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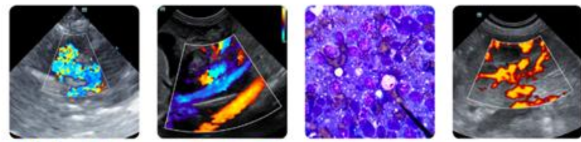


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Lemmy Hampton

SPECIES
Canine

BREED
Shepherd Mix

SEX
MN

AGE
9.5yr

WEIGHT
45.8kg

INTERPRETED BY
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY
Hovenden

HOSPITAL NAME
Wilvet Salem

REFERRING VET
Hovenden

INVOICE
23048

DATE
11-24-25

PRESENTING CLINICAL SIGNS

Vomiting over last 2 days approx. 6-7 hours after eating. Has been eating and drinking. Normal bowel movement over the last two days. Past history of chronic erosive gastritis with regenerative mucosal hyperplasia. Also had mass in lesser curvature of stomach that was leiomyoma with low mitotic count that was completely excised with 1mm margins. Leiomyoma is a benign neoplasm that originates from the smooth muscle wall of the gastrointestinal tract. These tumors are often small and multiple, and may cause gastrointestinal obstruction. Complete resection is usually curative. In some cases, histologic differentiation from low grade leiomyosarcoma is difficult, and an aggressive clinical behavior may be the only indication of malignancy. Histologic findings should be correlated with clinical impressions. 11/23: CBC/Chem17/Epoc: WNL AM radiographs: No obvious pulmonary metastasis. Stomach full of heterogenous material. No obvious gastric mass noted although cannot rule out due to recent meal. Remainder of abdomen consistent with most recent abdominal radiographs. Spleen WNL of breed. Fasted PM radiographs: Progression of gastric material into small intestines/colon. Gastric wall appears similar in thickness to previous radiographs once now that ingesta has moved through. SI gas patterns improved significantly

Abnormal PE/Chem/CBC/UA Results: 11/24: 3-view rads: 1. Disseminated pulmonary nodular change, as described. Given the reported history of previously diagnosed gastric neoplasia, this finding is concerning for pulmonary metastasis. 2. Subjectively normal abdomen. Given the reported history of a previously resected neoplastic gastric mass, a radiographically inconspicuous mural lesion remains possible. On exam: Abdomen palpates tense and painful. Amb x 4. Reactive for attempted extension of both hips.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was subnormal in size owing to lack of urine distension which prohibited full evaluation of the urinary bladder walls. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 6.8 cm in length. The right kidney measured 7.1 cm in length.

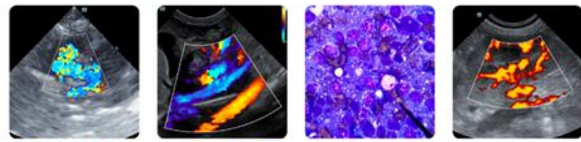
The area of the aortic trifurcation was free of pathology.

The area of the residual prostate appeared normal and free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral adrenal glands.

Spleen



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The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact, mildly thickened wall. The stomach contained a mild amount of retained anechoic fluid. No evidence of shadowing content or obstruction to pyloric outflow. The stomach wall measured 0.6 cm in width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

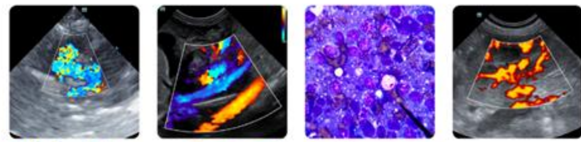
ULTRASONOGRAPHIC FINDINGS

Primary

- Mild thickened hypomotile stomach
- Empty small intestine
- Sonographically normal area of pancreas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Definitive or recurrent gastric mass was not overtly visualized. The intact to mildly thickened stomach and retained fluid is suggestive of mild hypomotile gastritis criteria, potential for early to emerging gastric neoplasia thought less likely yet not definitively excluded in conjunction with patient history. No evidence of small intestinal mural pathology, mechanical /metabolic intestinal ileus or sonographically active pancreatitis. Low-grade pancreatitis or non-specific enteritis may present sonographically normal. Empirical therapy for gastritis which may include canned novel protein or hydrolyzed diet with avoidance of dry food, as needed gastric protectants +/- empirical helicobacter coverage with clinical and as needed sonographic monitoring would be reasonable.



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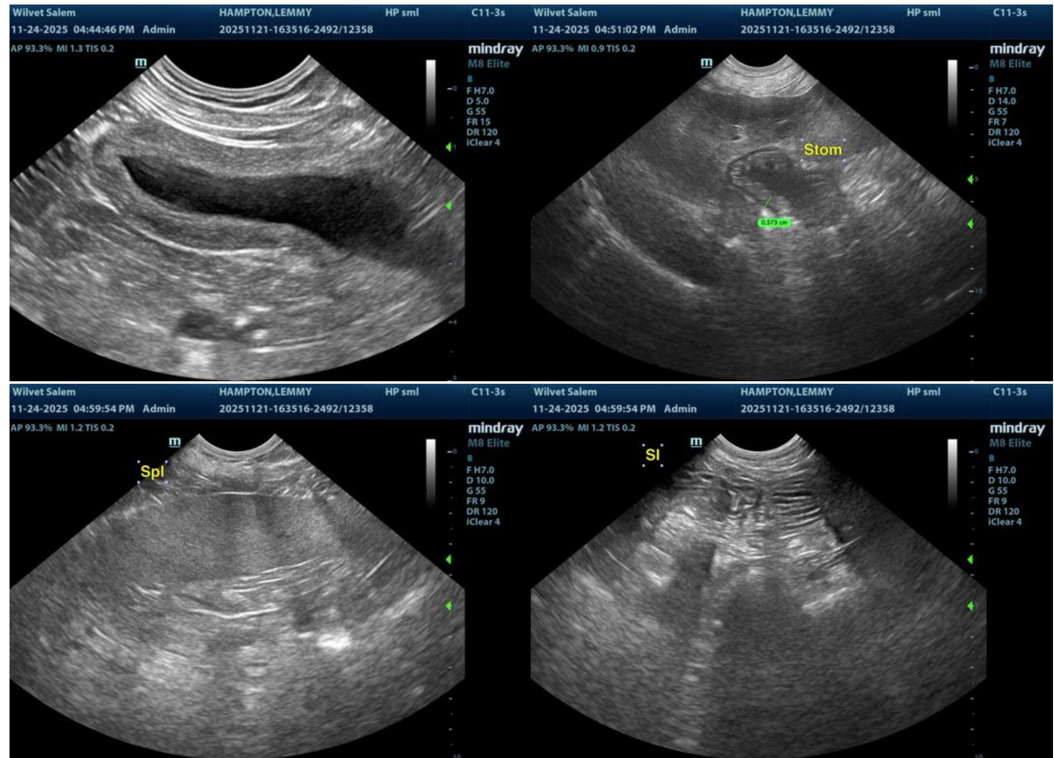
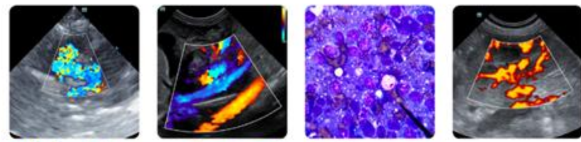
Upper gastrointestinal endoscopy with potential for biopsies may be indicated if persistent clinical signs. Although considered unlikely, a screening cortisol level to rule out occult Addison's disease is suggested.





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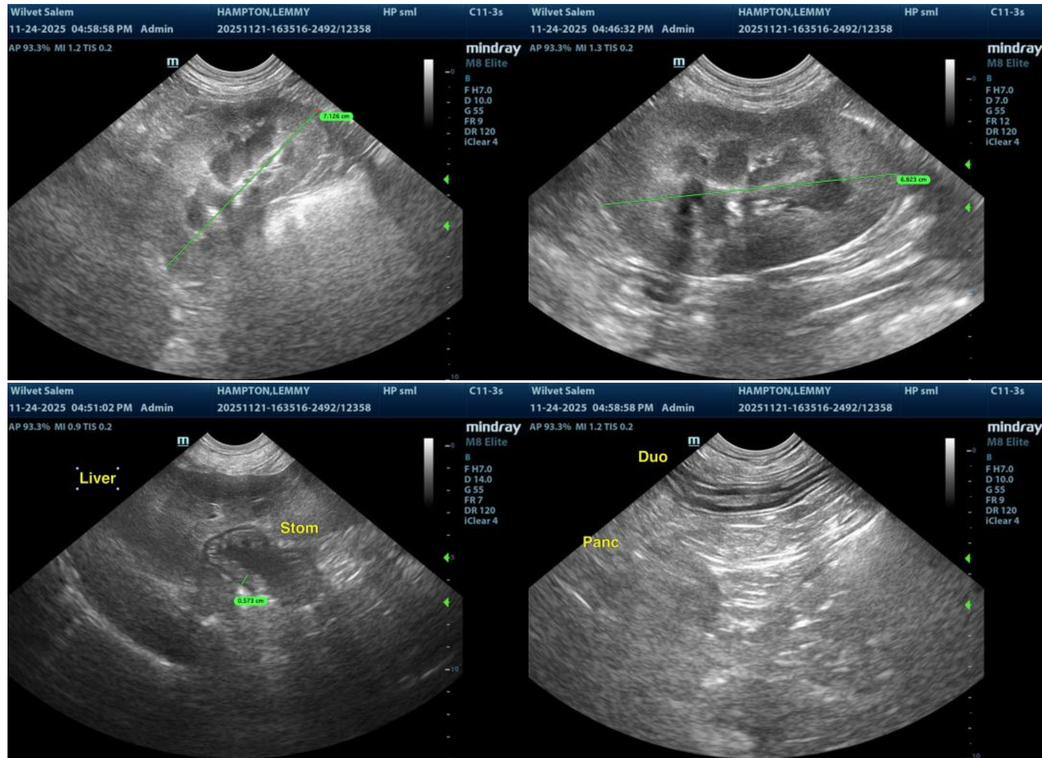

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com