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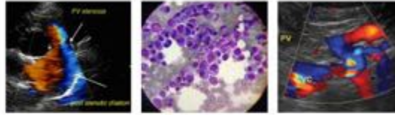


SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Logan Overeem
278391

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

5 years

WEIGHT

36.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC- Dr. Cavanaugh

INVOICE

11564

DATE

9.1.22

PRESENTING CLINICAL SIGNS

History: Presented for continued vomiting after outpatient care (SQ fluids and ondansetron) provided on 8/30. The owner arrived home today around 3PM and found a bile of dark green/brown vomit. She notes that Logan was lying in a pool of his own urine when she arrived home and he has been asking to go outside every 2 hours. Logan was initially regurgitating as well as vomiting- she is unsure of his event today as it was not witnessed.

Abnormal PE/Chem/CBC/UA Results: CBC/Chem: WNL Painful with cranial abdominal palpation, otherwise benign PE

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** 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 prostate is normal in size (0.73 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The **left kidney** is normal size (5.99 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.

The **right kidney** is normal size (6.38 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.

Adrenal Glands

The **left adrenal gland** is normal size (0.46 cm at cranial pole) (0.63 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 (0.69 cm at cranial pole) (0.59 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.

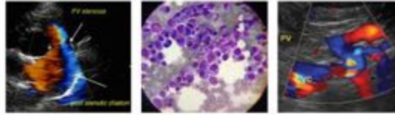
Spleen

The **spleen** is normal in size (2.15 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 small in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. No 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 anechoic. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal

The **gastric lumen** is severely fluid-distended and hypomotile. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. In the region of the pylorus, the wall is thickened (up to 1.08 cm) with questionable retention of the normal layering pattern. Surrounding mesentery is hyperechoic. The proximal duodenum is mildly to moderately fluid-distended. The wall is normal in thickness with a normal layering pattern. As the duodenum extends towards the caudal flexure, the lumen becomes empty. The remaining small intestinal segments are also mostly empty. The remaining small intestinal walls are normal in thickness with a normal with a normal layering pattern and appropriate mural detail. The ileocecocolic junction and colonic wall are normal.

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

There is no obvious evidence of free fluid. A 1.39 cm **lymph node** is observed at the aortic trifurcation. In addition, one to two prominent mesenteric lymph nodes are visualized, the largest measuring 3.26 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pyloric wall thickening could be consistent with inflammation, hypertrophy or emerging neoplasia. Adjacent peritonitis is present. The gastric distention/hypomotility differentials include ileus versus partial outflow obstruction (i.e.,secondary to pyloric wall thickening).

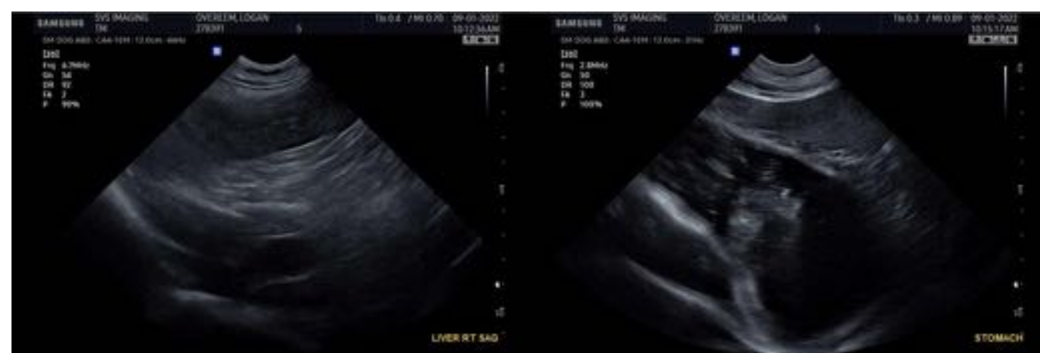
Secondary Findings

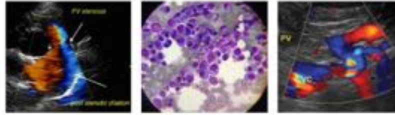
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

- Suspected microhepatica. This may be a normal variant for this patient or may be secondary to chronic liver disease. Correlation with the patient's clinical history and liver values is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If an aggressive approach is desired, consider an upper GI endoscopy or an abdominal exploratory with gastrointestinal biopsies, with particular attention to the pyloric wall. Three-view thoracic radiographs should be performed prior to anesthesia to assess the esophagus (given the regurgitation) and to evaluate for occult aspiration pneumonia. In the meantime, supportive care for acute gastroenteritis/esophagitis is recommended.





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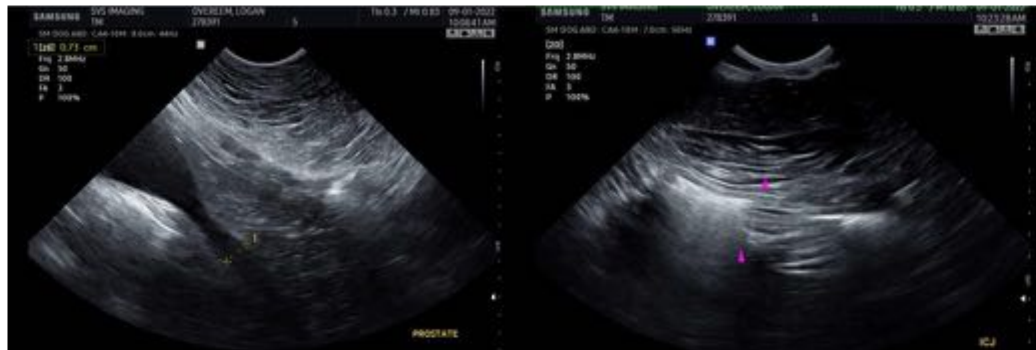

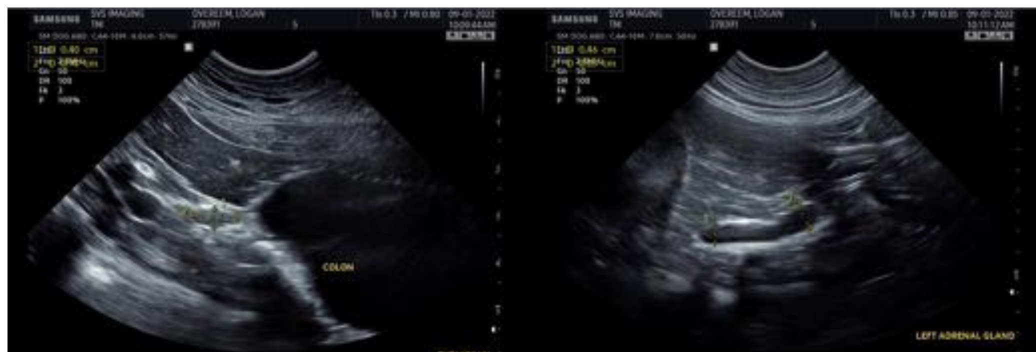

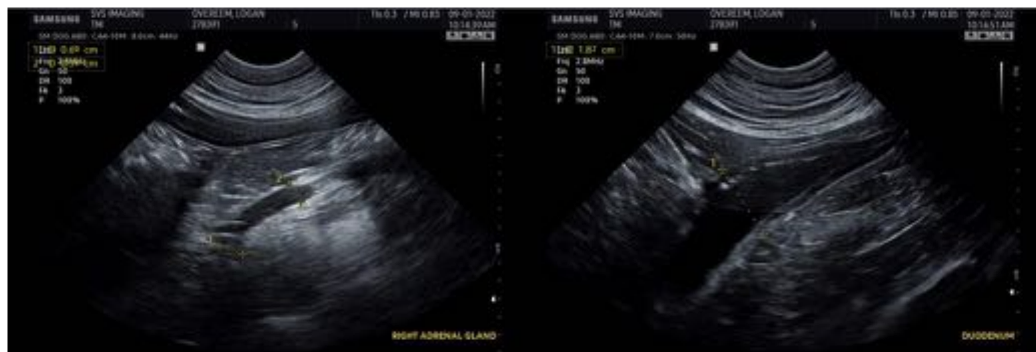

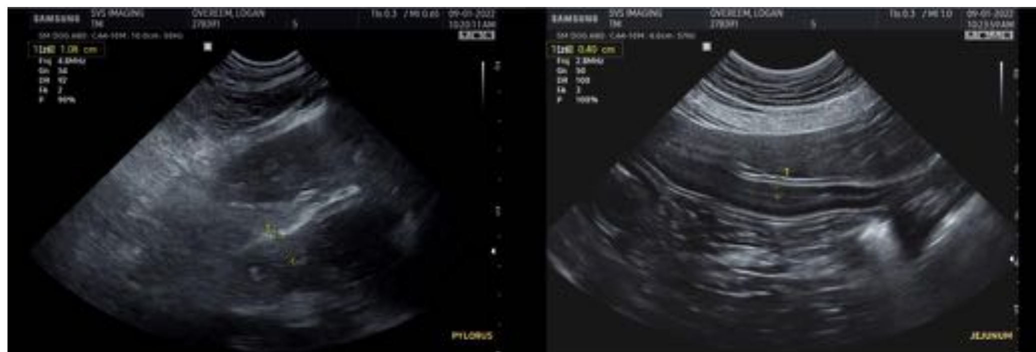

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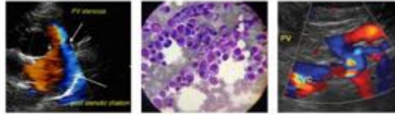

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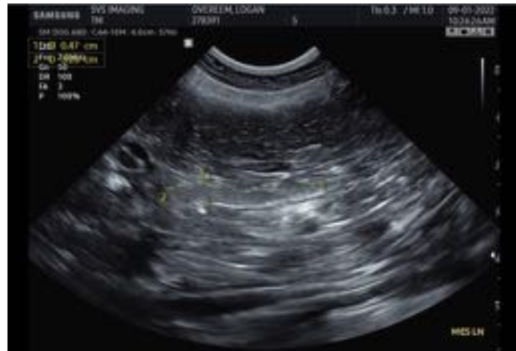

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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