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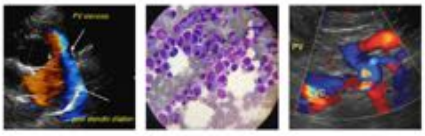

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Lily Schwartz

SPECIES

Canine

BREED

Jack Russell Terrier

SEX

Spayed female

AGE

11 years

WEIGHT

11.81 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging Michigan

REFERRING VET

Union Lake VH

INVOICE

39997

DATE

10/10/22

PRESENTING CLINICAL SIGNS

History: Not eating well the past few days and has had some wt loss as well seems depressed. Owner describes possible seizure like episode that has occurred two times in the last 2 days. Lily will become stiff and rigid for a few minutes and then is dazed for a few minutes after that. She has also been vomiting as well many times yesterday. No pu/pd no history of ingestion of anything Has had a history of vomiting in the past and has been on reglan and famotidine. Other than a murmur all is good on pe Abnormal PE/Chem/CBC/UA Results: Labs normal, stomach distended in spite of not eating and drinking

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

Left kidney is normal is size (3.79 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal is size (4.02 cm),shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.53 cm at the cranial pole and 0.57 cm at the caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.57 cm at the cranial pole and 0.59 cm at the caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. A discrete, 1.5 x 1.0 cm hyperechoic nodule was noted in the left liver. Visible vasculature and biliary tree appear normal without distension or congestion.

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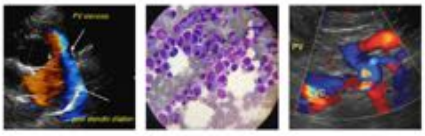

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Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The stomach is mildly diffusely thick with a focal 3.0 cm long x 1.0 cm thick area along the caudal body of the stomach and approached the pyloric antrum, which also appears mildly thick. Layering is still visible; however, there is an enlarged lymph node and enhanced fat in the mesentery at the pyloric, duodenal junction.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

Aggressive lymphadenopathy was noted at the pyloric, duodenal junction.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- **Gastric wall** thickening with enhanced fat and mesentery in the area of the pyloric duodenal junction. **Aggressive lymph nodes** in the area of the pyloric duodenal junction **–** most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture. However, given the aggressive lymphadenopathy the appearance trends away from benign.
- **Pancreatic age-related remodeling –** Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.**Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered. **Liver nodule –** Differentials for a discrete liver nodule include primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.

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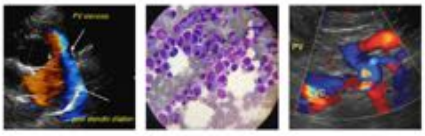

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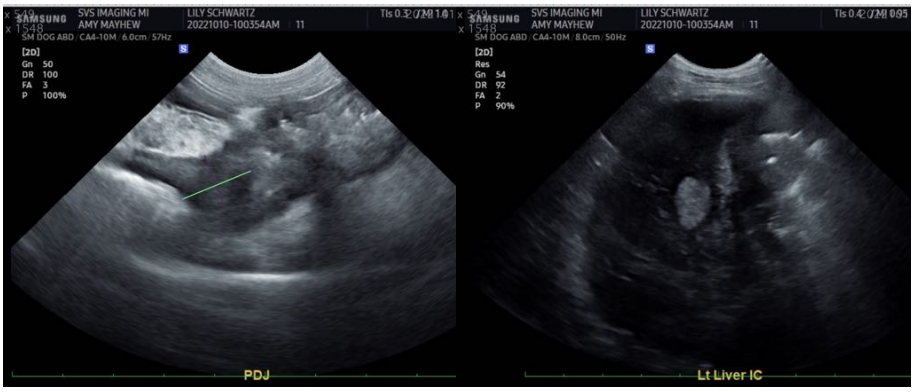
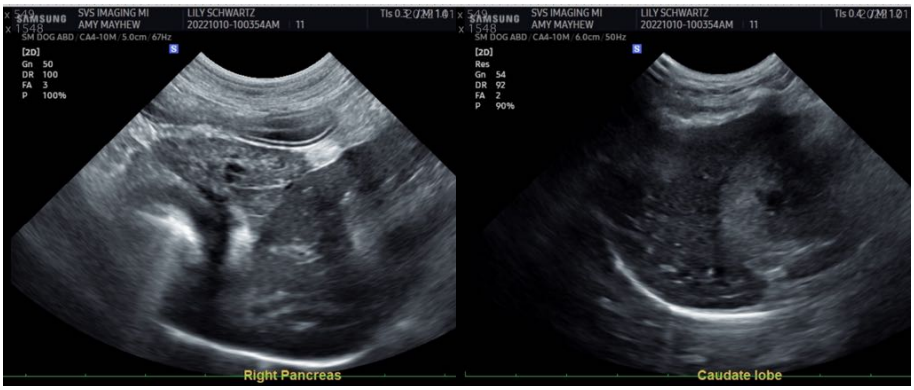
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.
FNA of the enlarged lymph node near the pyloric duodenal junction is recommended if the patient's coagulation status is appropriate. Additionally, if possible a FNA of the thick gastric wall can be considered. Ultimately if a diagnosis cannot be obtained cytologically upper GI endoscopy/gastroscopy can be considered for biopsies of the gastric wall with special attention pain to the pyloric area. Additionally given the reported seizure like activity a blood pressure measurement is recommended if not recently evaluated. Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

In the meantime, supportive/symptomatic medical management of gastritis +/- microulceration is recommended in the form of anti-emetics and gastroprotectants including b.i.d. antacids and Sucralfate as well as empirical deworming with a 5 day course of Panacur. Given the reported chronicity of the vomiting a chronic inflammatory lesion is very possible and transition to a hydrolyzed protein diet can be considered.





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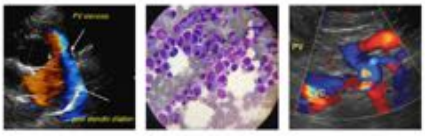

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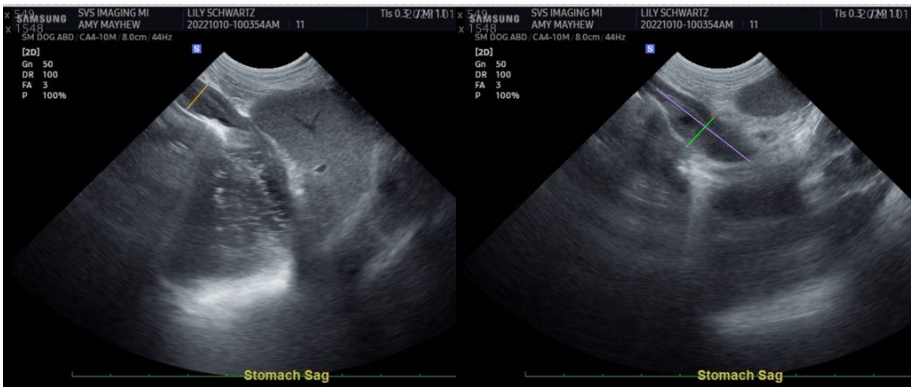

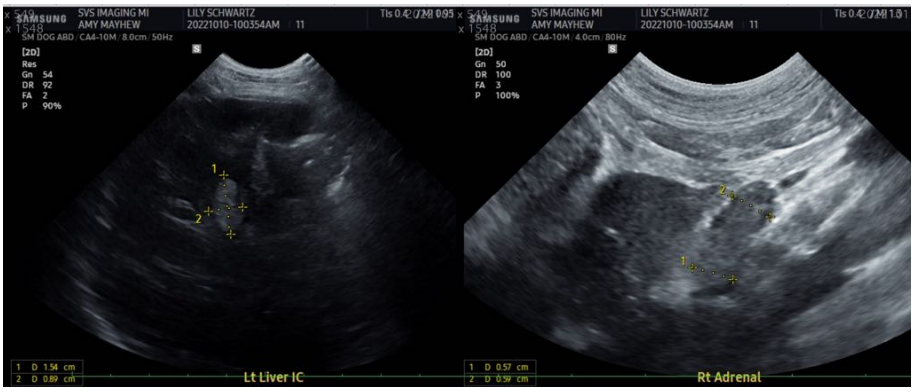

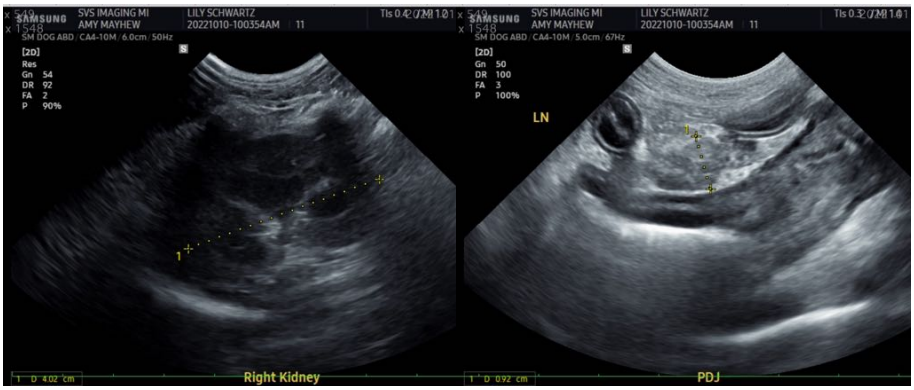

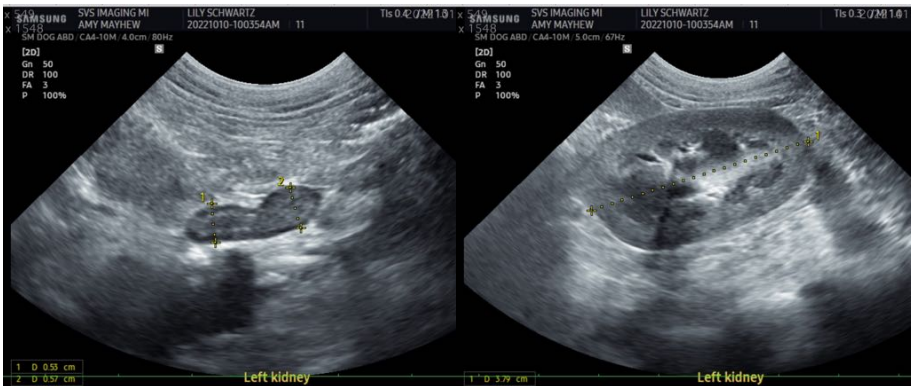

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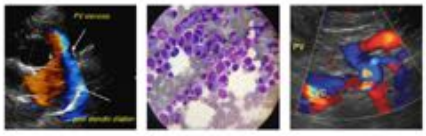

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com