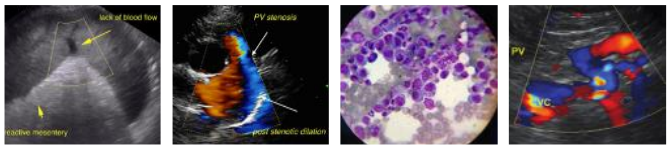
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Coal Long

SPECIES
Canine

BREED
Labrador Retriever

SEX
Spayed Female

AGE
12 Years

WEIGHT
28.2 kg

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Erin Wicks

HOSPITAL NAME
Shores VEC

REFERRING VET
Dr. Miller

INVOICE
17640

DATE
10/11/22

PRESENTING CLINICAL SIGNS

History: Presented at our hospital for possible GDV. O said Coal was vomiting last night and this am. Around 1 pm, he started retching. Previous Health Concerns: Laryngeal paralysis, mega esophagus, Addison's, elbow arthritis, sx on both elbows, entropion surgery, masticatory myositis Current Medications: Pred 2.5mg twice a week, Fludrocortisone 0.2mg SID (switched from Zycortal 2 months ago), Proin, Tacrolimus OU BID, Gut Guard by 4 Leaf Rover = glucosamine, fibers, probiotic, Homeopathic Multivitamin = probiotics, pancreatic enzymes

Abnormal PE/Chem/CBC/UA Results: Cardiovascular: pulses weak, HR high Respiratory: panting heavily Abdominal: thin, distension caudal to ribcage 1) 2V Abd Rads: stomach gas-distended but in normal position, intestines gas-distended 2) CBC/Chem/EPOC: elevated BUN, hypoproteinemia, hypoalbuminemia, mild hyperlactatemia, lymphopenia 3) Cortisol: low normal Removed aprox 700ml of gas from stomach via NG tube.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (7.42 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 (7.12 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. An approximately 1.0 cm cortical cyst is noted in the cranial and caudal pole of the right kidney.

Adrenal Glands

Left adrenal gland is flat (0.58 cm thick at caudal pole), consistent with the previous diagnosis of hypoadrenocorticism.

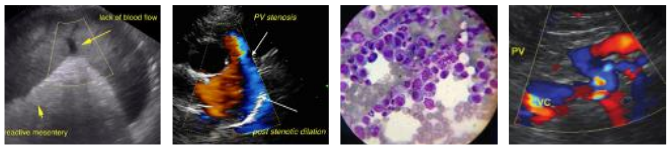
Right adrenal gland is unable to be visualized, likely due to its flat size.

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). A 0.4 cm nodule (non-capsule disrupting) is noted near the tail of the spleen. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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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 visible stomach is diffusely thick, measuring approximately 1.3 cm – 1.5 cm thick with a hypoechoic wall and loss of mural detail. The lumen of the stomach is mildly distended with fluid and echogenic debris. There is no visible sign of foreign material or outflow tract obstruction present in these images at this time.

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 and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Diffusely thick gastric wall is concerning for infiltrative disease with both benign inflammatory disease, as well as infiltrative neoplasia, such as lymphoma versus other being differentials. Normal patient variant/rugal folds, combined with chronic gastritis given the concurrent metabolic conditions present, cannot be definitively ruled out.

Secondary Findings

- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

- Flat adrenal glands consistent with the historical diagnosis of hypoadrenocorticism

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patients metabolic status, history of hypoadrenocorticism, and currently high BUN, low albumin, low normal cortisol, etc., management of suspected gastritis, possible microulceration secondary to hypoadrenocorticism, as well as further work up of the hypoalbuminemia is recommended as a first step and includes 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. A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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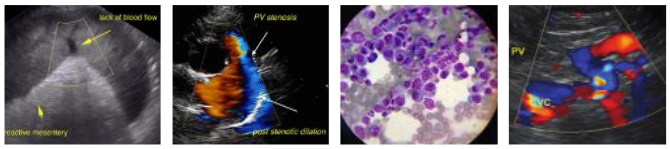

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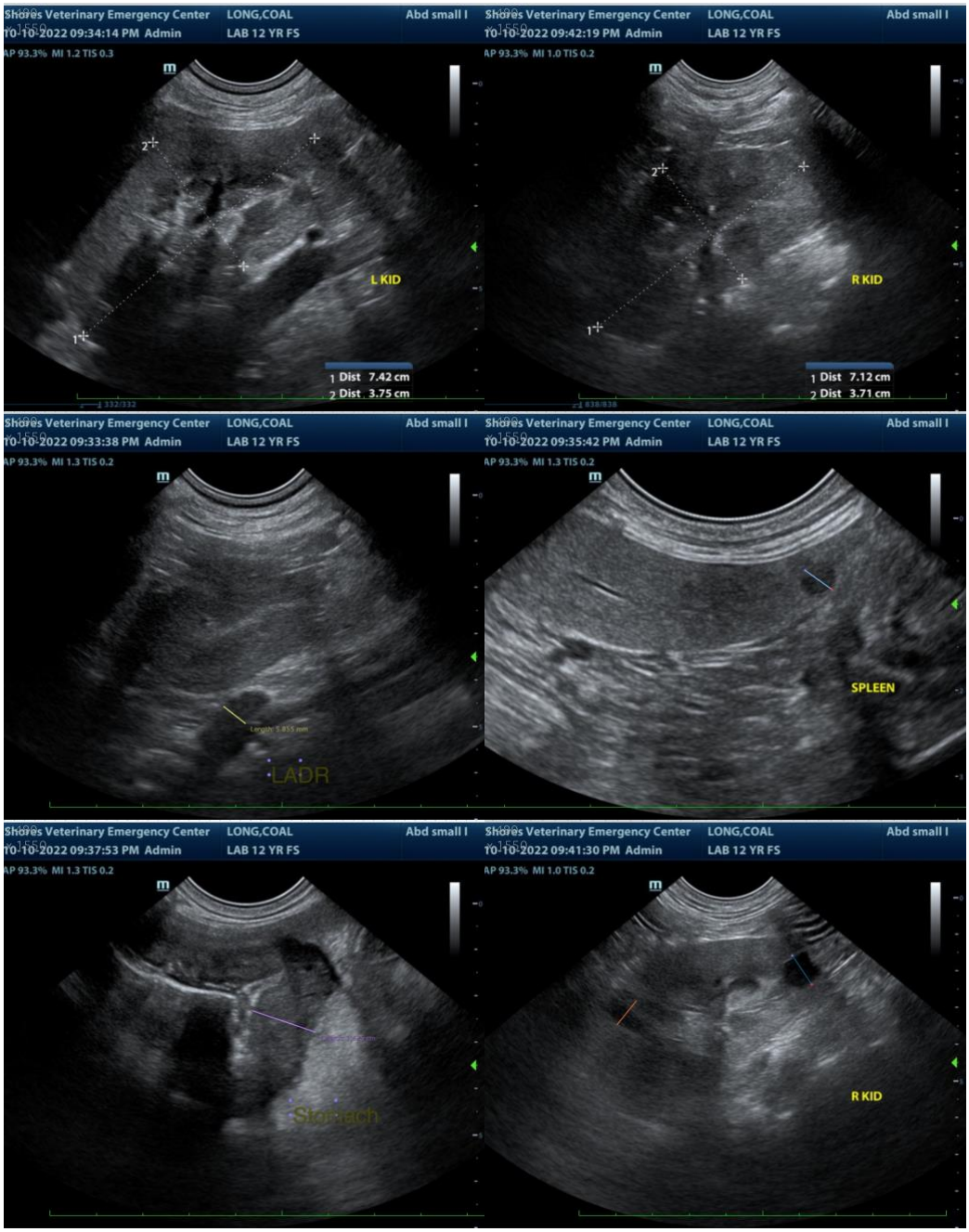
Supportive/symptomatic medical management with antiemetics, gastroprotectants, including twice per day antacids and sucralfate, empirical deworming with a 5-day course of Panacur in addition to a potential adjustment/increase of corticosteroid administration is recommended. Additionally, aerophagia from the patients reported laryngeal paralysis could potentially have resulted in this patients reported gas distention. Ultimately, if supportive care and readjustment of therapies to address overall metabolic disease doesn't result in clinical improvement, and/or improved appearance of the gastric wall, a fine needle aspirate of the gastric wall could be considered of patients coagulation status is appropriate. If a diagnosis is not obtained cytologically, upper GI endoscopy with gastric biopsies planned may be warranted.



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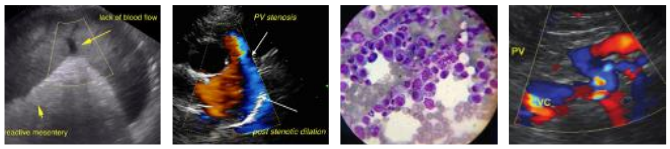

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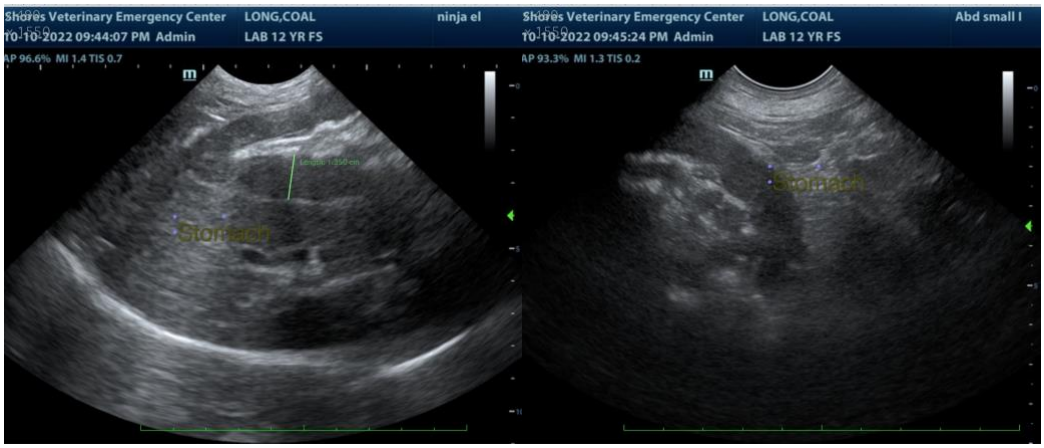

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com