



PATIENT

Princess Putera

SPECIES

Canine

BREED

Pit Bull

SEX

Spayed Female

AGE

13 Years

WEIGHT

53.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Diane McFadden

HOSPITAL NAME

Wantage Vet Hospital

REFERRING VET

Dr. Bullock

INVOICE

44952

DATE

2/9/23

PRESENTING CLINICAL SIGNS

Possible abdominal mass or GI disease; or mucocele; mild anemia, elevated liver values for years, current UTI. On amoxicillin and sucralfate

Abnormal PE/Chem/CBC/UA Results: USPG 1.020

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall is diffusely mildly thickened (0.64 cm), and the mucosa is mildly irregular. The trigone, ureteral papillae, and visible urethra (to a depth of 2cm) appear normal with no evidence of severe mucosal irregularities, masses or cystic calculi. Findings are most consistent with bacterial cystitis or lack of urine distension. Recommend urinalysis and culture.

The left kidney has a normal shape and size (6.66 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.

The right kidney has a normal shape and size (6.62 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.65 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 in size measuring 0.59 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 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.



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Gastrointestinal

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The stomach is severely fluid distended with mobile, non-progressive intraluminal contents. This distention extends into the proximal pylorus, where a large hypoechoic, mixed echogenic mass effect is visualized, measuring approximately 4.08 cm x 3.46 cm, likely causing a partial or complete outflow tract obstruction.

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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 0.40 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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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.

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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.

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ULTRASONOGRAPHIC FINDINGS

- Severely fluid distended stomach with mass effect at the outflow tract – Findings are concerning for a benign or neoplastic mass effect (carcinoma, lymphoma, leiomyoma, leiomyosarcoma, etc.) causing a partial or complete outflow tract obstruction.
- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.
- Mild thickening and irregularity of the urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The stomach is severely distended with churning fluid and gas. This gastric distention can be followed to the outflow tract where there is a large hypoechoic, mixed echogenic mass effect that appears to be at the outflow tract, causing a partial or complete obstruction. Options moving forward would be to consider a fine needle aspirate of the mass lesion if an appropriate angle can be identified. Alternately, exploratory surgery with the intent to possibly perform a Billroth or pylorotomy may need to be considered. Prior to surgery, consider decompression of the stomach with a nasogastric tube and correction of any significant electrolyte disturbances.

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



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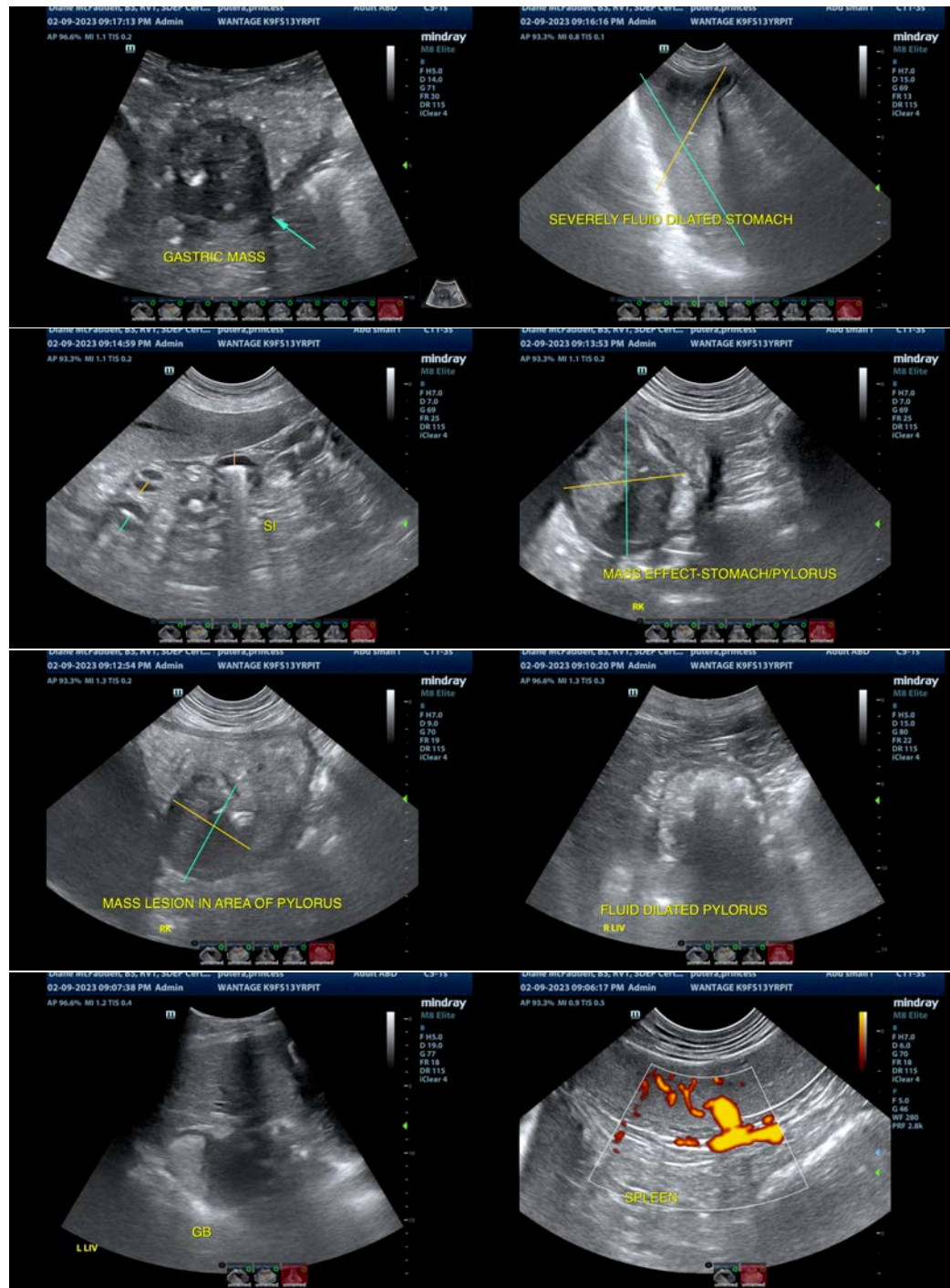
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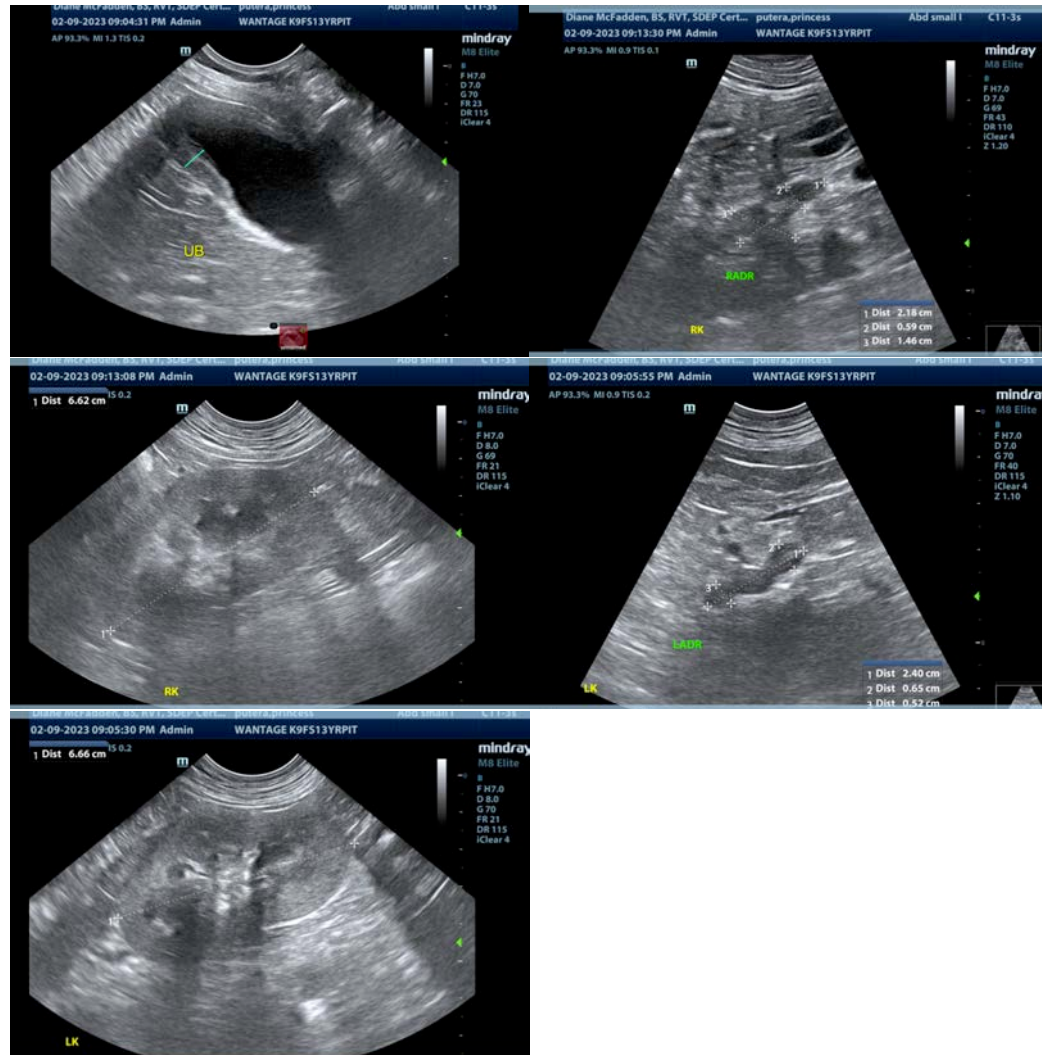
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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