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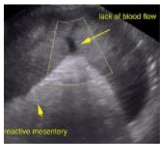
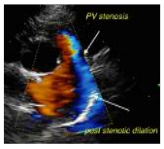
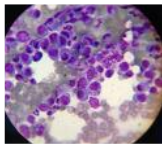
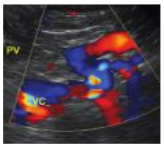
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Velvet Burke

SPECIES
Canine

BREED
Bernese MD

SEX
Female Spayed

AGE
6

WEIGHT
41 kg

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

IMAGING PERFORMED BY
Dr. Belan

HOSPITAL NAME
Creature Comforts VC

REFERRING VET
Dr. Decker

INVOICE
13825

DATE
5/6/22

PRESENTING CLINICAL SIGNS

Inappetent and lethargic. Patient sedated with butorphanol IV for scan.
Abnormal PE/Chem/CBC/UA Results: Blood work non diagnostic

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction 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.

The area of the aortic trifurcation was free of pathology.

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 6.3 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.77 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.51 cm width at the caudal pole and 0.67 cm width at the cranial 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.

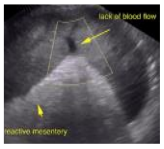
Liver/ Gallbladder

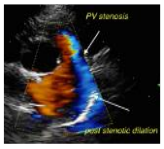
The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature was normal in appearance without signs of congestion.

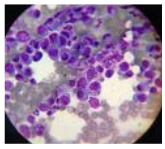
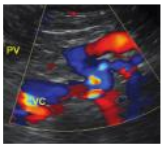
The gallbladder was non-distended in size containing mild, nondependent, particulate, nonorganized gallbladder debris. The gallbladder was otherwise normal. The gallbladder debris is likely secondary to fasting and Inappetence and is considered incidental. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach exhibited regional moderate hypoechoic mural hypertrophy to thickening with indistinct to loss of discernable wall layering in the area of wall thickening. The stomach was primarily empty with luminal gas and minor retained antrum and pyloric fluid. The pylorus body wall width measured up to 1.0 cm. Regional perigastric hyperechoic mesentery was present.





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The small intestine exhibited subjective intact wall layering and primarily maintained a 1:3 muscularis/mucosa ratio with mild subjective prominent duodenum walls. The duodenum wall width measured 0.42 cm. The jejunum wall width measured 0.35 cm.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Multiple gastric and cranial omental lymph nodes were present. The lymph nodes hypoechoic to swollen. An example measured 3.2 cm x 1.2 cm. Perilymphatic reactive mesentery was present.

ULTRASONOGRAPHIC FINDINGS

- Thickened gastric antrum / pylorus exhibiting decreased mural echogenicity and indistinct to loss of discernable wall layering
- Possible concurrent mild duodenitis
- Associated perigastric reactive mesentery and gastric to cranial omental lymphadenopathy
- Heterogeneous pancreas - reactive pancreatic changes secondary to gastric mural pathology, potential for concurrent low-grade to chronic inflammation
- Mild gallbladder debris - non-mucocele, suspected to be secondary to fasting / inappetence

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary finding of the thickened gastric antrum and pylorus and associated perigastric to cranial omental lymphadenopathy may indicate severe gastritis and perigastric to cranial omental reactive lymphadenitis. However, concern for infiltrative gastric neoplasia and concurrent metastatic to neoplastic gastric to cranial omental lymphadenopathy is warranted. If accessible, ultrasound guided FNA of an enlarged gastric or cranial omental lymph node could be considered for screening cytology +/- culture and sensitivity. Endoscopic or surgical gastric wall and lymphatic biopsies are likely required for a definitive diagnosis and should be considered. Three view chest radiographs are suggested.

Empirically, some or all of the following protocol could be considered;

A clinical trial of **Zithromax (*Dogs:*** 5-10 mg/kg p.o. q24h. May increase dosing interval to q48h after 3-5 days of treatment)**, Metronidazole** (10-20 mg/kg p.o. b.i.d.), **Pepcid** (0.5-1 mg/kg s.i.d.) and **Sucralfate** (0.5-2 g/dog PO) or **Omeprazole** (1 mg/kg p.o. s.i.d.) over the next 3 weeks along with a **novel-protein or hydrolyzed diet** with slurry feeding b.i.d./t.i.d. over the next 2-4 days and then increase to canned diet bid. Dry food should be avoided over the next 4 weeks. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.

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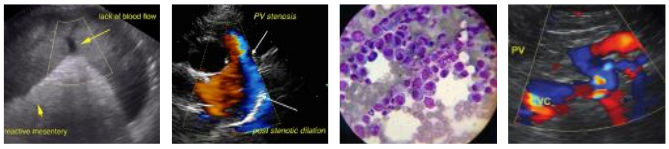

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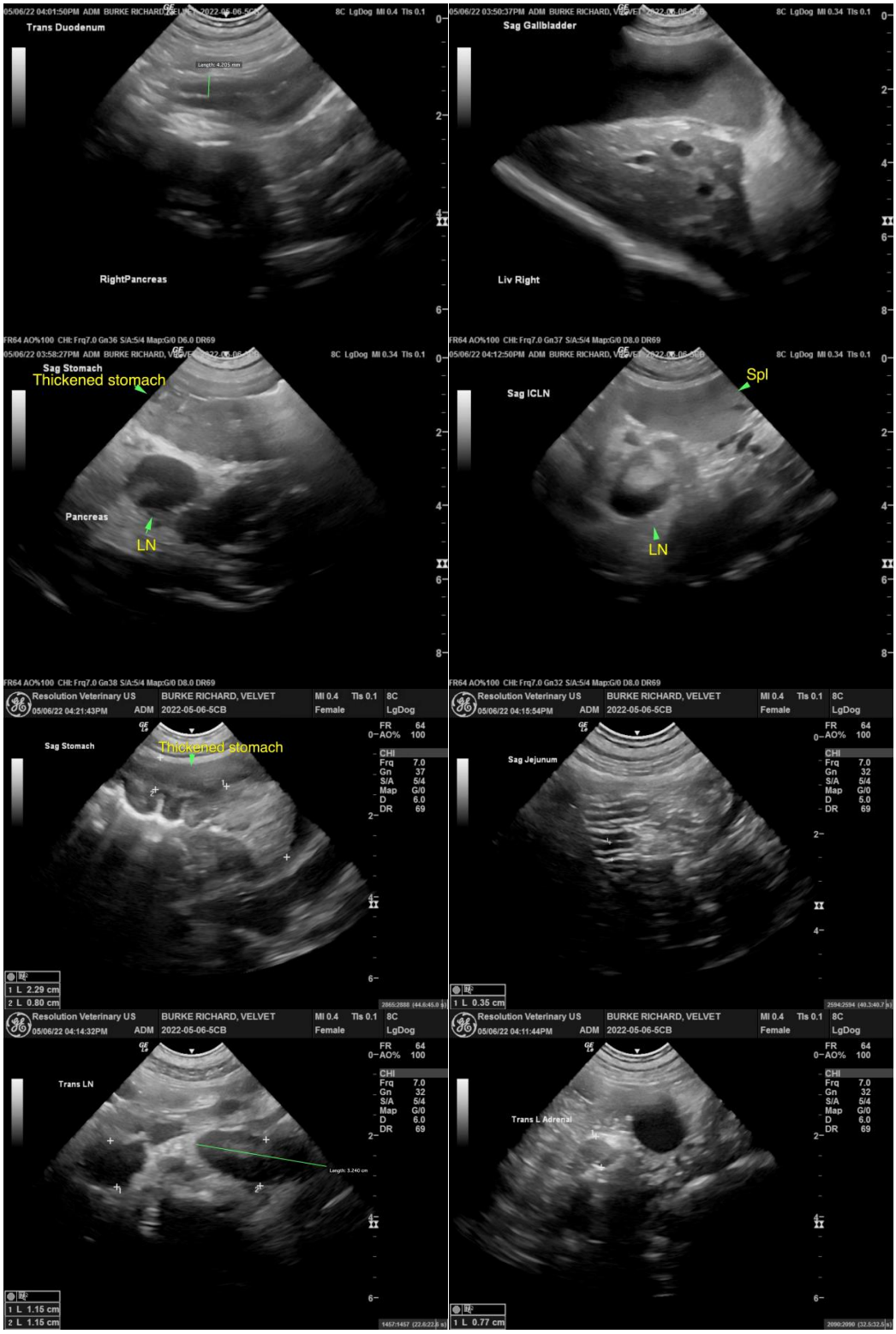

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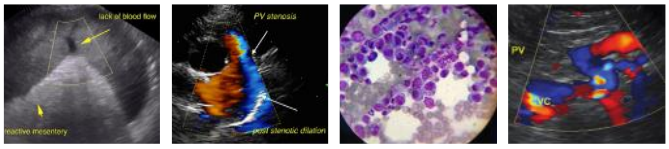

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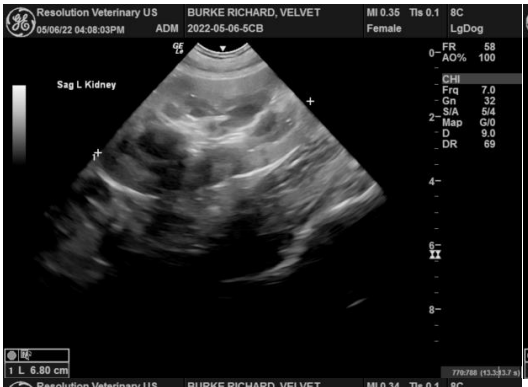

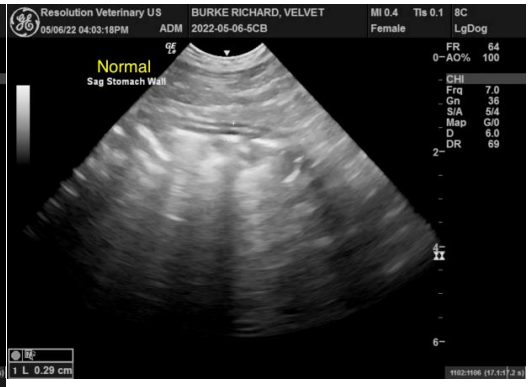

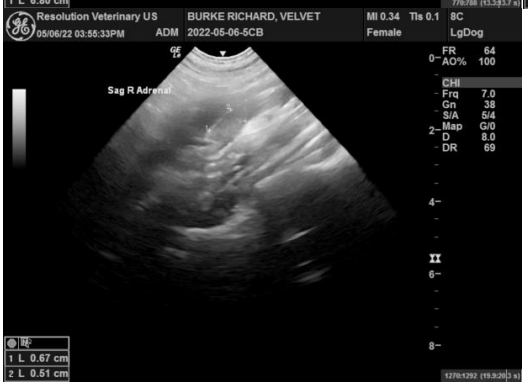

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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