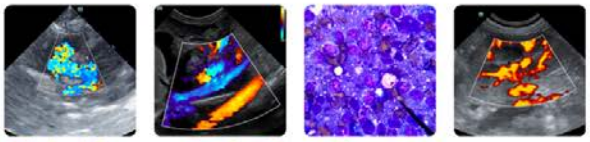

PATIENT

Daisey Ferrera

SPECIES

Canine

BREED

Pug

SEX

Spayed Female

AGE

8 Years

WEIGHT

26

INTERPRETED BY

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS

IMAGING PERFORMED BY

Dr. Samuel Gabriel

HOSPITAL NAME

Central Jersey Animal Hospital

REFERRING VET

Dr. Samuel Gabriel

INVOICE

73662

DATE

3/13/26

PRESENTING CLINICAL SIGNS

Chronic vomiting for 1 month, doing well otherwise

Abnormal PE/Chem/CBC/UA Results: cbc,chem,u/a.fecal : pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed a large amount of sand accumulation with apical ventral wall thickening of 0.85 cm. Suspended debris also noted. The pelvic urethra was imaged 1.0 cm beyond the cystourethral junction.

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. Left kidney measured 4.6 cm. Right kidney measured 4.1 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. Left measured 0.40 cm. Right measured 0.50 cm.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** was uniformly swollen with minor, excessive gallbladder debris and over distension with dependent and suspended bile without evidence of overt mucocele formation. However, excessive sludge was present. The liver presented coarse architecture with mildly increased portal markings and subtle, mixed echogenic changes. This is consistent with vacuolar hepatopathy and some level of remodeling and history of inflammatory component. There was no overt suspicion of neoplasia.

Gastrointestinal

The **gastric** wall was moderately thickened at 0.80 cm with some loss of mural detail and echogenic remodeling. Large amount of luminal shadowing material noted in the stomach. Some hyperechoic areas of penetration of the gastric wall noted. This may be related to ulcerative disease. Transit of chyme into the small intestine appeared to be occurring.

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Pancreas

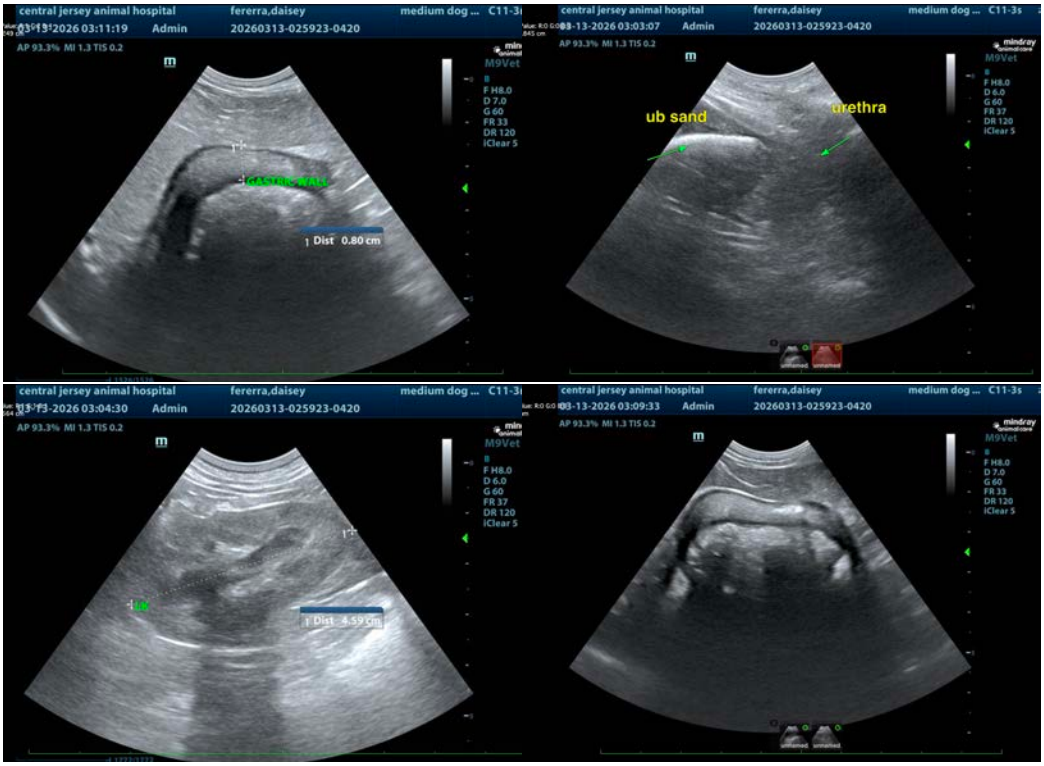
Diffuse hyperechoic changes were present in the area of the **pancreas**. The pancreatic remodeling was evident with multifocal to diffuse hyperechoic changes. These changes are consistent with fibrosis, amyloid, saponification of fat and may contain areas of low-grade chronic active inflammation especially if pain on imaging (+ Murphy sign) was present +/- focal subxyphoid palpation reveals pain response. No overt masses were noted.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder sand and chronic cystitis pattern. Minor potential for underlying neoplasia.
- Gastric wall thickening, non-specific – Chronic gastritis with ulcerative disease likely. However, underlying carcinoma cannot be ruled out.
- Vacuolar hepatopathy pattern.
- Pancreatic fibrosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastric wall thickening does not appear overtly resectable. However, sampling is essential. Recommend cystotomy, bladder lavage, sand analysis and culture, inspection of the cranial aspect of the gastric wall, and potential attempt at resection of the wall or at least biopsies, as some areas of the gastric wall appear somewhat precarious. Potential necrosis or ulcerative disease. If the patient was NPO at the time of the sonogram, delayed outflow pattern likely and possibility of soft luminal gastric material.



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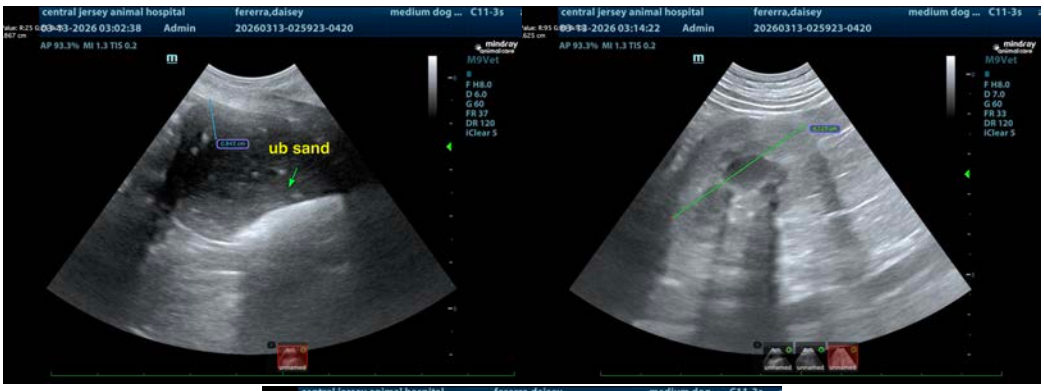

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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(CFM), Cert. IVUSS,
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