



**PATIENT**

Gizmo Stevens

**SPECIES**

Canine

**BREED**

Shepherd X

**SEX**

M/N

**AGE**

11

**WEIGHT**

33 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Belan

**HOSPITAL NAME**

Aspen AC

**REFERRING VET**

Dr. Ross

**INVOICE**

16766

**DATE**

5/4/23

**PRESENTING CLINICAL SIGNS**

Follow up scan to invoice 15372 Report done Nov 3 2022. Patient diagnosed with duodenal and pyloric polyps . Had surgical removal of pylorus and proximal duodenum Nov 2023 with histopath report attached. Chest x rays taken unremarkable . Patient lethargic since vaccinations last week.

Abnormal PE/Chem/CBC/UA Results: Mild elevation of SDMA and Hypoproteinemic.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and minor loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.2 cm in length. The right kidney measured 6.1 cm in length.

**Adrenal Glands**

Both adrenal glands were overtly normal in size, position, and shape. The left adrenal gland measured 0.61 cm width at the caudal pole and 0.42 cm width at the cranial pole. The right adrenal gland measured 0.57 cm width at the caudal pole.

**Spleen**

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. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing primarily anechoic content with mild, primarily dependent, nonorganized, hyperechoic gallbladder debris. The cystic and common bile ducts were normal.

**Gastrointestinal**

The stomach was non-distended in size containing mild luminal gas. The gastric fundus and ventral body wall appeared to be intact without evidence of mural pathology or hypertrophy. The ventral gastric body wall width measured 0.43 cm. Recurrent yet variable to moderately thickened gastric walls were



<b>PATIENT</b>	
Gizmo Stevens	noted in the area of the antrum and pylorus subjectively extending mildly into the pyloroduodenal junction and potentially very upper duodenum. Decreased to loss of wall layer detail in the thickened areas of pylorus were noted. The area of pyloric mural thickening measured approximately 5.4 cm x 2.5 cm. The pyloroduodenal junction measured approximately 2.6 cm in diameter. The possibility of recurrent ulceration cannot be definitively excluded. The pyloric to pyloroduodenal mural thickening did not appear to be obstructive to pyloric or upper duodenal outflow, given no evidence of gastric distention with retained ingesta or fluid.
<b>SPECIES</b>	
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Shepherd X	The mid to descending duodenum was sonographically unremarkable with intact visualized jejunal-ileal wall layering to the level of the colon. No evidence of an intestinal obstructive pattern was noted. Intact mid-duodenum wall width measured 0.43 cm.
<b>SEX</b>	
M/N	Normal visible colon wall layers were present with apparent formed feces in lumen.
<b>AGE</b>	
11	<b><i>Pancreas</i></b> The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.
<b>WEIGHT</b>	
33 kg	<b><i>Free Abdomen</i></b> No overt lymphadenopathy or peritoneal effusion was present.
<b>INTERPRETED BY</b>	
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	<b>ULTRASONOGRAPHIC FINDINGS</b>
<b>IMAGING PERFORMED BY</b>	<b><i>Primary Findings</i></b>
Dr. Belan	<ul style="list-style-type: none"> <li>• Nondistended stomach</li> <li>• Recurrent pyloric / pyloroduodenal variable to moderate mural thickening / mural mass lesion</li> </ul>
<b>HOSPITAL NAME</b>	<b><i>Secondary Findings</i></b>
Aspen AC	<ul style="list-style-type: none"> <li>• Mild gallbladder debris</li> <li>• Mild age-related renal changes</li> </ul>
<b>REFERRING VET</b>	<b><u>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</u></b>
Dr. Ross	The recurrent pyloric/pyloroduodenal junction mural pathology may be consistent with recurrent previously diagnosed pyloric and upper duodenal polyploid changes. This may not be a clinical issue at this stage, given the lack of gastric distention, evidence of mechanical pyloric outflow obstruction, and no reported clinical signs. The possibility of alternative etiology i.e., secondary inflammation / fibrosis owing to previous surgery, or other inflammatory / infectious / granulomatous disease, neoplasia, etc., cannot be definitively excluded. Additional biopsies with histopathology would be required for a definitive diagnosis.
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5/4/23	Conservatively, as-needed gastric support which may include canned hydrolyzed or novel protein diet with as-needed gastroprotectants, close monitoring for evidence of clinical signs, i.e., inappetence, vomiting, weight loss, etc., and sonographic monitoring would be reasonable.



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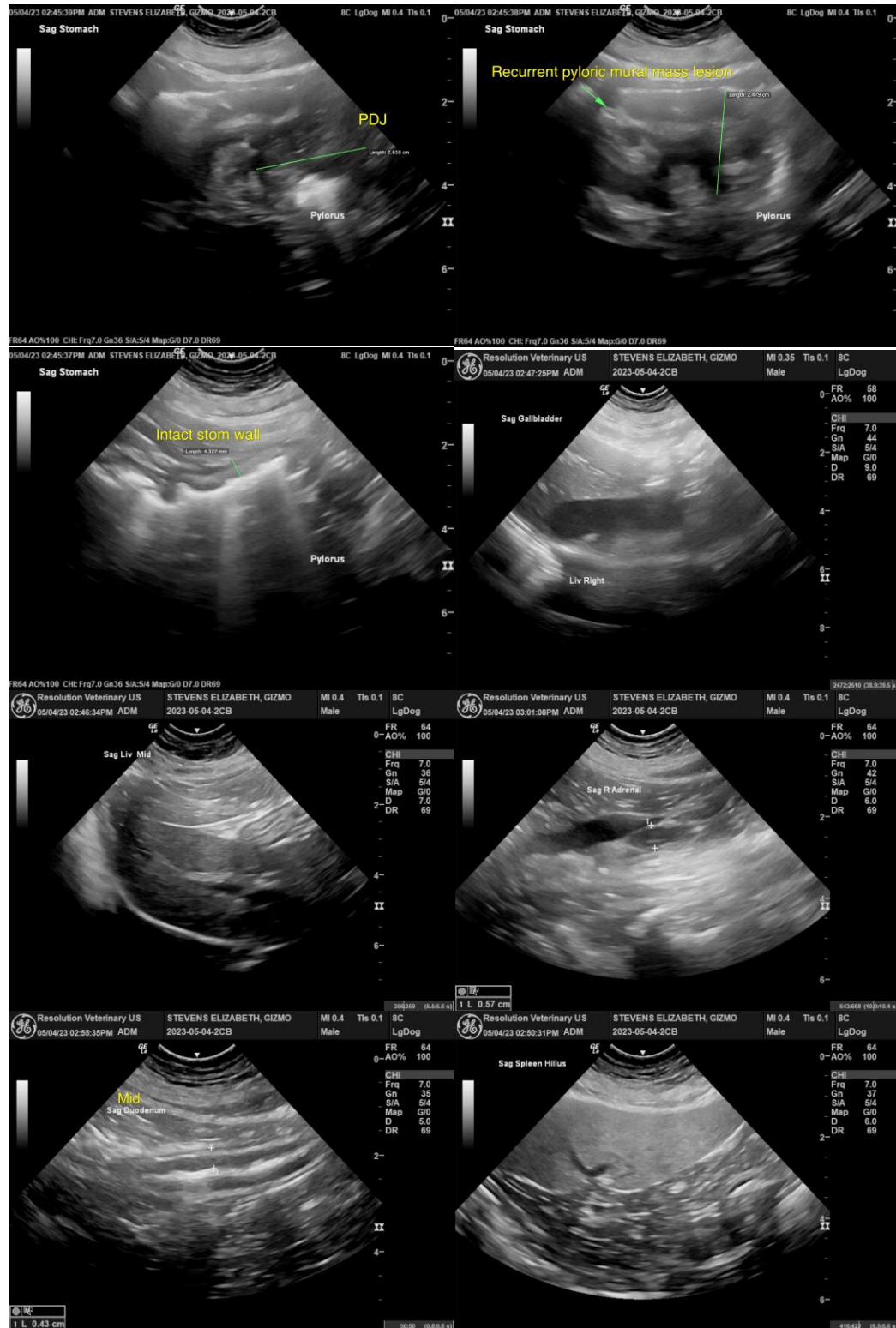
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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