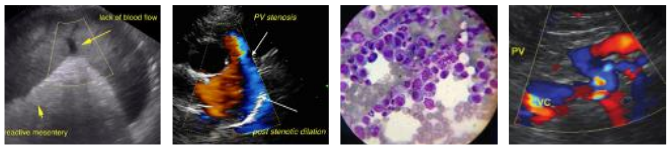

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1-800-838-4268 info@sonopath.com

PATIENT

Benny Lenox

SPECIES

Canine

BREED

Pekingese

SEX

Neutered Male

AGE

13 Years

WEIGHT

21

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Hope Brossman

HOSPITAL NAME

Animal Mansion VH

REFERRING VET

Shelley Parker, DVM

INVOICE

21509

DATE

3/9/23

PRESENTING CLINICAL SIGNS

History: Pet has not been eating. O stated this morning that he MAY have eaten something previously said not possible. To confirm FB

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.

The prostate is unable to be well visualized in these images.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia or infarcts observed. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted bilaterally. The left kidney measured 4.5 cm. The right kidney measured 3.8 cm.

Adrenal Glands

Left adrenal gland is normal in size (0.52 cm at caudal pole, the cranial pole is not well visualized in these images), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.0 cm at cranial pole and 0.61 cm at 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 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 diffusely thick with loss of mural detail and an overall mildly heterogenous hypoechoic appearance to the wall, it ranges in thickness between 0.8 and 1.0 cm maximally. Contents include echogenic granular appearing, possibly some mineral/sand debris, as well as gas and fluid. There is no evidence of obstruction noted.

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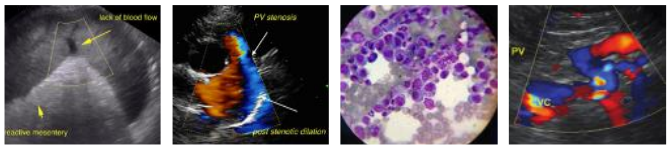

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The visible small intestines are normal in wall thickness and layering. Bowel is diffusely mildly fluid distended without evidence of an obstructive pattern, plication and/or visible foreign material. Small intestinal hyperperistalsis is noted.

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- This is concerning for infiltrative disease. Both benign inflammatory conditions, as well as infiltrative neoplasia should be considered.

- Gastroenteritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other.

  *There is no plication, typical obstructive pattern or evidence of visible foreign material to explain this patients inappetence. The appearance of the gastrointestinal tract is more consistent with dietary indiscretion of possibly dirt or sand vs other, and a secondary gastroenteritis with some concern for infiltrative disease affecting the stomach. Nonobstructive foreign material can't be definitively ruled out but is considered less likely.

Secondary Findings

- Age-related kidney changes with nonobstructive dystrophic mineralization bilaterally

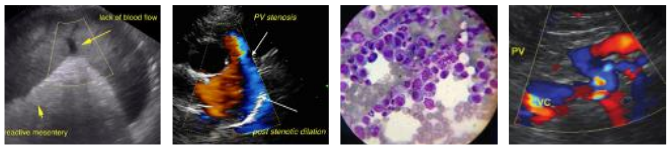
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a general metabolic health screen is recommended, including CBC/chemistry panel, electrolytes and urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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.

If possible to safely reach, and if patients coagulation status is appropriate, a fine needle aspirate of the gastric wall could be considered.

Alternatively, supportive/symptomatic medical management of acute gastroenteritis with antiemetics, gastroprotectants, empirical deworming with a 5-day course of Panacur, probiotics, such as Visbiome or Proviable (if diarrhea is present), and potentially (if tolerated) transition to a low fat or easy-to-digest bland diet with recheck imaging of the stomach pending patients clinical response to medical



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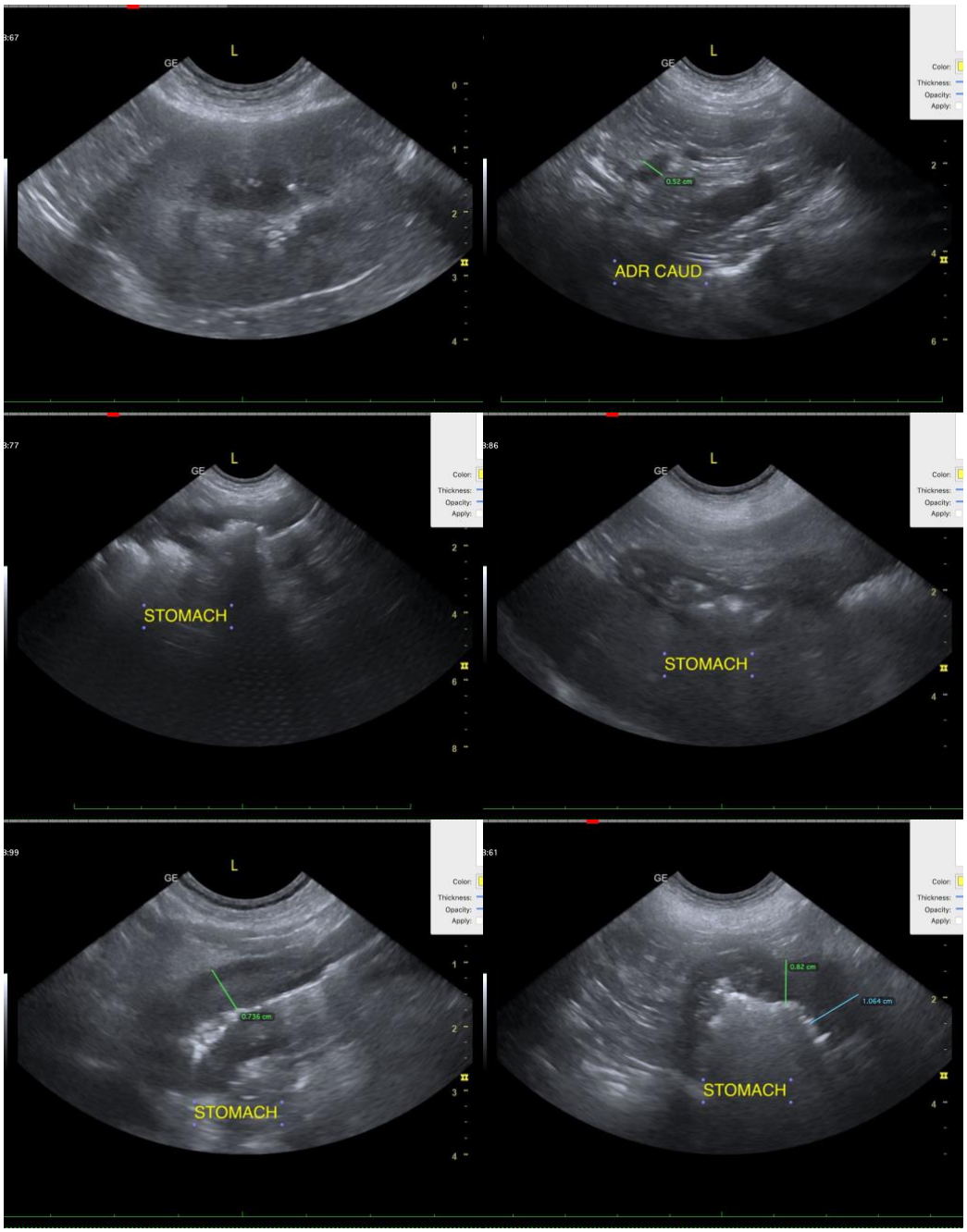
management.

If the thick gastric wall persists, and cytology is not diagnostic, ultimately, upper GI gastroscopy/endoscopy may be necessary for further visual evaluation and biopsies of the stomach and proximal small bowel.

If clinical signs persist and/or vomiting begins, recheck imaging is recommended sooner for further evaluation of possible emerging obstruction not visible in these images.



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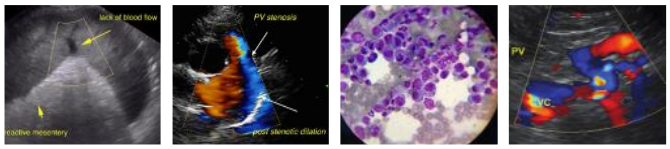

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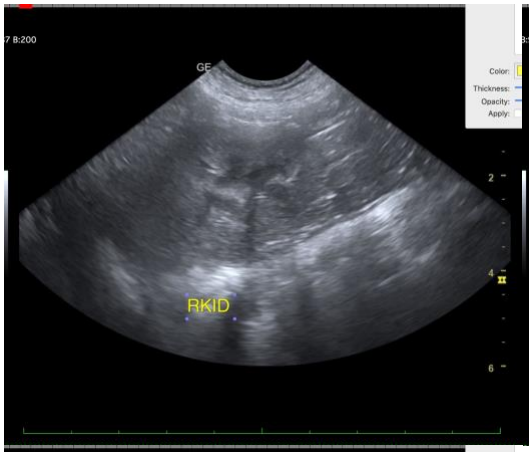

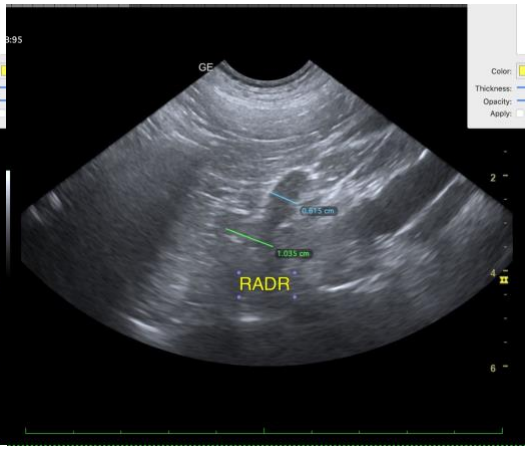

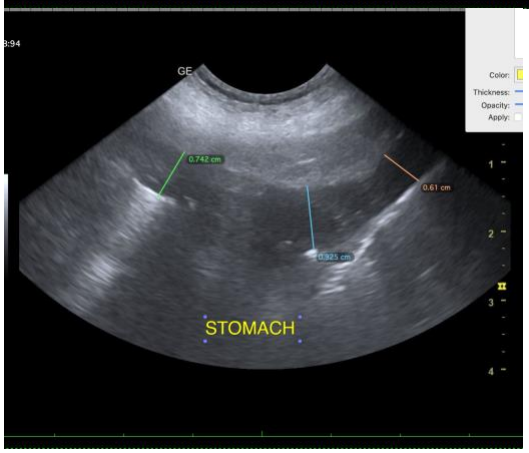

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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