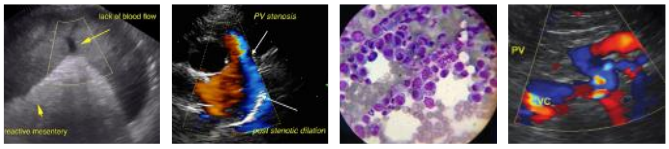
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Isla Christensen

SPECIES

Canine

BREED

Leonberger

SEX

FS

AGE

10 yrs

WEIGHT

39.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sarah Barthelemy

HOSPITAL NAME

Creature Comforts Animal Hospital

REFERRING VET

Dr. Decker

INVOICE

14972

DATE

9-23-22

PRESENTING CLINICAL SIGNS

Couple month hx of vomiting, weight loss, reduced energy.
Abnormal PE/Chem/CBC/UA Results: Mild ALP elevation on labs done in July.

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 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 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 7.3 cm in length. The right kidney measured 7.0 cm in length.

Adrenal Glands

A well-demarcated, mildly hyperechoic, nondisruptive nodule was present in the cranial left adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 0.85 cm in diameter. The overall left adrenal gland measured 0.85 cm width at the cranial pole and 0.87 cm width at the caudal pole.

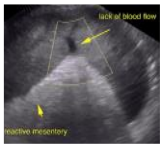
The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.83 cm width at the caudal pole.

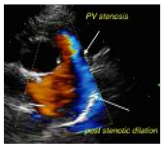
Spleen

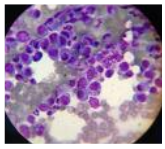
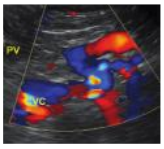
The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

Liver/ Gallbladder

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. Intermittent nondisruptive, mildly hyperechoic intraparenchymal nodules were present. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. An example of a liver nodule measured 3.4 cm in diameter. The gallbladder was non-distended in size containing mild, nondependent yet nonorganized, echogenic gallbladder debris present primarily in the caudal lumen and area of





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gallbladder neck. No evidence of gallbladder or peripheral gallbladder inflammatory criteria was noted. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach exhibited regional mild to moderate wall thickening exhibiting decreased mural echogenicity and loss of discernable wall layering in the subjective gastric body. Concurrent mild retained gastric ingesta / fluid and luminal gas were noted. No obvious evidence of a foreign body, which is considered unlikely.

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. The duodenum wall measured 0.36 cm width. The jejunum wall measured 0.35 cm width.

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

No omental masses or evidence of overt lymphadenopathy were noted. Potential for scant pockets of perigastric gastric free fluid noted between the stomach and caudal liver, possible although not definitive.

ULTRASONOGRAPHIC FINDINGS

- Regionally thickened stomach walls exhibiting decreased mural echogenicity and loss of discernable wall layering
- Sonographically unremarkable small bowel
- Subjective vacuolar hepatopathy pattern with likely intermittent benign intraparenchymal nodules - nodules suggestive of lipogranulomas or potential nodular hyperplasia
- Mild age-related kidneys
- Nonspecific left adrenal nodule - suspect adenoma

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the regionally thickened stomach may include primary concern for emerging infiltrative neoplasia i.e., lymphoma, adenocarcinoma, or other. Inflammation / gastritis, infectious gastropathy i.e., helicobacter, and potential for ulceration if evidence of hematemesis, are possible. Concern for emerging gastric neoplastic criteria is warranted, given decreased mural echogenicity and loss of discernable wall layer detail. Endoscopic or surgical biopsies are required for a definitive diagnosis.

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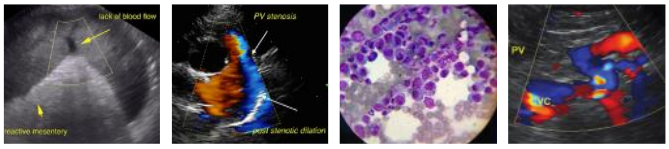

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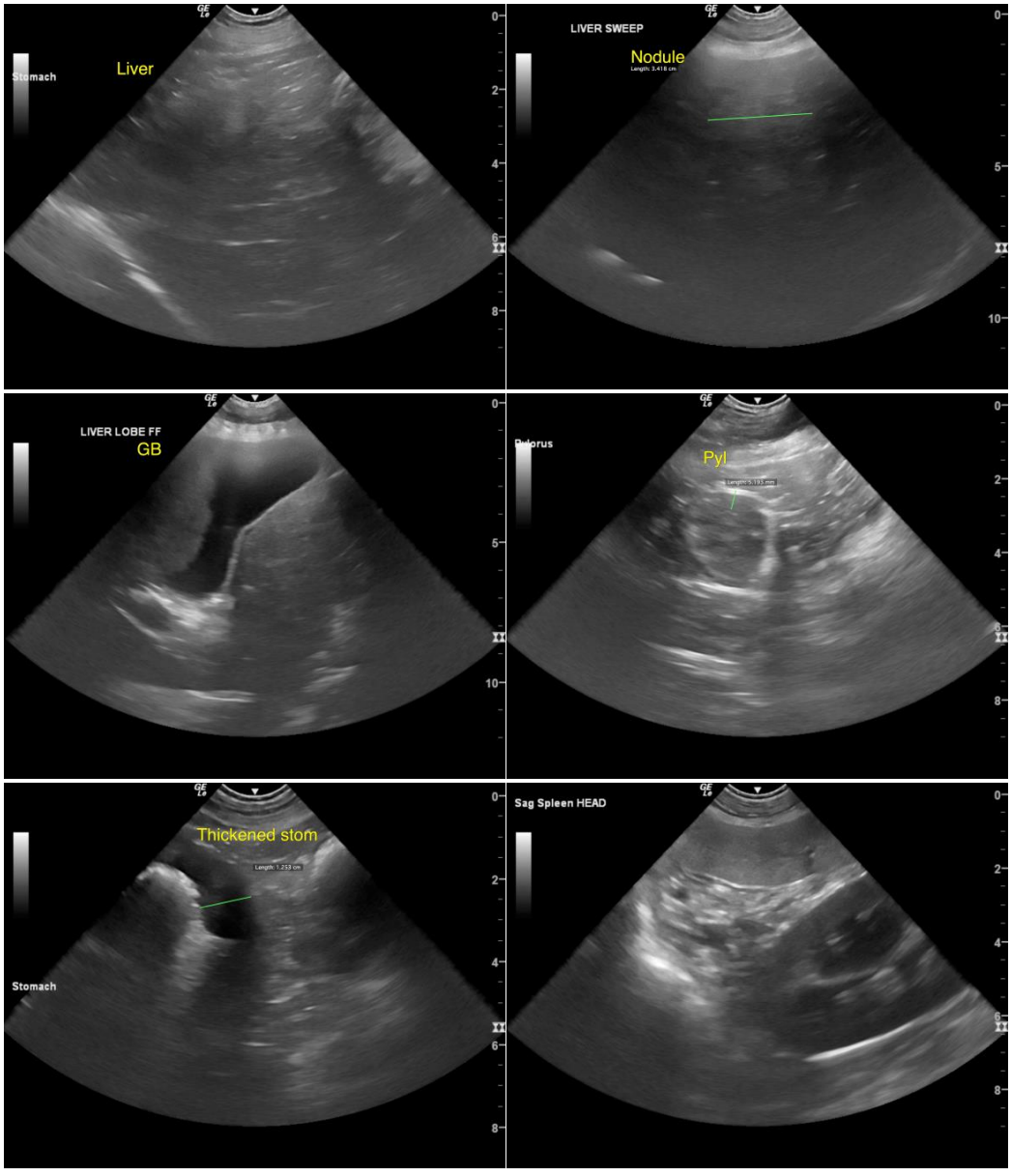
Assuming normal clotting status screening hepatic FNA cytology could be considered primarily to ensure only benign changes are present. Empirically, gastroprotectant protocol, smaller more frequent feedings of canned hydrolyzed diet, +/- empirical helicobacter therapy, and gastric sonographic reassessment in 2-3 weeks would be a more conservative approach.



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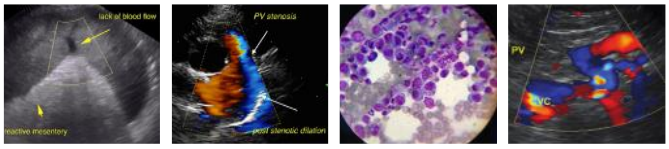

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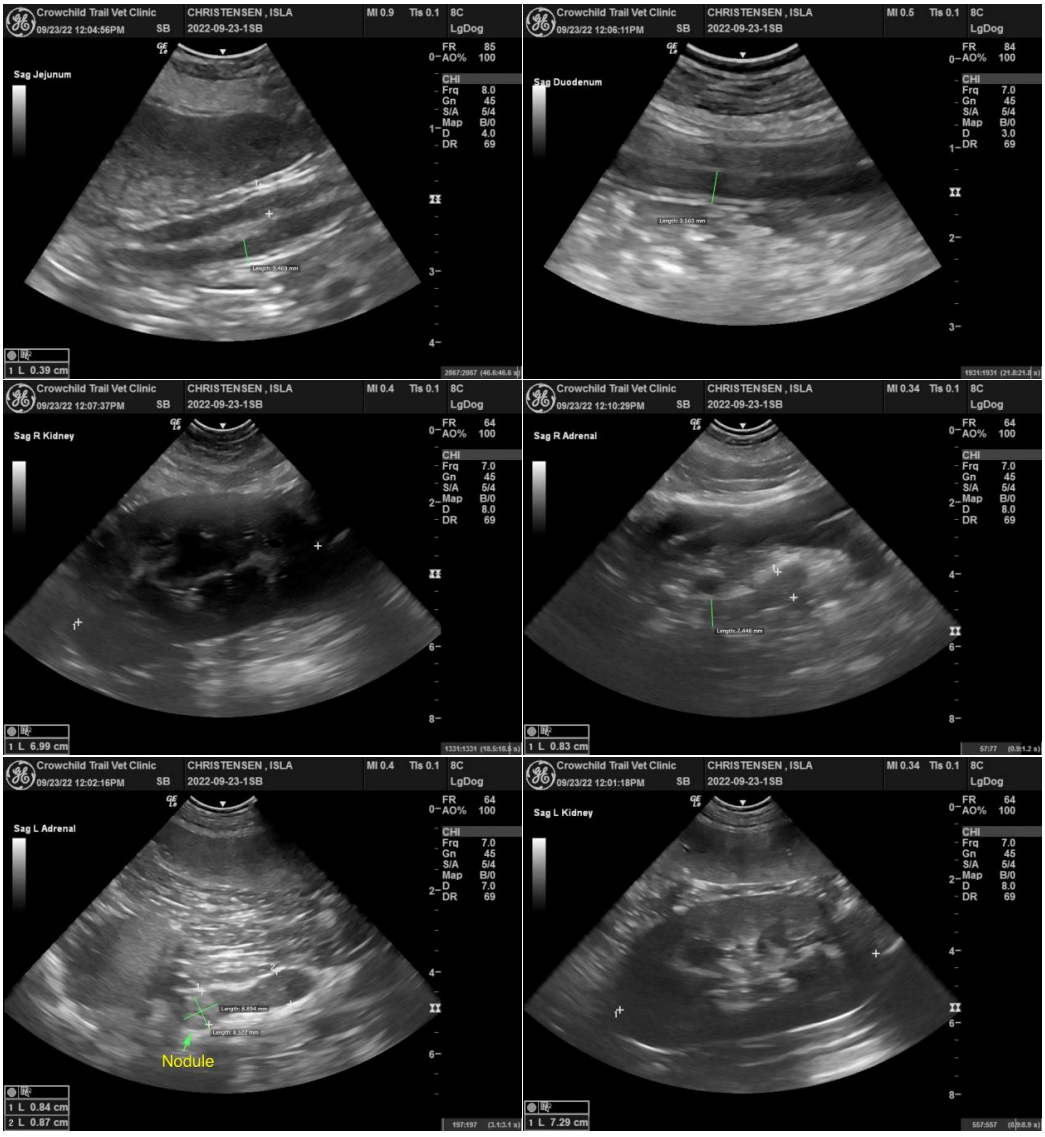

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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