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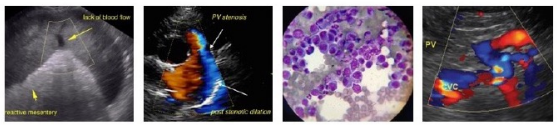


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Maddie Bickerton

SPECIES

Canine

BREED

Dachshund

SEX

Spayed Female

AGE

13 Years

WEIGHT

4.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Dundas AH

REFERRING VET

Dr. Middleton

INVOICE

35881

DATE

2/25/22

PRESENTING CLINICAL SIGNS

Intermittent vomiting. anorexia omeprazole 10 mg q24 hrs Tumor? Vs Gastric ulcer
Abnormal PE/Chem/CBC/UA Results: n/a

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.

The left kidney has a normal shape and size (4.26 cm) with pinpoint non-obstructive nephroliths. 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.31 cm) with pinpoin non-obstructive nephroliths. 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal/borderline large in size measuring 0.79 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.

The right adrenal gland is normal/borderline large in size measuring 0.79 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.

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.

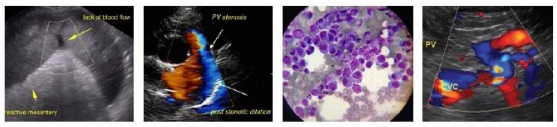
Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. An ill-defined hyperechoic irregular nodule is visualized measuring 0.65 cm within the parenchyma.

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 is moderately to mildly distended with fluid. It largely measures at a normal thickness of <0.7 cm with some variability due to the presence of rugal folds. In these areas, the distinction of wall thickness is adequate, and there is no impression of reduced peristaltic activity. There are some areas of the gastric wall that have the impression of increased thickness with less distinct layering. In the area



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near the gastric outflow tract (pylorus). This area measures approximately 1.7 cm x 1.4 cm. It could be consistent with a mass effect or an irregular rugal fold.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Duodenum wall measured 0.52 cm. Jejunum wall measured 0.32 cm. Visualized peristalsis appears appropriate. There is a large section of bowel that appears thickened and irregular. In this area, there is a decreased distinction of wall layering, and the wall thickness is 0.75 cm.

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.

PRIMARY FINDINGS

- Bilateral adrenomegaly (borderline) – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.

- Heterogeneous liver with small hyperechoic nodule – 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 appearance of the nodule is most consistent with a benign lesion, but continued monitoring is warranted.

- Focal thickening of the gastric wall – The significance of this is unclear. There is concern for a possible inflammatory or infiltrative lesion. Differentials include inflammation, edema, an ulcer, or a benign or neoplastic mass effect.

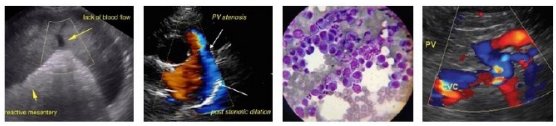
- Thickened small intestine with loss of layering – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. A reduction in the detail of wall layering favors either severe intestinal disease or neoplastic infiltration. Biopsy is recommended.

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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are changes observed in both the stomach and small intestine. Gastric lesions can be challenging to definitively identify, as sometimes abnormal rugal folds can mimic thickening, but I believe this irregularity was visualized on several views. Additionally, there is a segment of abnormal bowel that is extremely thickened and has a loss of distinct wall layering. Options moving forward include:



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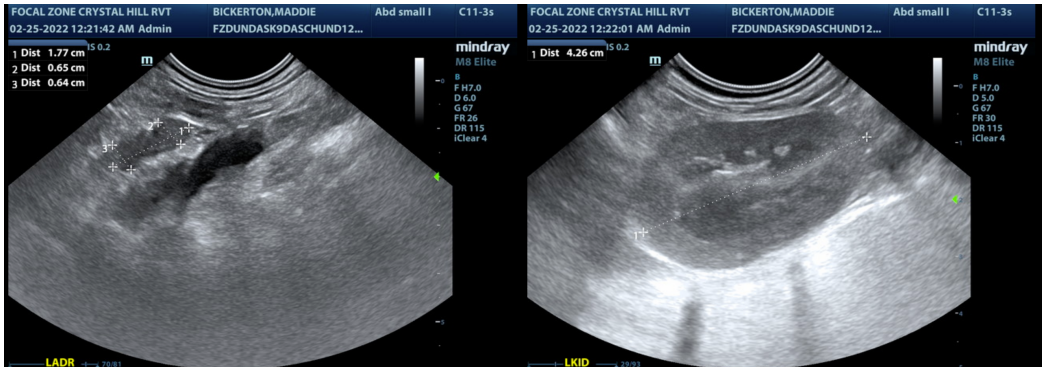
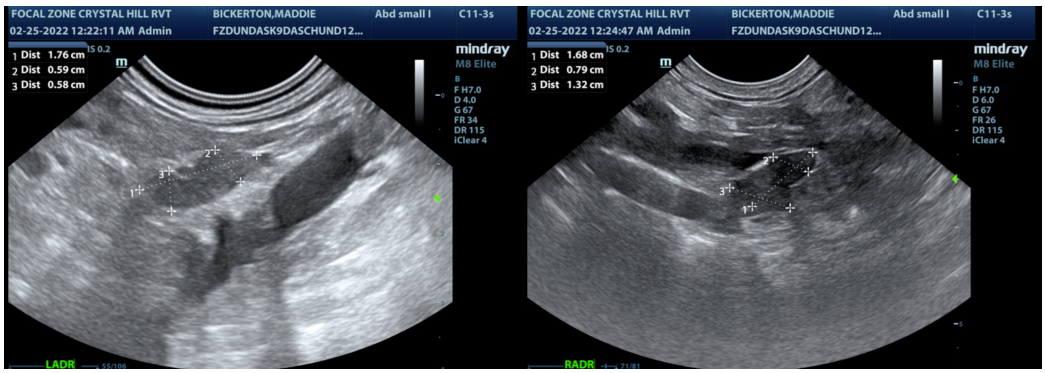
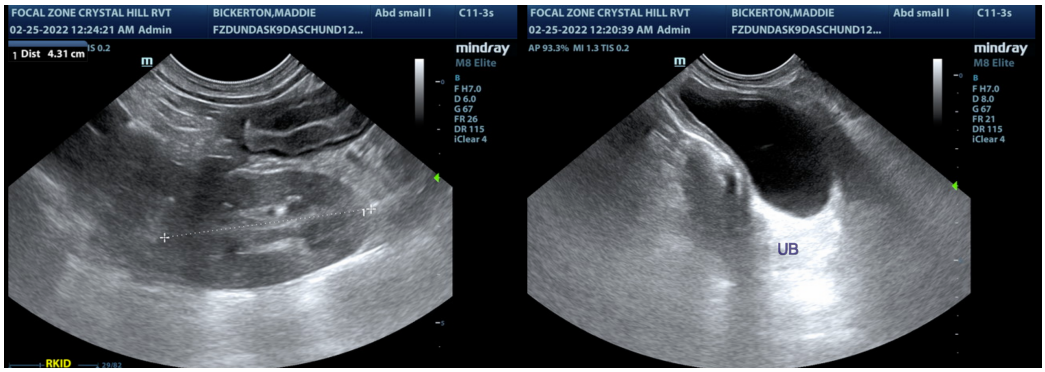
- Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.
- Surgical biopsy and evaluation of the gastric wall and small intestine.
- Consider endoscopic evaluation, but I suspect this would be less helpful to evaluate the bowel lesion.
- Fine needle aspirate of the small bowel mass may be possible.

If surgical evaluation is not an option, consider medical therapy for gastroenteritis, anti-ulcer therapy, etc., and re-evaluation with ultrasound, but concern is high for a potential neoplastic process.







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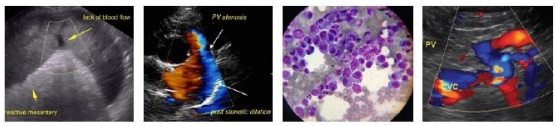

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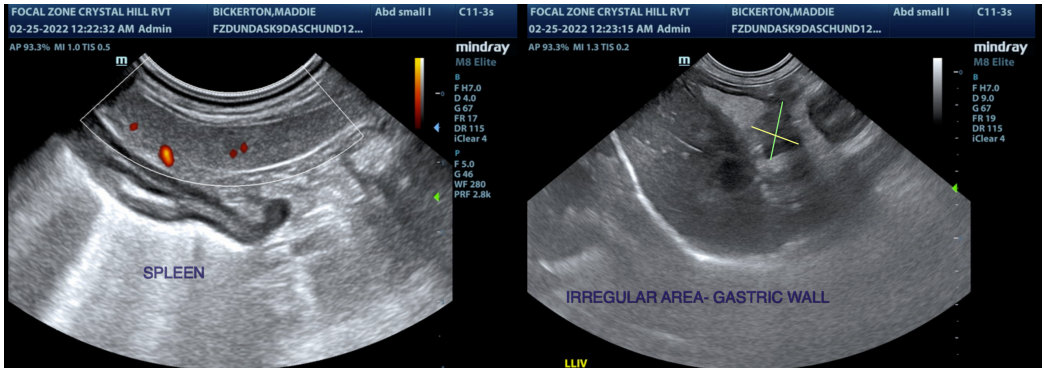

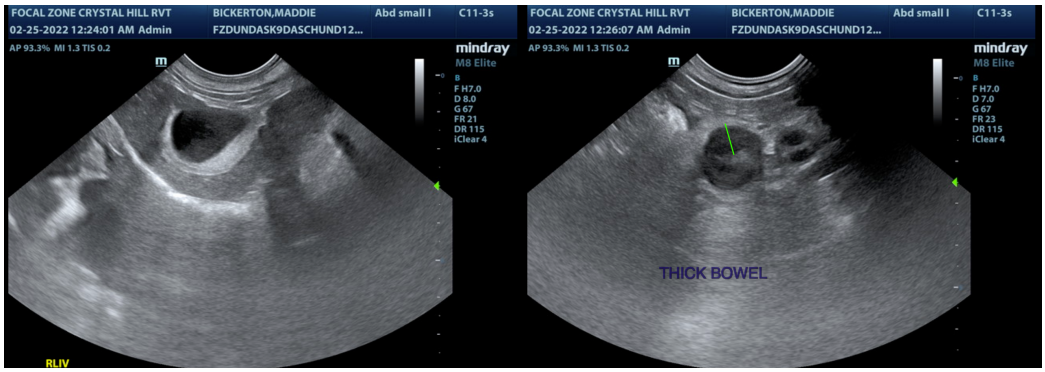

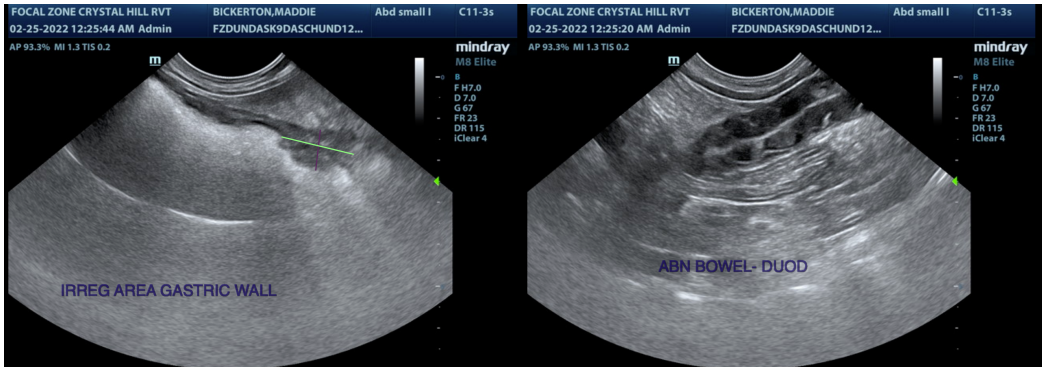

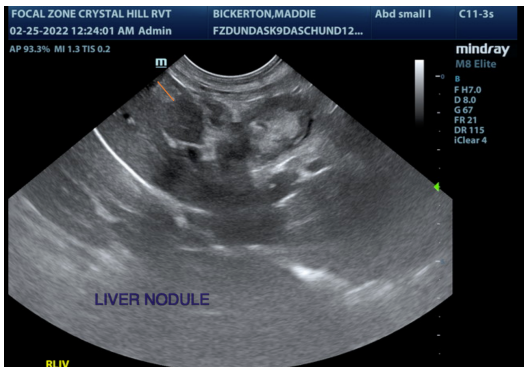

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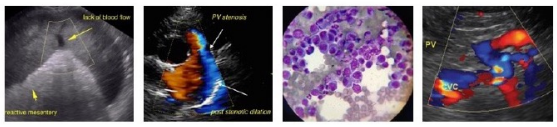

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com