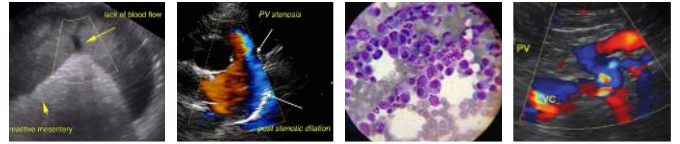
SonoPath
Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Mimi Depietro

SPECIES
Canine

BREED
Heeler

SEX
FS

AGE
10y 7m

WEIGHT
41

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

IMAGING PERFORMED BY
Carly Pate

HOSPITAL NAME
VCA McKenzie AH

REFERRING VET
Dr. Fricke

INVOICE
16778

DATE
5/9/23

PRESENTING CLINICAL SIGNS

P was seen ~4/27/23 for vomiting frank red blood- P was acting off, seeming painful, restless. C had noted a diminished appetite over the past 2 weeks. Since then P has been intermittently eating, intermittently uncomfortable. In house blood (CBC/Chem) work was WNL, CBC/Chemistry panel -

Normal Abdominal radiographs - Spondylosis noted at the caudal thoracic to upper lumbar spine andlumbosacral join

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.7 cm in length. The right kidney measured 6.0 cm in length.

Adrenal Glands

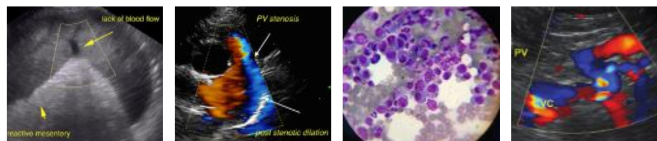
The bilateral adrenal glands were overtly normal in size, position, and shape. The left adrenal gland measured 2.5 cm length x 0.56 cm width at the caudal pole. The right adrenal gland measured 2.3 cm length x 0.77 cm width at the caudal pole.

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 mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. Intermittent to multiple, well-demarcated, uniform hypoechoic intraparenchymal nodules were present with an example measuring 1.3 cm in diameter. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.



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Gastrointestinal

Regional moderate to severe gastric wall thickening and loss of gastric wall layer detail were present. The thickened gastric walls exhibited decreased echogenicity and an asymmetrical luminal surface. Mild retained, mildly echogenic chyme / fluid was present in the gastric lumen without evidence of foreign material, potentially suggestive of associated mild functional to paralytic gastric stasis. Abnormally thickened hypoechoic gastric wall measured up to 3.0 cm wall width. By comparison, normal-appearing intact gastric wall measured 0.5 cm wall width. Regional perigastric hyperechoic omentum was noted.

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 ileus, obstruction, or foreign material.

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

Pancreas

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.

Free Abdomen

Multiple perigastric to cranial abdominal mesenteric lymph nodes were present. The lymph nodes exhibited symmetrical to rounded margination with abnormal width: length ratio (>0.5). The enlarged lymph nodes were bordered by echogenic to reactive mesentery. An example of a mesenteric lymph node measured 3.5 cm x 2.5 cm. No overt evidence of peritoneal free fluid was noted. Regional perilymphatic hyperechoic omentum was noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

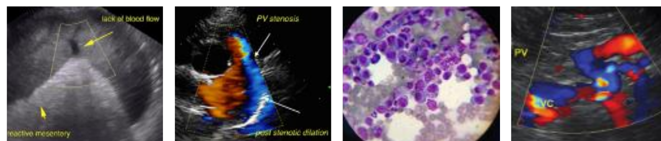
- Gastric mural mass with perigastric hyperechoic omentum
- Associated perigastric to cranial abdominal variably enlarged to irregular hypoechoic mesenteric lymphadenopathy with perilymphatic hyperechoic omentum
- Nonspecific yet highly suspicious liver nodules

Secondary Findings

- Mild chronic renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although sampling is required for further assessment, the gastric mass and associated lymphadenopathy are consistent with multicentric neoplastic criteria with primary concern for round-cell neoplasia i.e., lymphoma or other. Highly suspect hepatic metastasis, given the concurrent hypoechoic hepatic intraparenchymal nodules. If accessible, stomach wall FNA cytology, as well as accessible lymph node FNA cytology is recommended for further clarification and potential for oncology consult. This case does not appear to be surgical at this stage. Three-view chest radiographs are suggested if not done.



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Empirically, gastroprotectant protocol and canned novel protein or hydrolyzed diet trial with potential slurry feeding may be considered.

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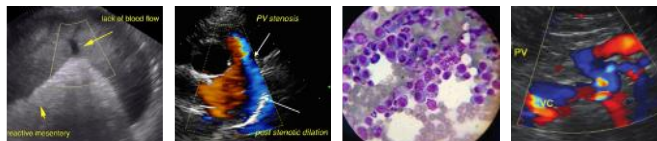

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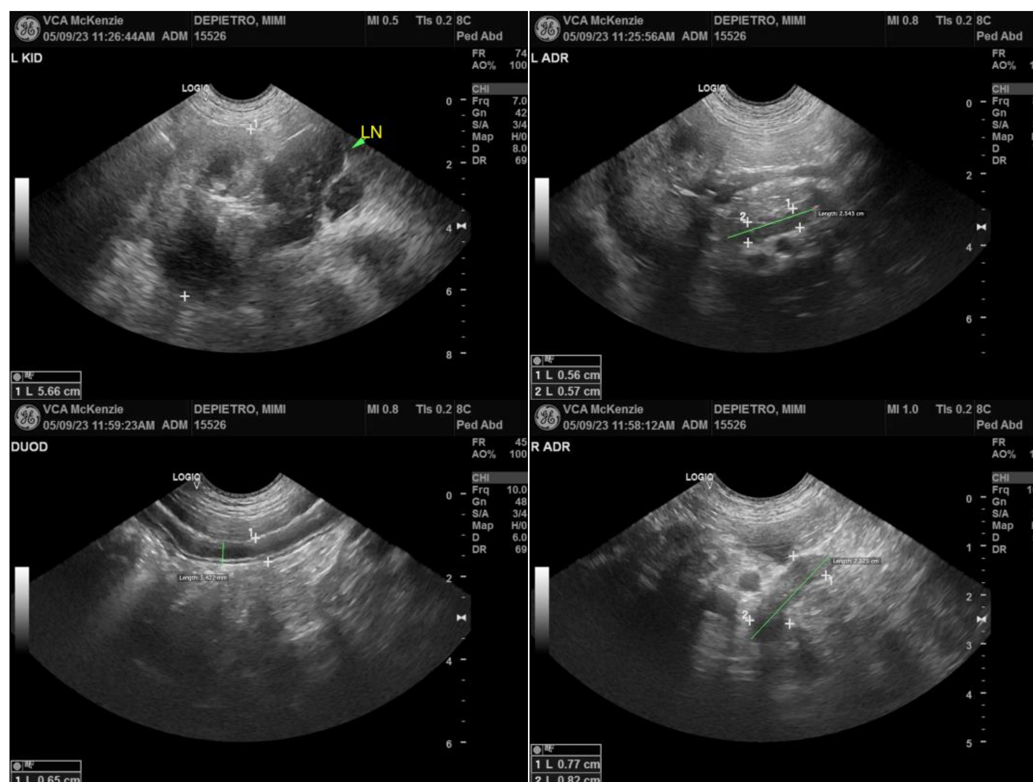

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com