

PRESENTING CLINICAL SIGNS

History: Acute onset of repeated vomiting on 8/17, especially when patient drinks water. On exam, abdomen tense and patient mildly to moderately dehydrated.
Current Medications: Cerenia 0.8 ml SQ on 8/17.
Lab Results: CBC: Elevated Neuts 13.65 K/uL, Elevated Monos 1.13 K/uL, Decreased PDW, Chem: WNL

Radiographs: Marked distension of gastric lumen with area of gastric thickening
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not needed.
Stat Report: Approved/Requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended. A small to moderate amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (4.23 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.24 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.63 cm at cranial pole) (0.65 cm at caudal pole) (1.57 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 mildly enlarged (0.72 cm at cranial pole) (0.69 cm at caudal pole) (1.98 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

A 3.71 x 3.04 cm isoechoic, vascular mass is arising from the cranial aspect. In the remainder of the spleen, there are normal curvilinear peripheral contours and homogeneous parenchyma. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen with minor changes consistent with age-related remodeling. No focal lesions are observed. Hepatic vasculature 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 to moderate amount of aggregated echogenic suspended debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. The gastric lumen is severely distended with suspended and gravity-dependent echogenic debris and is hypomotile. A 2.11 cm soft shadow is observed intermittently in the pyloric antrum. Smaller soft shadowing material is also seen within the gastric lumen. The pyloric outflow tract appears patent. The wall of the pylorus is thickened (up to 0.88 cm) with a prominent muscularis layer. The small intestinal lumen is not dilated. The duodenal and jejunal walls are normal in thickness with a normal layering pattern and appropriate mural detail. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. The distal ileum at the level of the ileocecal colic junction is thickened (up to 0.68 cm) with a prominent muscularis layer and suspected loss of the normal layering pattern. The colonic wall is normal. The lumen of the descending colon is air filled.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portions, no obvious pathology is seen.

Free Abdomen

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

Other

A brief echocardiogram reveals no evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Splenic mass. Neoplasia (i.e., sarcoma, round cell tumor) is considered likely with a lower possibility of benign pathology.
- Gastric stasis with shadowing material within the lumen, which may be causing an intermittent pyloric outflow tract obstruction. The pyloric wall thickening could be consistent with hypertrophy, inflammation or emerging neoplasia.
- The distal ileal wall changes are concerning for infiltrative neoplasia (i.e., round cell tumor) with a possibility of a severe inflammatory process. The diffuse small intestinal wall changes could be consistent with inflammatory disease or emerging neoplasia.

Secondary Findings:

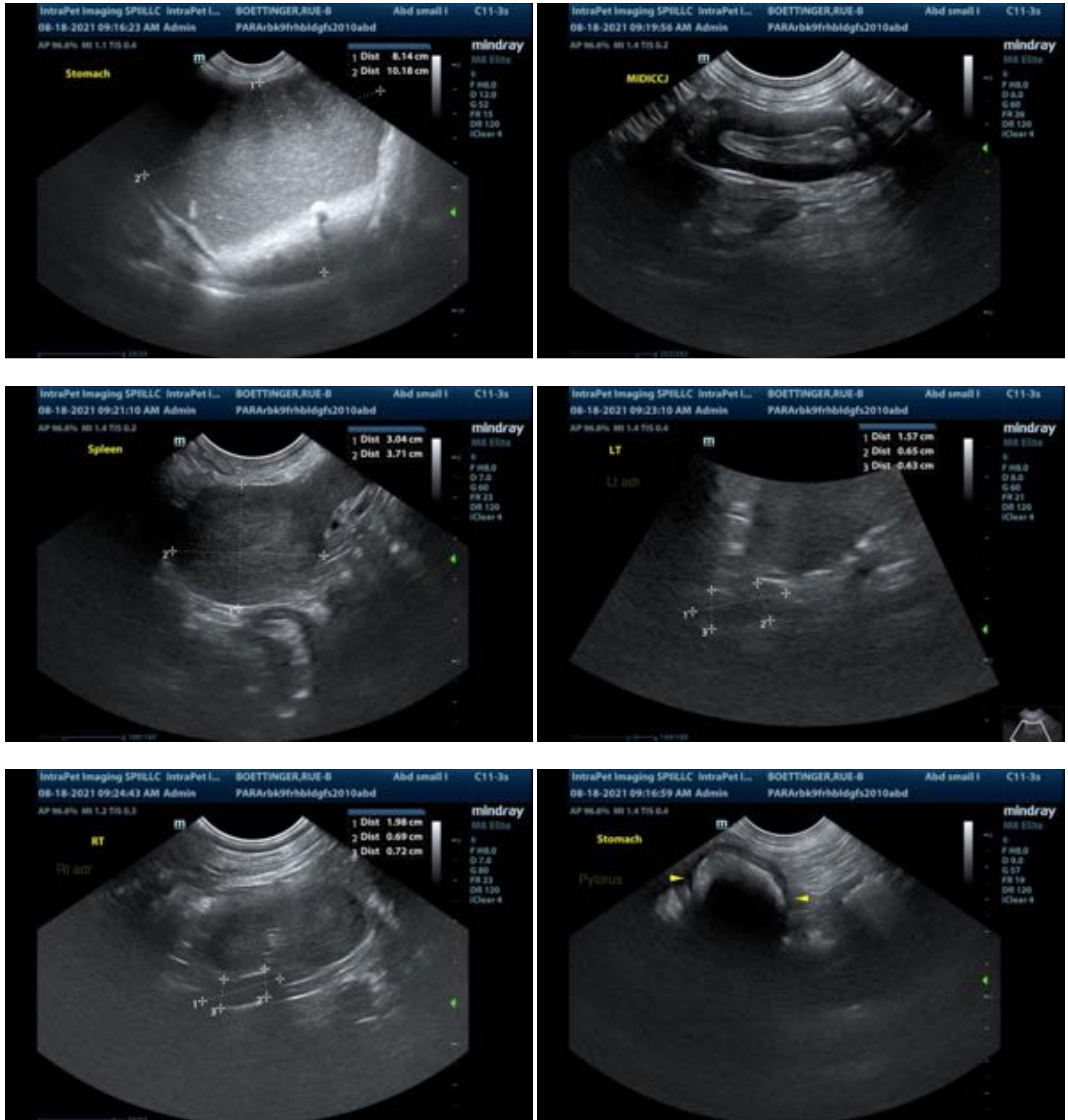
- Urinary bladder debris.
- Bilateral adrenomegaly (mild).
- The hepatic changes are consistent with age-related parenchymal remodeling and are not considered clinically significant at this time.

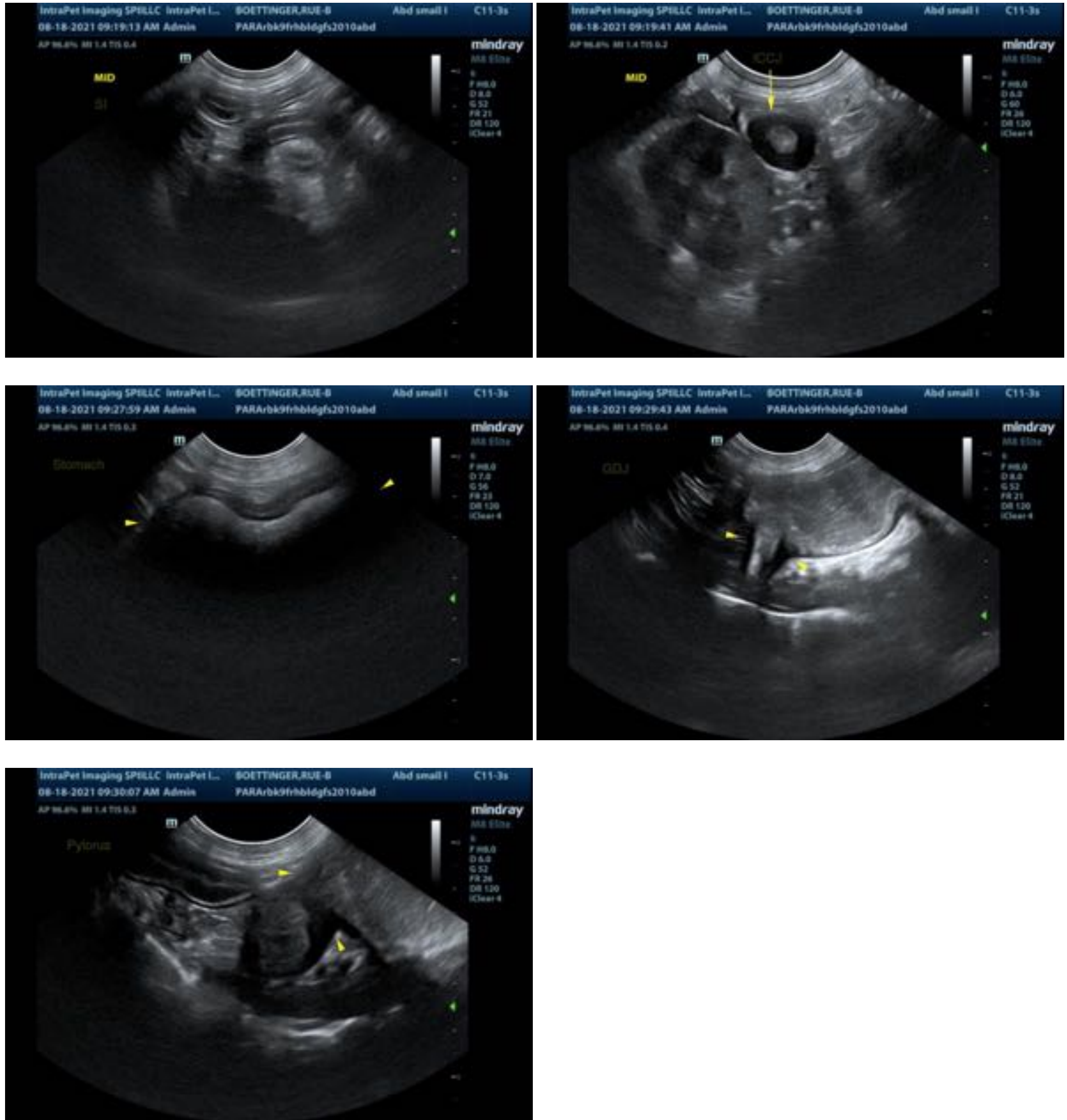
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases. If there is no evidence of pulmonary metastatic disease, consider an abdominal exploratory with splenic mass removal, ileal biopsy and evaluation of the stomach for foreign material with removal, if present. A more conservative approach would be to consider a fine needle aspirate of the spleen and distal ileal

wall (if accessible) with stat cytology and repeat sonographic evaluation of the stomach in 12 hours to determine if the shadowing material has passed into the small intestine.

- Given the small intestinal changes, a malabsorption panel should also be considered.





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