

**DATE PRESENTING CLINICAL SIGNS**

1/21/22 History: chronic inappetence for a few months; sporadic vomiting episodes over past 2 weeks; of suspected pancreatitis - 6 years ago; hx of atopy.

**PATIENT**

Grace Chatham Current Medications: Mirtazapine 22.5mg SID (started 1/18/2022)  
Cerenia 60mg SID 1/7-1/11, 2022, started again 1/18/2022.

Lab Results: cbc/chem - wnl. Attached separately.

**SPECIES**

Canine

Radiographs: suspreios opacity, summation at pylone region of stomach. Attached separately.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

**BREED**

Golden Retriever

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****SEX**

Spayed Female

**Urinary System**

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

**AGE**

4/30/14

The left kidney has a normal shape and size (7.5 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**WEIGHT**

74.2 Pounds

The right kidney is not visualized and is suspected to be absent or very small (this has been previously documented).

**INTERPRETED BY**

Kathleen Sennello DVM,  
MS, Diplomate ACVIM  
(Small Animal Internal  
Medicine)

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.61 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

**IMAGING PERFORMED BY**

Stephanie Pearce  
RDMS, RVT

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

**Spleen**

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

**HOSPITAL NAME**

Northwind AH

**Liver**

The liver is subjectively normal in size, and echogenicity with irregular shape. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are numerous isoechoic nodules throughout the liver, many deforming the liver nodules and appear expansile, measuring 0.42, 0.9, 3.2 and 3.4 cm.

**REFERRING VET**

Dr. Miller

**INVOICE**

35006

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a mild amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

### ***Gastrointestinal***

The stomach is minimally distended with ingesta. Much of the gastric wall appears normal, measuring at a normal thickness of <0.7 cm with some variability due to the presence of rugal folds. These areas with normal thickness appear to have normal intact layering. On the caudal surface of the gastric wall, there is a large, heterogeneous, partially cystic/cavitated mass effect, measuring approximately 6.0 cm in diameter. This mass effect appears to arise from the gastric wall, although the possibility of pancreatic origin with adherence to the gastric wall is possible.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measured 0.37 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

### ***Pancreas***

There is no evidence of pancreatic pathology in the left limb of the pancreas. There is a large cranial abdominal mass involving the area of the right limb of the pancreas, obscuring visualization. The mass is suspected to be of gastric origin, but pancreatic origin cannot be excluded as a possibility.

### ***Free Abdomen***

There is scant free fluid present. No lymphadenopathy. The omentum is of increased echogenicity around the cranial abdominal mass.

## **PRIMARY FINDINGS**

- Large cystic/cavitated cranial abdominal mass – likely gastric origin. Pancreatic origin is possible, but thought less likely.
- Isoechoic hepatic nodules with irregular margins – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The expansile nature of these nodules is concerning for possible metastatic disease, but benign lesions are possible.

## **SECONDARY FINDINGS**

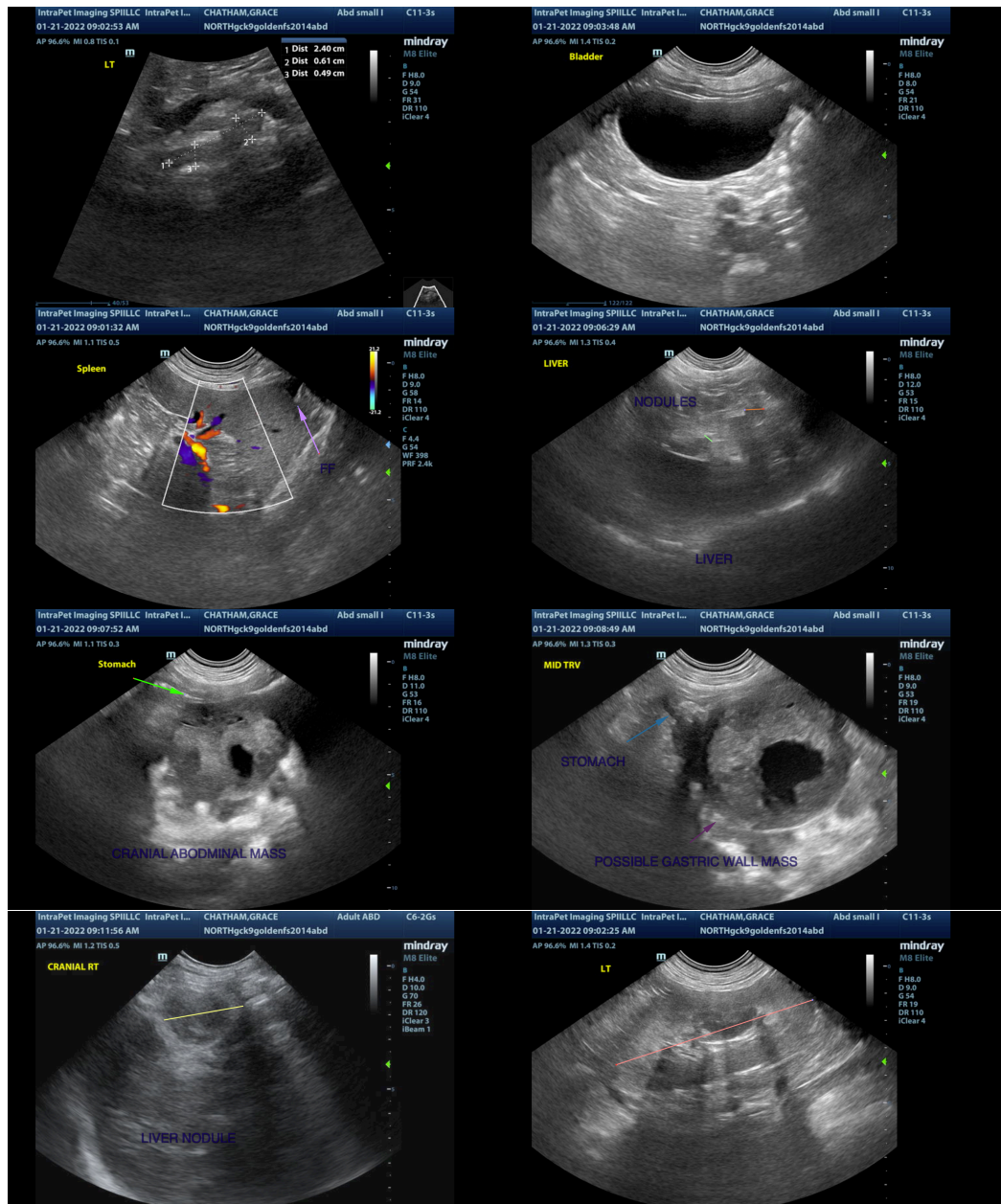
- Moderate gallbladder debris – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.
- Absent right kidney – This could be due to agenesis or a very small/abnormal kidney.
- Small volume free abdominal fluid.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

A large cranial abdominal mass is visualized. It appears to be either arising from the gastric wall or to be adhered to it. Recommend a fine needle aspirate of this lesion, as there is a high concern for underlying neoplasia. If a cytologic diagnosis is not obtained, then options include either referral to a veterinary surgeon for exploratory surgery, biopsies, and possible resection, or preferably a contrast CT scan to evaluate the

extent and location of the lesion, as well as the hepatic nodules visualized.

Recommend 3-view thoracic radiographs.



**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.

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