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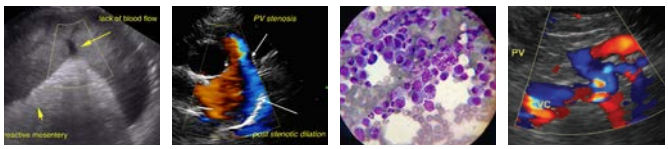
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Elly Haftner

SPECIES
Canine

BREED
Lab

SEX
Spayed Female

AGE
7 Years

WEIGHT
27.9 kg

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

IMAGING PERFORMED BY
Dr. Alastair Westcott

HOSPITAL NAME
Dr. Alastair Westcott

REFERRING VET
Dr. Alastair Westcott

INVOICE
38411

DATE
6/4/22

PRESENTING CLINICAL SIGNS

Chronic, intermittent vomiting with recent, acute exacerbation
Abnormal PE/Chem/CBC/UA Results: Normal PE Mild elevation in SDMA Unremarkable UA

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm 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 were 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 6.6 cm. The right kidney measured 6.8 cm.

Adrenal Glands

The left adrenal gland exhibited subtle uniform, mildly echogenic nodular changes, more prominent in the cranial left adrenal pole with maintained capsule integrity and symmetrical contour. No overt evidence of parenchymal escape or obvious vascular invasion associated with the left adrenal gland nodules. Cranial left adrenal nodule measured 1.2 cm x 1.0 cm. The overall left adrenal gland measured 2.7 cm x 1.1 cm at the cranial pole and 0.75 cm at the caudal pole.

The right adrenal gland exhibited concurrent mildly prominent size with subjective mild asymmetrical capsule contour. Non-homogeneous pinpoint hyperechoic right adrenal parenchyma. The right adrenal gland measured 2.7 cm length x 1.4 cm at the cranial pole and 1.5 cm 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.

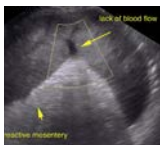
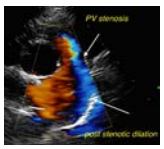
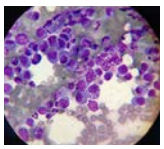
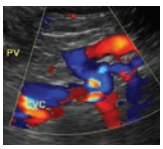
Liver

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 with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach exhibited subjective intact yet mildly thickened wall layering. Ventral gastric body wall measured 0.62 cm. Ventral pylorus wall measured 0.90 cm. The stomach was empty with mild luminal gas and potential for minor retained fluid. No evidence of mechanical pyloric outflow obstruction.

The small intestine presented intact wall layering with primarily maintained 1:3 muscularis/mucosa ratio. Subjective propensity for mildly prominent segmental to generalized submucosa. No evidence of loss of

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intestinal wall layering or mechanical/metabolic ileus pattern. Duodenum wall measured 0.53 cm. Jejunum wall measured 0.28 cm.

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 was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Bilateral nodular to irregular adrenal glands
- Gastritis pattern
- Intact small bowel wall layering with subjective propensity for segmental to generalized mildly prominent submucosal layer

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, the appearance of the stomach is suggestive of inflammatory criteria. Minor potential for early infiltrative criteria cannot be excluded, yet thought less likely. Potential for generalized inflammatory gastroenteropathy cannot be excluded, yet given the lack of additional gastrointestinal signs (i.e., weight loss or diarrhea), potential for concurrent inflammatory enteropathy may be considered less likely.

Some or all of the following protocol may be considered empirically. Endoscopic upper gastrointestinal biopsies may be indicated for further assessment if persistent/progressive vomiting noted, despite conservative therapy.

Considerations for the bilateral adrenal glands may include adenomatous change, benign hyperplasia, while the possibility of emerging neoplastic criteria, specifically involving the right adrenal gland (i.e., pheochromocytoma, adenocarcinoma) cannot be excluded. Screening blood pressure recommended to assess for evidence of hypertension, which may allude to a pheochromocytoma. Potential for very early vascular invasion associated with the right adrenal gland, yet not definitive. Abdominal CT for further assessment would be ideal. Sonographic reassessment of the bilateral adrenal glands as well as the stomach in 4 weeks would be a more conservative approach.

Helicobacter/Gastritis protocol
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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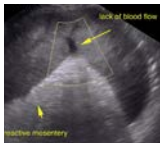
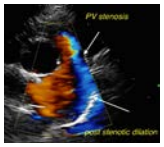
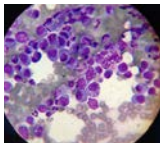
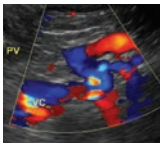

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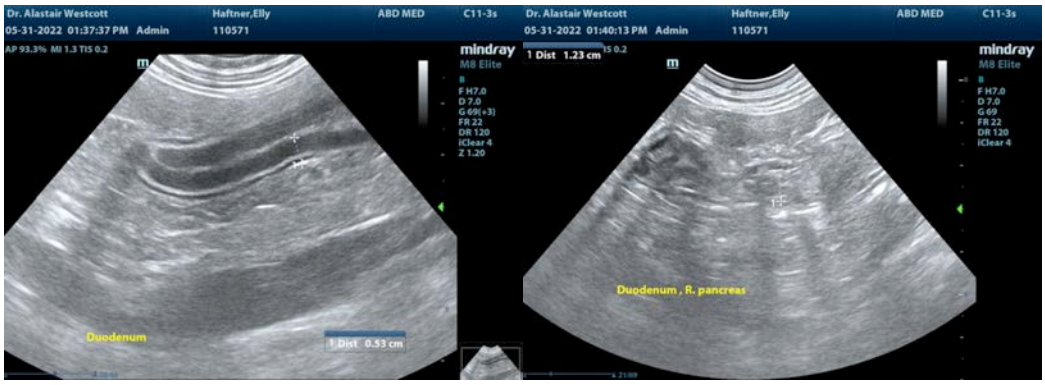

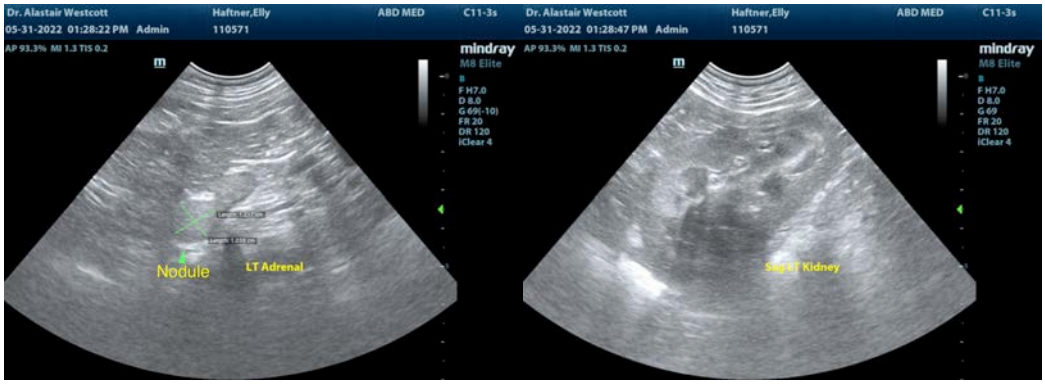

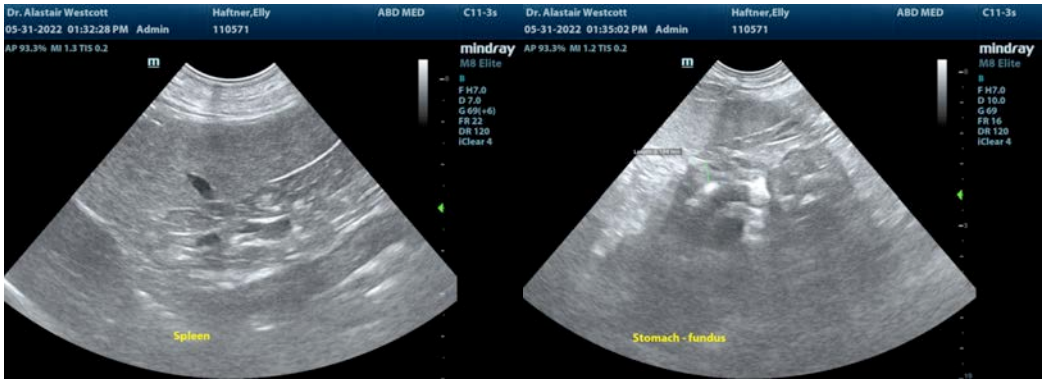

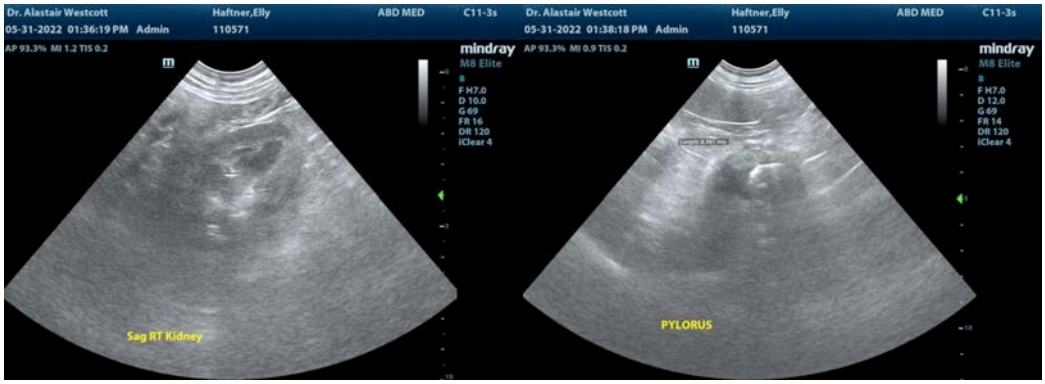

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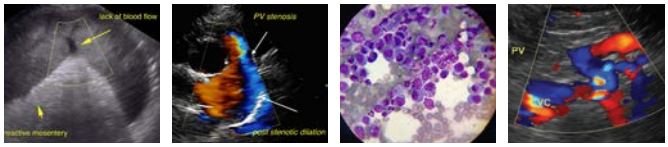

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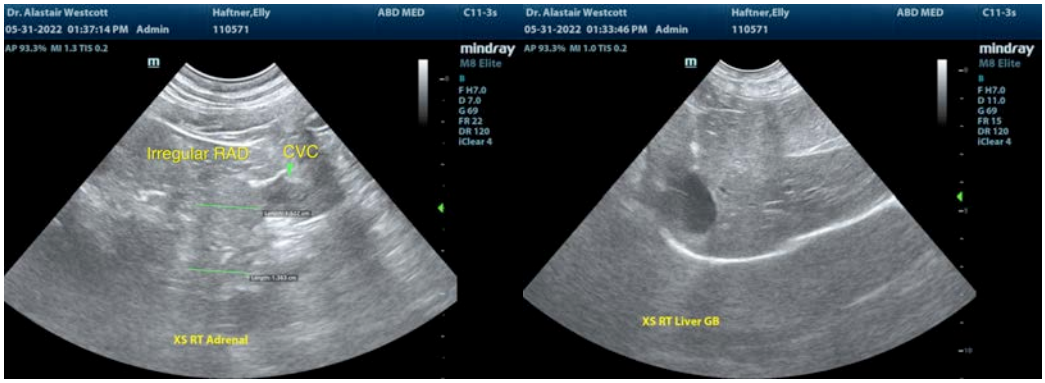

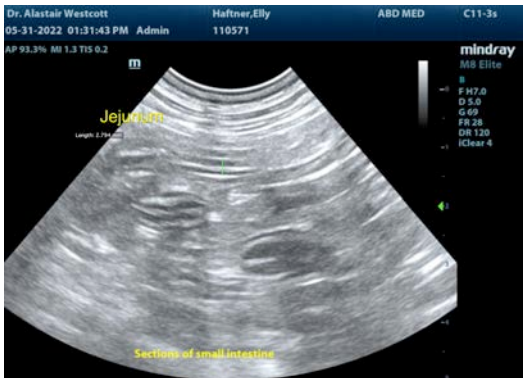

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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