

**PATIENT**

Cooper Kaltehmofrad

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

3 Years

WEIGHT

20.8 kg

INTERPRETED BYEric Lindquist, DMV
DABVP, Cert. IVUSS**IMAGING
PERFORMED BY**

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison VS

INVOICE

13716

DATE

2/1/22

PRESENTING CLINICAL SIGNS

History: Cooper presented for a history of vomiting and diarrhea. Physical exam revealed mild ptyalism, soft, non-painful abdomen, dilated intestines palpated. Rectal exam revealed loose yellow stool. Abdominal radiographs were unremarkable.

Abnormal PE/Chem/CBC/UA Results: Hyperalbuminemia (4.0), hypokalemia (140), thrombocytopenia (111k with clumping present).

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 residual **prostate** was uniform, measuring 5.0 mm.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The right kidney measured 5.6 cm. The left kidney measured 6.17 cm.

Adrenal Glands

Both **adrenal glands** were 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 right adrenal gland measured 0.45 cm. The left adrenal gland measured 0.44 cm at the cranial pole and 0.52 cm at the caudal pole.

Spleen

The **spleen** revealed subtle micronodular changes yet fairly normal to slightly excessive size. No evidence of masses.

Liver

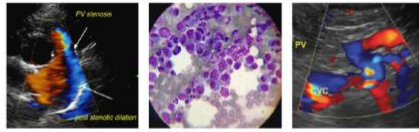
The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

The **gastric** wall was significantly thickened (up to 1.24 cm) with hypertrophied wall. Loss of mural detail noted in the stomach which meets neoplastic criteria; however, severe inflammation can present

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in this fashion. No evidence of foreign bodies. The small intestine and colon were unremarkable, curvilinear patterns were maintained.

Pancreas

The left and right limb of the **pancreas** was slightly hypoechoic and rounded.

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The mesenteric **lymph nodes** presented normal length to width ratio with slight, swollen contour. There was no loss of parenchymal detail. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia.

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The iliac lymph nodes were slightly enlarged and reactive, measuring 0.6 cm.

An epigastric lymph node was slightly enlarged as well.

ULTRASONOGRAPHIC FINDINGS

AGE

3 Years

- Concentric gastric wall thickening. Severe gastritis versus round cell neoplasia. Neoplastic criteria is met, however, complicated inflammatory disease can present in this fashion.
- Slight micronodular splenic changes
- Hypoechoic pancreas
- Minor iliac, epigastric and mesenteric lymphadenopathy. The lymph node pattern would suggest reactive nodes.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Eric Lindquist, DMV
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I strongly recommend full thickness biopsies in the pyloric outflow where the primary concentric thickening is present. The lesions are non-resectable. Ultrasound guided FNA, under heavy sedation, could be considered with corkscrew FNA technique to assess the gastric wall in the region indicated in the attached images to assess for underlying neoplasia. Aggressive GI protectant protocol warranted in the meantime. Endoscopy could also be considered with focus on examination and biopsies of the pyloric antrum. Otherwise, full thickness pyloric biopsies would be appropriate. Prognosis is guarded. FNA of the accessible lymph nodes would also be ideal.

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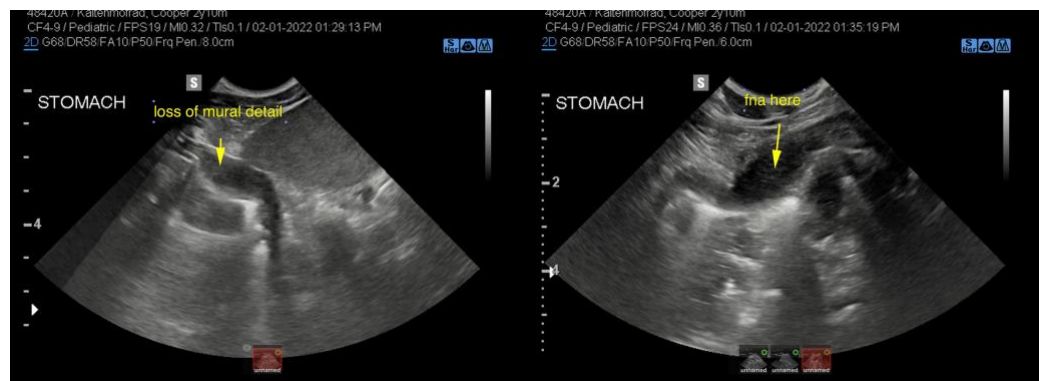
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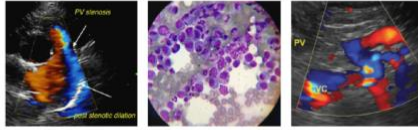
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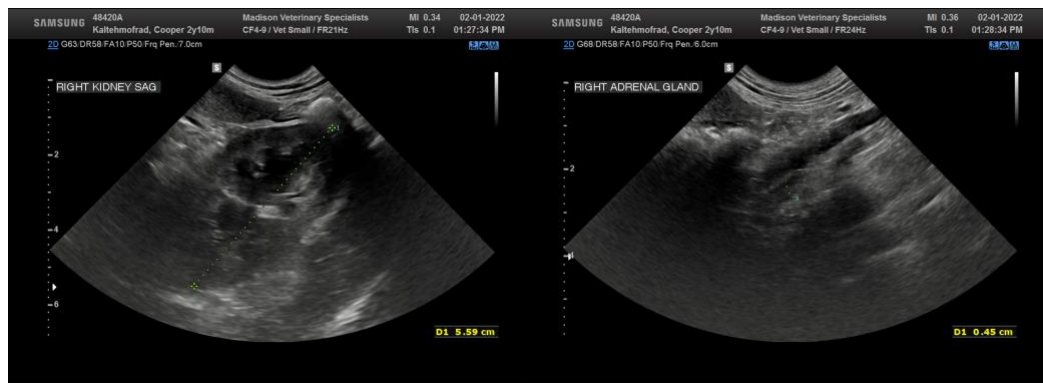
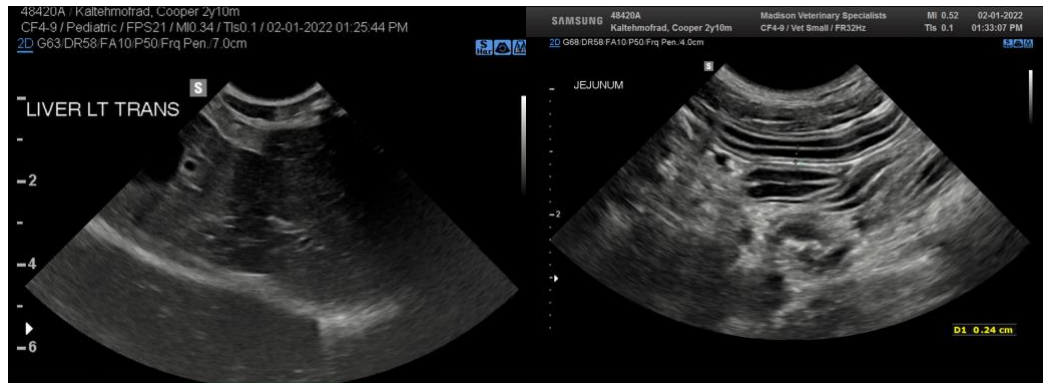
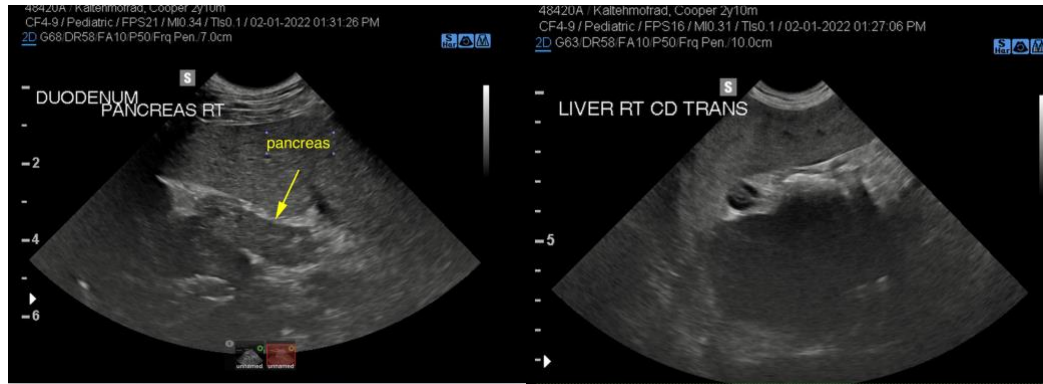
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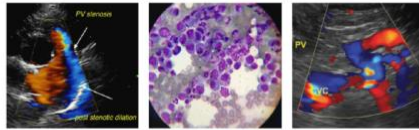
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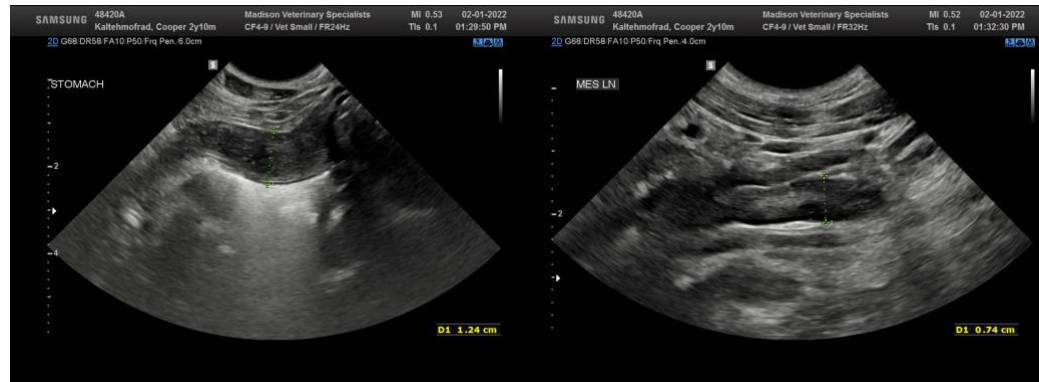
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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