



**PATIENT**

Layla Quinones

**SPECIES**

Canine

**BREED**

Boxer

**SEX**

Spayed Female

**AGE**

14 Years

**WEIGHT**

44 Pounds

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Jenn

**HOSPITAL NAME**

Rockaway AH

**REFERRING VET**

Dr. Bednar

**INVOICE**

34271

**DATE**

1/15/22

**PRESENTING CLINICAL SIGNS**

chronic vomiting, hyperexia, cachexia, xrays show prominent cranial mediastinum, gastric wall lesion, Current meds Clindamycin, Cerenia  
Abnormal PE/Chem/CBC/UA Results: WNL

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The right kidney measured 5.3 cm. The left kidney measured 5.37 cm.

**Adrenal Glands**

The **left adrenal gland** was visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.6 cm.

The **right adrenal gland** was nodular and slightly irregular, measuring 1.2 cm in width.

**Spleen**

The **spleen** presented hypoechoic nodular changes, mildly irregular, yet relatively normal size.

**Liver**

The **liver** presented coarse architecture and nodular changes. Increased portal markings noted. The gallbladder and common bile duct were unremarkable.

**Gastrointestinal**

The **stomach** presented severe concentric wall thickening with loss of mural detail and enhanced surrounding mesentery, consistent with transmural inflammation. The small intestine

**Pancreas**

The **pancreas** presented heterogeneous parenchymal changes with inflammation extending from the stomach.

**ULTRASONOGRAPHIC FINDINGS**

- Nodular adrenals
- Concentric gastric thickening – consistent with severe gastritis, possibility of emerging gastric carcinoma or lymphoma.
- Undefined nodular splenic and hepatic changes



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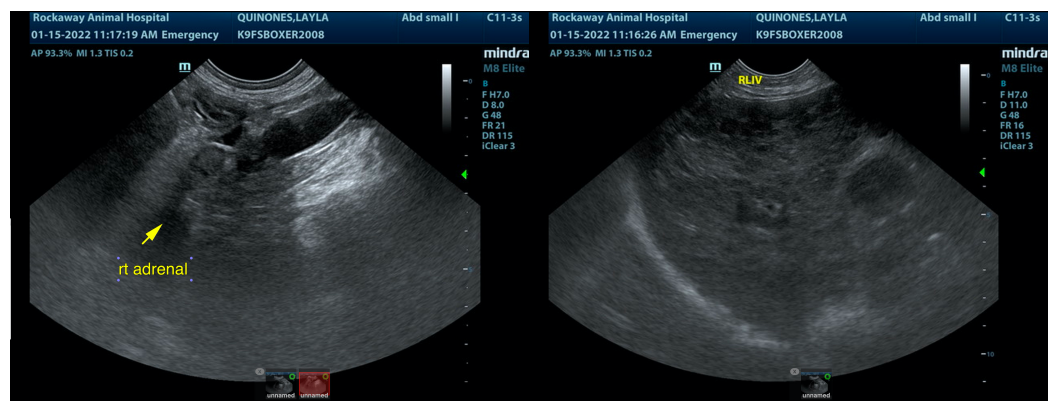
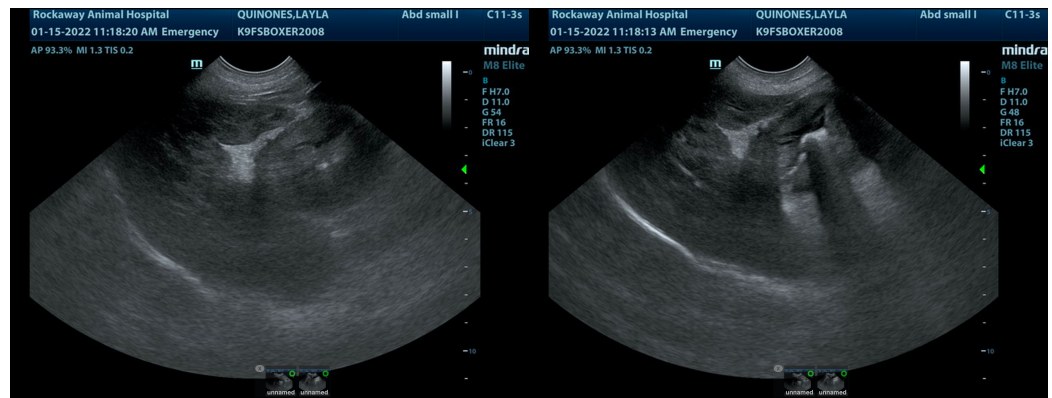
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Endoscopy with mucosal biopsies would be ideal. FNA spleen and liver warranted. Bile acid profile warranted. Aggressive treatment for gastritis warranted and recheck sonogram in one week if sampling is not an option. A clinical trial of the following could prove effective. Assessment for NSAID use in this patient should be evaluated and may predisposing towards this type of gastric presentation.

**Helicobacter/Gastritis protocol**

A clinical trial of **Zithromax** (Dogs: 5-10 mg/kg p.o. q24h. May increase dosing interval to q48h after 3-5 days of treatment), **Metronidazole** (10-20 mg/kg p.o. b.i.d.), **Pepcid** (0.5-1 mg/kg s.i.d.) and **Sucralfate** (0.5-2 g/dog PO) or **Omeprazole** (1 mg/kg p.o. s.i.d.) over the next 3 weeks along with a **novel-protein or hydrolyzed diet** with slurry feeding b.i.d./t.i.d. over the next 2-4 days and then increase to canned diet bid. Dry food should be avoided over the next 4 weeks. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.





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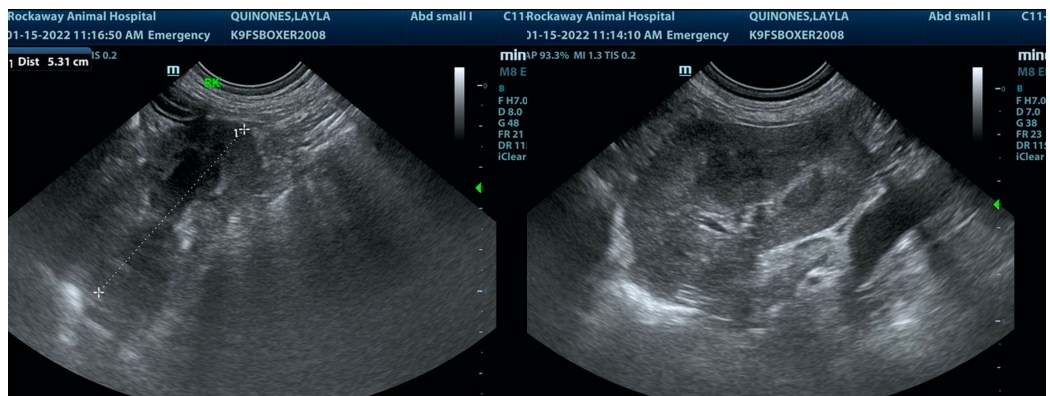
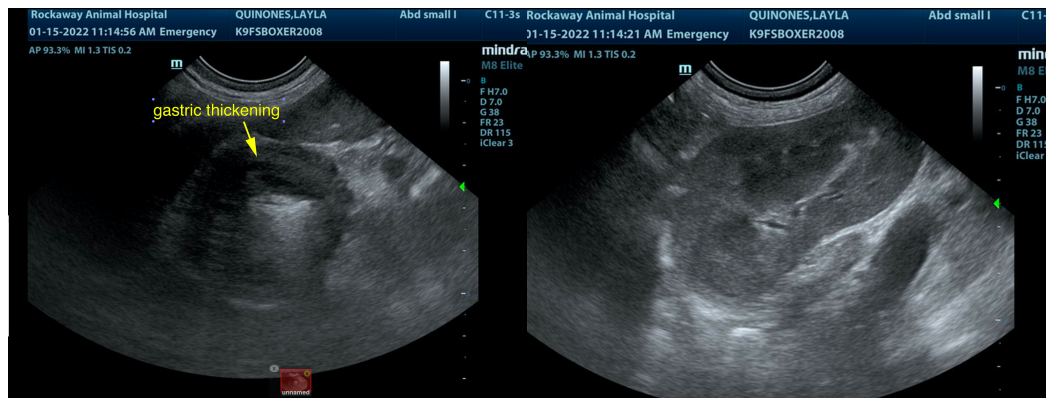
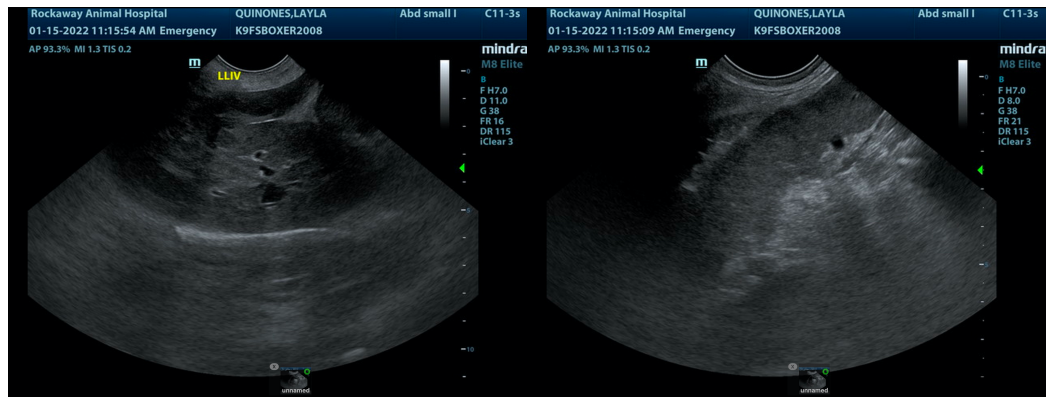
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com**  
[info@SonoPath.com](mailto:info@SonoPath.com)