

**DATE PRESENTING CLINICAL SIGNS**

12/2/22

**PATIENT**Gracie Barker  
Colondres

Chronic history of vomiting once per day, particularly overnight, usually foam/bile, Have tried Famotidine & Prilosec with no luck- D+ on prilosec, no change on famotidine, allergy testing revealed food allergies, 1 week ago o eliminated food allergens from diet, pancreatitis evident on bloodwork, treated symptomatically, tried metoclopramide but made symptoms worse, maropitant helped with symptoms but since stopping maropitant vomiting has been up to 3 times per day, exam and BW otherwise unremarkable

**SPECIES**

Canine

Current Medications: Maropitant - 48mg SID for 4 days, restarted 11/28, Gabapentin-last dose given Tuesday

Lab Results: See attached.

Date of Previous IntraPet Ultrasound: No previous.

**BREED**

English Bulldog

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

**SEX**

Spayed Female

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

7/8/13

The left kidney has a normal shape and size (5.91 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**WEIGHT**

54 Pounds

The right kidney has a normal shape and size (5.96 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**INTERPRETED BY**Kathleen Sennello DVM,  
MS, Diplomate ACVIM  
(Small Animal Internal  
Medicine)**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.74 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**

Andi Parkinson RDMS

The right adrenal gland is normal in size measuring 0.80 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

**HOSPITAL NAME**

Homeward Bound VS

**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.

**REFERRING VET**

Dr. Williams

**INVOICE**

43112

**Liver**

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

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 moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

### ***Gastrointestinal***

The stomach contains minimal luminal contents. Portions of the stomach measure at a normal thickness of <0.70 cm with some variability due to the presence of rugal folds. In these regions, distinction of gastric wall layering is adequate. In the area of the fundus, the gastric wall appears significantly thickened, measuring up to 1.56 cm. In these areas, gastric wall layering is very indistinct/absent, creating concerns for a possible mass effect.

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 measures 0.49 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***

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

### ***Free Abdomen***

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

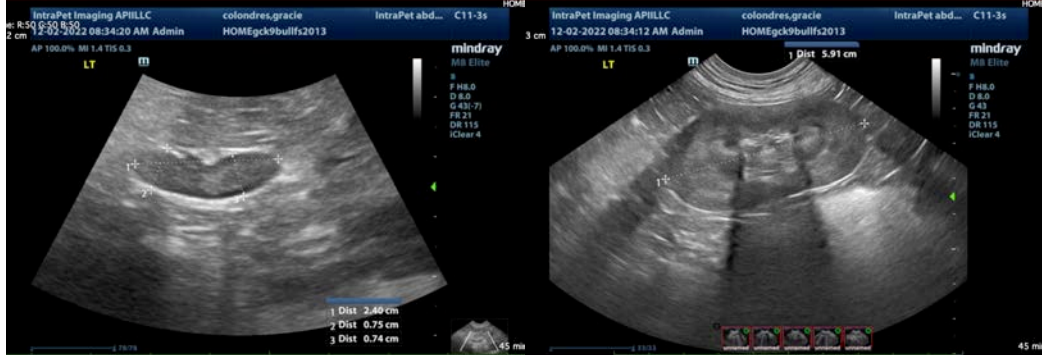
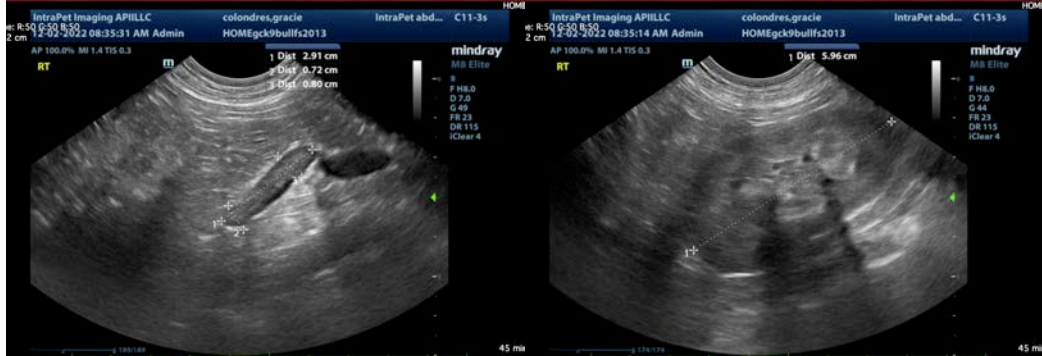
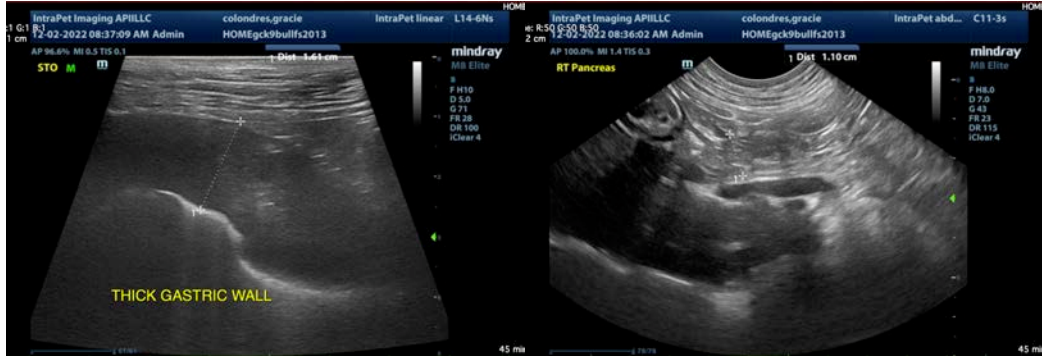
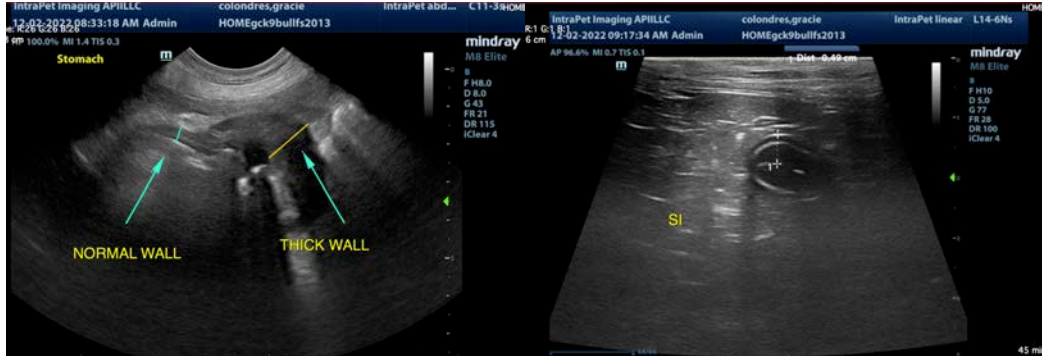
## **ULTRASONOGRAPHIC FINDINGS**

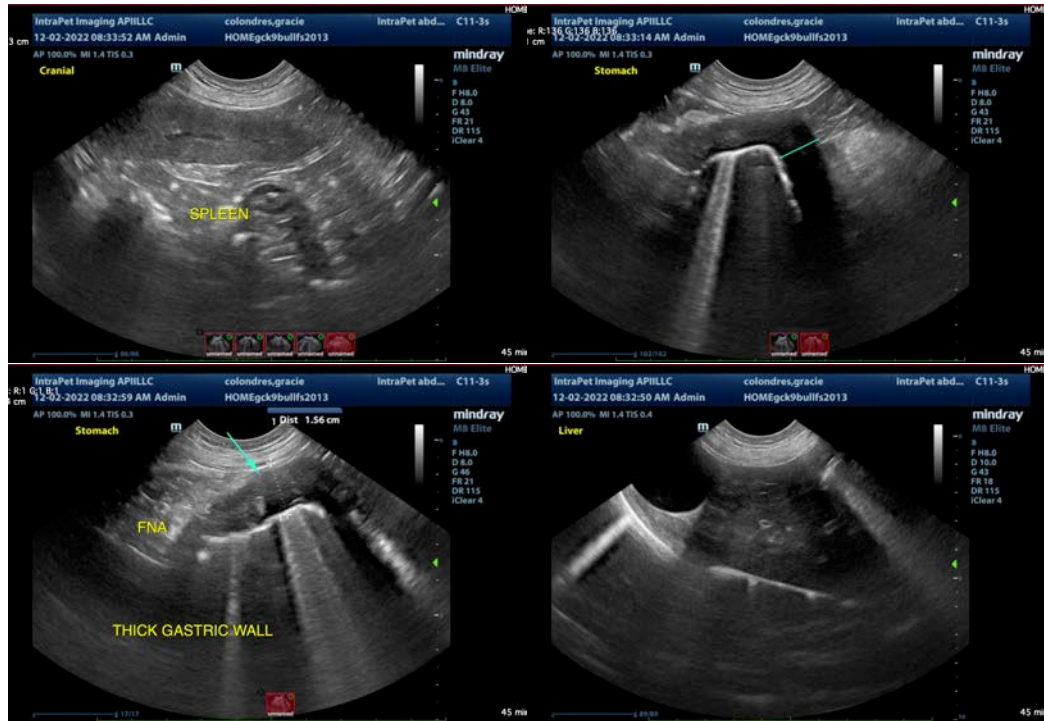
- Focal area of stomach wall thickening with greatly reduced/absent wall layering – Findings are concerning for possible infiltrative disease. Primary differential would be neoplasia (lymphoma, carcinoma, etc.), although other differentials such as severe gastritis, fungal disease, etc. are possible.

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

There is focal severe thickening of the gastric wall. This is highly concerning for a neoplastic process, although other possible differentials exist. Consider a fine needle aspirate of the gastric wall (see images). If a cytologic diagnosis cannot be obtained, recommend surgical biopsies with the possibility of resection if there is an adequate amount of normal stomach present.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.





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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