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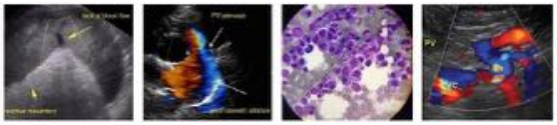


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Cruise Taylor

SPECIES

Canine

BREED

Schnoodle

SEX

Male, neutered

AGE

12 Yrs.

WEIGHT

9.2 kg.

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

New Hamburg VC

REFERRING VET

Dr. Findlater

DATE

5/3/23

PRESENTING CLINICAL SIGNS

History: was at emerg clinic-not eating, in pain, stretching, restless, shaking-had eaten some steak earlier in the week-had vomiting/diarrhea resoled but appetite slow decreased. Pain is better on gaba/cernia but still not eating. Has lost 2kg since last July. meds: cerenia, mirtazapine, gaba
Abnormal PE/Chem/CBC/UA Results: CBC mild monocytosis, mild neutrophilia normal SNAP cPLi, chem normal.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is distended. The wall is normal in thickness with a smooth mucosal surface. At least one cystic calculus is visualized (0.99 cm in diameter) along with a scant amount of suspended echogenic debris. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney is normal size (5.52 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.88 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with 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 (0.42 cm at cranial pole) (0.47 cm at caudal pole) (1.69 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.

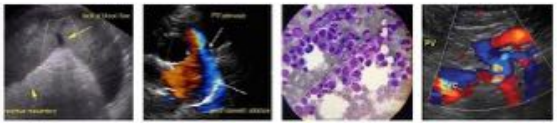
The right adrenal gland is borderline enlarged (1.91 cm at cranial pole) (0.55 cm at caudal pole) (1.87 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.38 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 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 mostly gravity-dependent echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal

The gastric lumen is gas distended. The gastric wall in the region of the fundus is thickened (up to 0.89 cm) with suspected loss of the normal layering pattern. The wall in the region of the pylorus is normal in thickness with a 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 obvious 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. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gastric wall thickening in the region of the fundus could be consistent with emerging neoplasia (i.e., lymphoma, adenocarcinoma) or severe gastritis.
- Cystic calculus.

Secondary Findings:

- Mild bilateral chronic renal changes.
- The hepatic changes are consistent with age-related parenchymal remodeling and are not considered clinically significant at this time.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- Consider a fine needle aspirate of the thickened gastric wall, if accessible and if clotting status is appropriate. A 25-gauge needle should be used. If cytology results are inconclusive or if the region is not accessible, consider endoscopic or surgical biopsies.
- Given the history of weight loss, also consider a malabsorption panel including serum cobalamin, folate, TLI and PLI as well as a fecal evaluation for ova and Giardia.
- Regarding the cystic calculus, if surgical GI biopsies are pursued, consider a cystotomy with stone removal, analysis, and culture. If a more conservative approach is desired at this time, an attempt at medical dissolution can be considered. However, if the stone size is not reduced within 4-6 weeks of initiating therapy, a cystotomy should be revisited.

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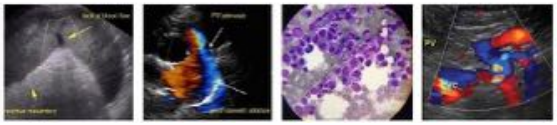

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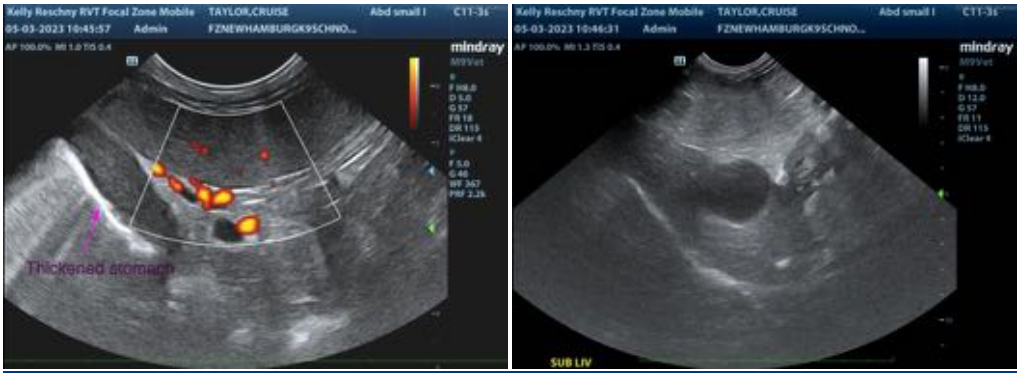

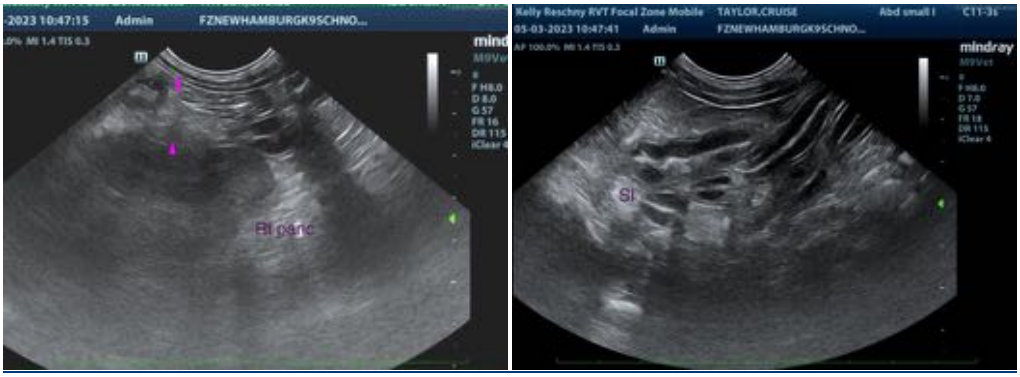

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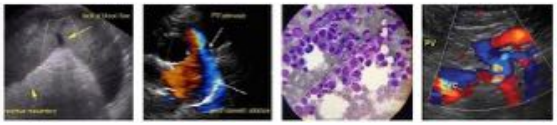

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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