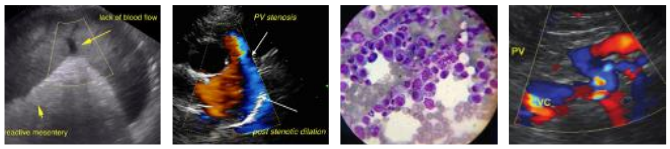
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Mia Gamble

SPECIES

Canine

BREED

Golden Retriever

SEX

Spayed Female

AGE

7 Years

WEIGHT

54 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Sue Hartmann

INVOICE

17594

DATE

10/5/22

PRESENTING CLINICAL SIGNS

History: Vomiting. Mia has vomited regularly for most of her life and owner mentioned this on routine exam 2 months ago. They also mentioned that during a time that she was treated for a skin issue with prednisone the vomiting subsided. With suspected IBD, we started Z/D diet - no improvement.

Abnormal PE/Chem/CBC/UA Results: Chem 17, lytes, CBC - unremarkable Fecal - Nops

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 (7.56 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.

The right kidney is small (3.99 cm), irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed.

Adrenal Glands

Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measures 2.5 cm long x 0.4 cm at the cranial pole and 0.34 cm at the caudal pole. The right adrenal gland measures 2.2 cm long x 0.59 cm at the cranial pole and 0.33 cm at the caudal pole.

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.

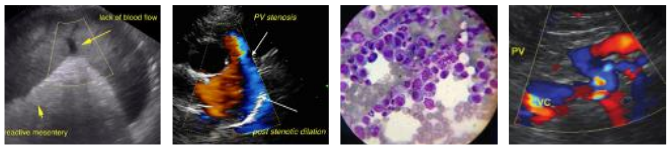
Liver

Liver is subjectively 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.

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 wall is normal, except for an approximately 3.5 cm length of stomach along the lesser curvature that is focally thick, measuring approximately 2.0 cm thick and is hypoechoic in appearance. Loss of layering is suspected. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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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

- Focal gastric wall thickness along the lesser curvature with some early loss of layering noted. This is concerning for infiltrative neoplasia, such as round cell neoplasia versus carcinoma versus other. A benign tumor or benign inflammatory response, edema, etc., especially given the chronicity of this patients reported vomiting also cannot be ruled out.
- Bilaterally flat adrenal glands – This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.
- Chronic Kidney Disease affecting the right kidney with a normal appearing left kidney – This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the reported chronicity of this patients vomiting, 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.

Given the flat adrenal glands, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

In the meantime, therapeutic recommendations include antiemetic therapy, gastroprotectant therapy, such as twice per day Omeprazole, +/- a complete helicobacter protocol course. Empirical deworming with a 5-day course of Panacur is recommended and transition from ZD to a different hydrolyzed protein diet is recommended as some patients respond to one brand over the other.

Finally, a fine needle aspirate of the gastric wall is recommended if patients coagulation status is appropriate and if a diagnosis is not obtained cytologically, then upper GI endoscopy/gastroscopy is recommended for further evaluation of the gastric mucosa and biopsies. Depending on owner preference, this more invasive step could be pursued if clinical signs persist beyond the above-mentioned diagnostics and therapeutics in case the gastric thickening is just inflammatory/edematous due to chronic vomiting or it could be pursued now to more definitively rule out more serious, possibly neoplastic disease sooner. If sampling is not pursued now, recheck imaging of the stomach is recommended in 2-4 weeks.

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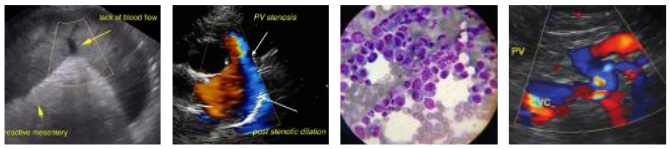

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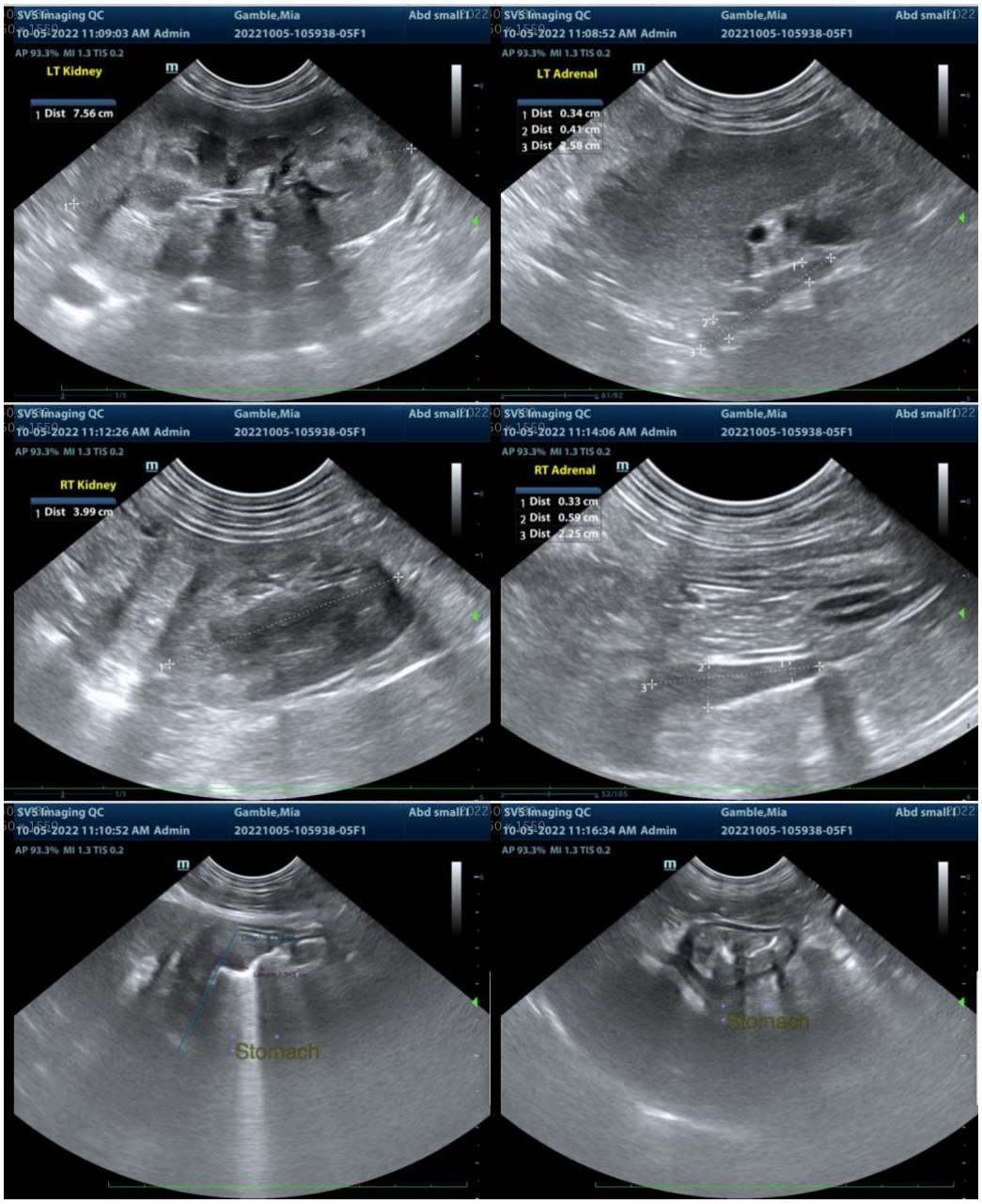

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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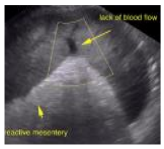
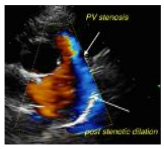
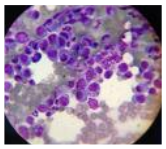
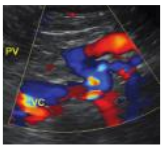

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