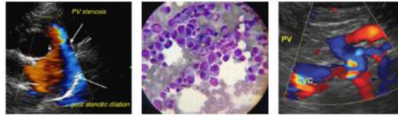


PATIENT

Cash Lofquist

SPECIES

Canine

BREED

Lab

SEX

NM

AGE

10 years

WEIGHT

65 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Doerscher

INVOICE

15043

DATE

9-29-22

PRESENTING CLINICAL SIGNS

since sx, straining w/defecation. Rads showed food in stomach, extended feces in colon. Labwork unremarkable. Presumptively tx for poss constipation/nausea w/bland diet, Cerenia, Miralax. P did okay with this for a little while. 9/26/22 O called reporting that P is back to vomiting, not eating, poss constipated. We got P in for a recheck on 9/29 and O reported continued V and now loose stools. Took recheck rads after a 12 hr fast and noted possible mass effect along caudal border of stomach body.. Vomited this morning prior to scan. Has been fasted.
Abnormal PE/Chem/CBC/UA Results: P has lost 5 lbs since August - was lean to begin with Possible mass effect on caudal border of stomach Labwork unremarkable - stress LG, Amylase slightly decreased

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.

No evidence of pathology was noted in the area of the residual prostate.

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 6.6 cm in length. The right kidney measured 6.6 cm in length.

Adrenal Glands

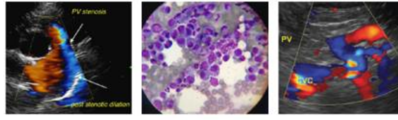
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 2.4 cm length x 0.71 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 3.1 cm length x 0.68 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 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



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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

Regional to generalized moderate gastric wall thickening exhibiting decreased mural echogenicity and indistinct to loss of discernable wall layer detail was present. The thickened gastric walls exhibited mild asymmetrical luminal surface with the possibility of focal ulceration exhibited by potential luminal crater and concurrent gas artifact. Mild retained anechoic fluid was present in the gastric lumen without evidence of overt foreign material. Gastric body wall width measured up to 1.7 cm. No evidence of mechanical pyloric outflow obstruction was noted. The pylorus wall width measured 0.83 cm width.

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 small intestinal mechanical / metabolic ileus, loss of intestinal wall layering, intestinal masses, 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

Mild regional perigastric hyperechoic mesentery was present. Potential for minor gastric lymphadenopathy, although evidence of significant gastric or cranial omental lymphadenopathy was not obvious. No evidence of peritoneal free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

- Reginal to generalized variable gastric wall thickening exhibiting indistinct to loss of gastric wall layer detail, possible focal ulcer
- Sonographically unremarkable small bowel
- Mild hepatic parenchymal remodeling - benign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

General considerations for the thickened stomach may include inflammatory, infectious (helicobacter), or neoplastic etiologies. Although sampling is required for a further assessment, primary concern for infiltrative gastric neoplasia such as lymphoma or other with potential for ulcerative lymphoma if current or future hematemesis is noted. Endoscopic or surgical gastric biopsies are required for further assessment.

Empirically, gastroprotectant protocol including Omeprazole and Sucralfate, hydrolyzed diet trial with potential initial slurry feeding progressing to canned diet, and as-needed gastrointestinal support with a sonographic reassessment of the stomach in 3-4 weeks would be a more conservative approach. A guarded prognosis is warranted.

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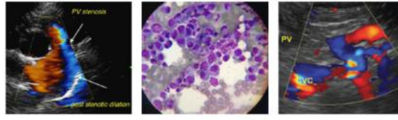

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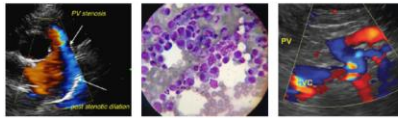

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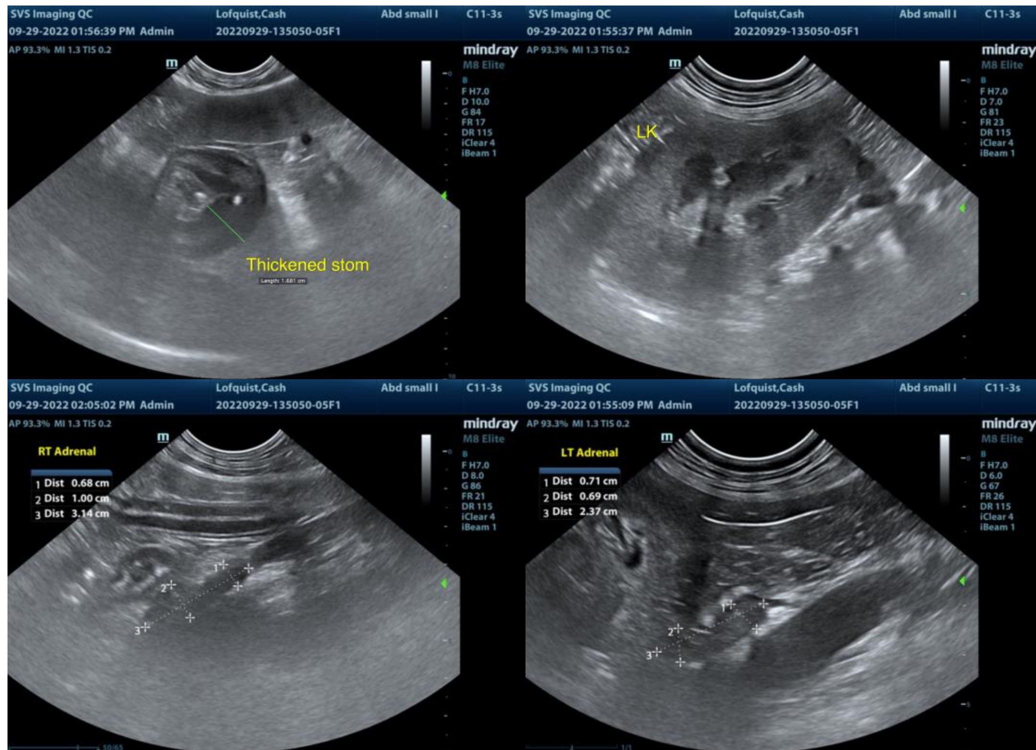

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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