

**PATIENT**

Kobe Perez

**SPECIES**

Canine

**BREED**

Aust. Labradoodle

**SEX**

Male Neuter

**AGE**

23 Months

**WEIGHT**

30

**INTERPRETED BY**

Sebastian Jawinski,  
German Board Certified  
Vet Specialist in  
Diagnostic Imaging

**IMAGING PERFORMED BY**

Dr. Gabriel Ferrer  
DVM

**HOSPITAL NAME**

Pulse: Pet Ultrasound  
Services

**REFERRING VET**

Dr. Alfred Marzan

**INVOICE**

48250

**DATE**

11-5-21

**PRESENTING CLINICAL SIGNS**

Kobe presented today for an abdominal ultrasound. Pt has history of vomiting and having gastritis. These episodes of gastritis seems to be very frequent. This patient have developed about 5 or more of these episodes of vomiting. Pt seems to have a very sensitive stomach. Want to further evaluate the GI tract to make sure no major abnormalities are seen.

Abnormal PE/Chem/CBC/UA Results: The PE was unremarkable The bloodwork: CBC and Chem were all within normal limits

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary system**

The urinary bladder, trigone and pelvic urethra present normal findings without evidence of uroliths or sediment. Wall layering is intact on all views without focal or diffuse thickening. Ureters are not visualized and considered to be normal. No evidence of an inflammatory or neoplastic process are noted.

Both kidneys are inconspicuous with a clear corticomedullary definition and an indicated hyperechoic band of the outer medulla. Left kidney measures 5.2 cm length, right kidney 4.8 cm. Renal pelvises and exits to the ureters are unremarkable.

**Reproductive tract**

The prostate is small and homogeneous and appears smoothly margined.

**Adrenal glands**

Both present normal size, shape and echogenic texture.

**Spleen**

The spleen is inconspicuous in terms of size, surface and echotexture and shows diameters of 1.4 cm. Splenic vasculature presents normal course of vessels and unremarkable perfusion of the splenic veins. There are no signs of nodular/focal changes are noted.

**Liver/Gallbladder**

The liver echogenic texture appears generally and mildly hyperechoic and shows multiple small vessel-like structures similar to portal veins. Evidence of nodular or focal changes is not visible.

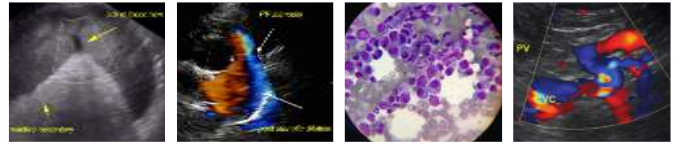
The gallbladder and -wall are unremarkable without signs of relevant sludge, a florid process or cholestasis.

**Gastrointestinal**

The gastric wall appears thickened with maximum diameters of 0.41 cm including all wall layers. The muscular layer demonstrates multiple, small hyperechoic infiltrates. Pyloric outflow obstruction is not recognized. The small intestine and colon present intact wall layers being normal in width and echogenicity. Adjacent mesentery and fat tissue are of normal appearance. There is no overt evidence of an ileus, a florid inflammatory or even neoplastic process.

Mesenteric lymph nodes are subtly enlarged but inconspicuous in shape and periphery.

**Pancreas**



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All pancreatic parts displayed show isoechoic echogenicity to the surrounding omental fat. Signs of inflammatory changes or focal lesions are missing.

**Free Abdomen**

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There is no evidence peritoneal or retroperitoneal effusion noted.

Abdominal fat and great vessels show no pathological findings.

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**ULTRASONOGRAPHIC FINDINGS**

**Primary**

- Thickened gastric wall with hyperechoic muscular infiltrates

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**Secondary**

- Prominent hepatic portal vasculature vs. intra-hepatic biliary distension
- Subtle mesenteric lymphadenopathy

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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Ultrasonographic findings reflect the reported patient's history of vomiting and are likely consistent with gastritis. This however is unspecific from a sonographic point of view. The hyperechoic changes of the muscular layer may represent erosive gastritis (history of steroids/NSIADs/mast cell tumor?) but lymphoplasmocytic or -histiocytic and infectious gastritis are also common. An obstructive issue is not noted but cannot be fully excluded.

A specific therapy depends on its etiology, but an empiric approach could be performed prior to further diagnostics such as endoscopy and gastric biopsy/brush cytology.

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Recommended therapy for gastritis:

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- highly digestible and low-residue therapeutic diet and feeding management: multiple, small meals
- anti-emetics: maropitant citrate (Cerenia) 1 mg/kg SQ once daily or 2 mg/kg PO once daily up to 5 days
- odansetron (Zoran) 0.11 - 0.22 mg/kg IV/IM/SQ or metoclopramide 0.2 - 0.5 mg/kg SC
- omeprazole 0.7 - 1.5 mg PO Q24hr
- amoxicillin 15 mg/kg PO BID, or combination with metronidazole 10 mg/kg PO BID and famotidine
- in IBD conditions additionally steroids may be required.

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Regarding the normal blood results, I suspect the liver changes to be non-relevant. A normal variant is likely. Possible differentials include intra-hepatic biliary distension due to cholangitis/-hepatitis.

A sonographic follow-up study is recommended in 14 days to monitor gastric wall thickness and liver changes.

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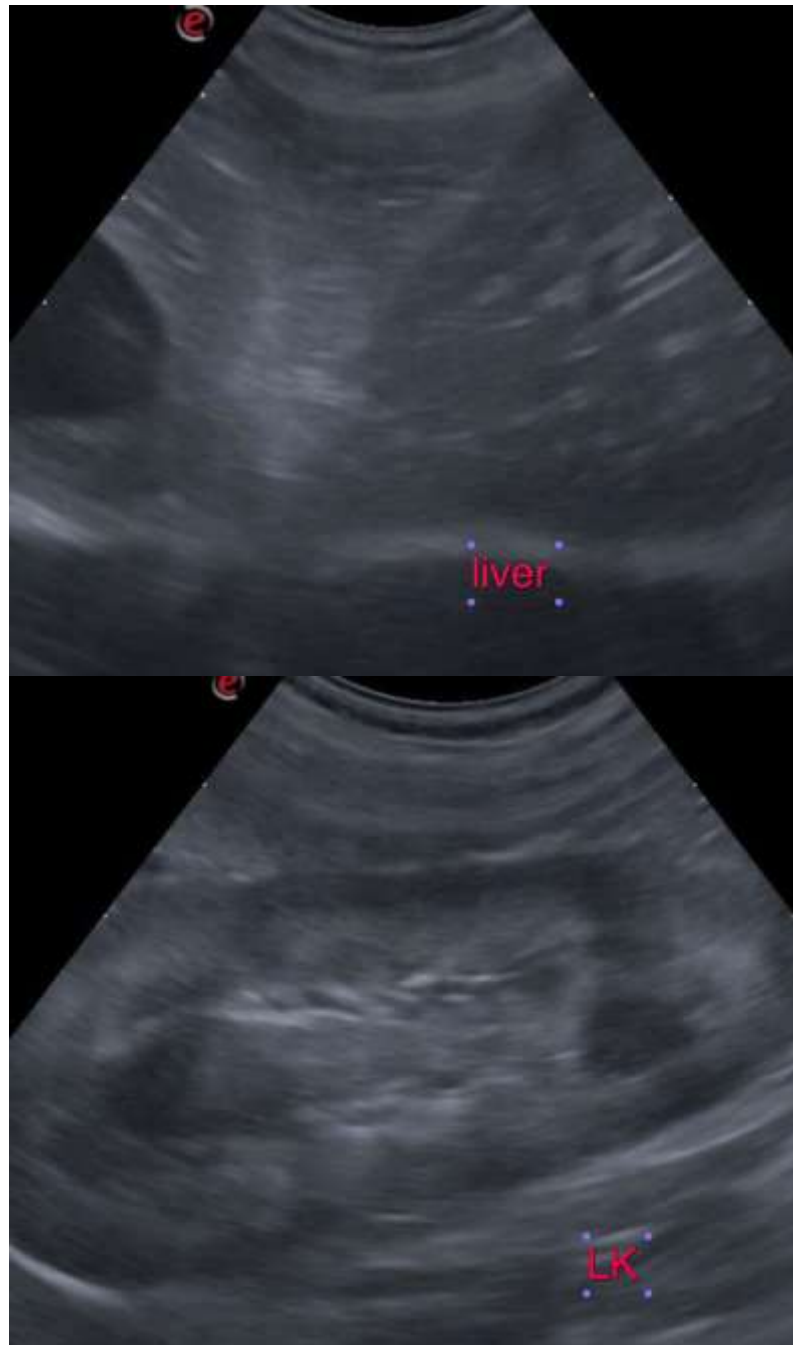
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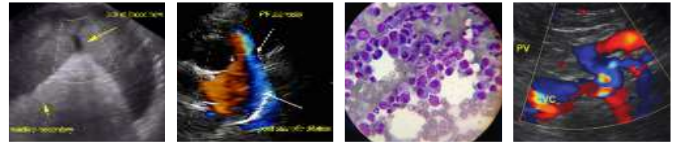
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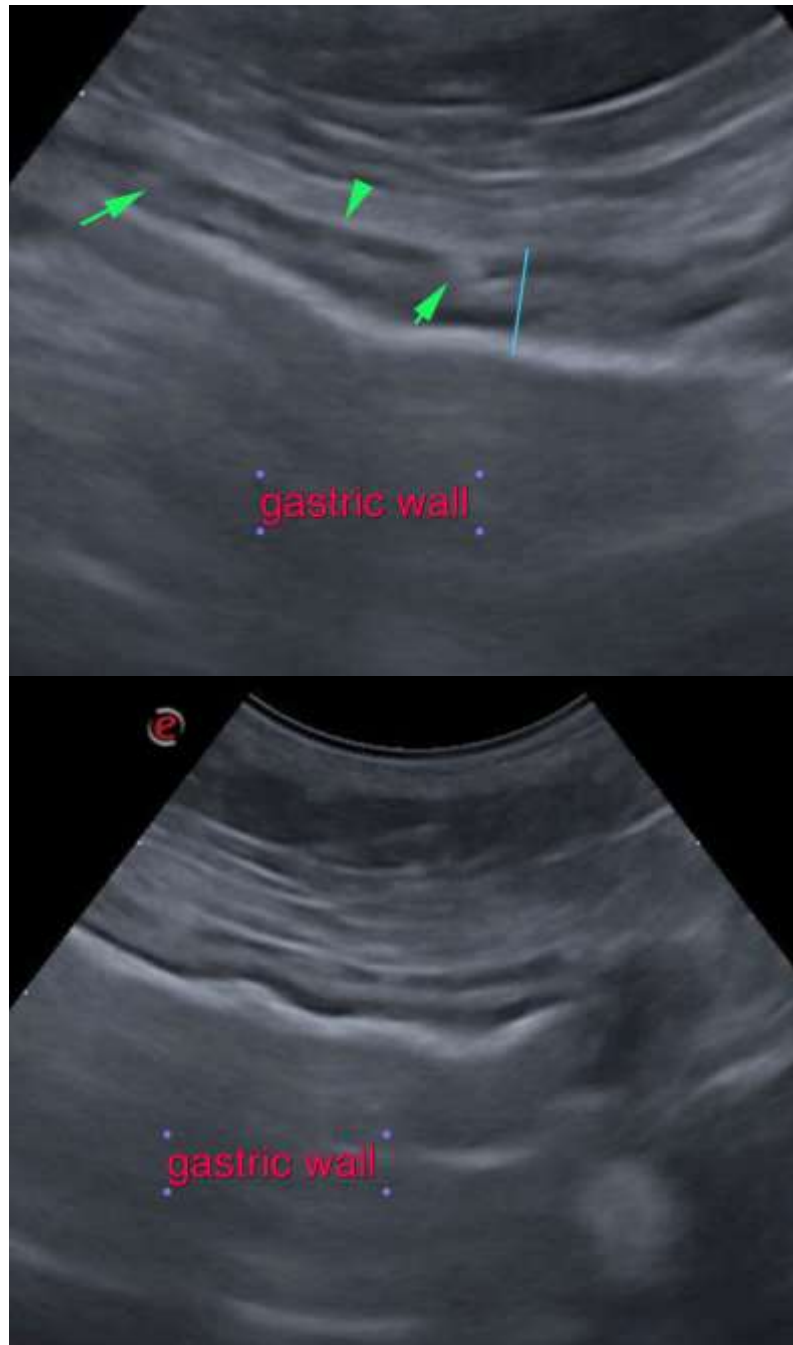
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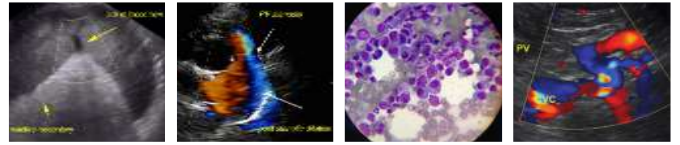
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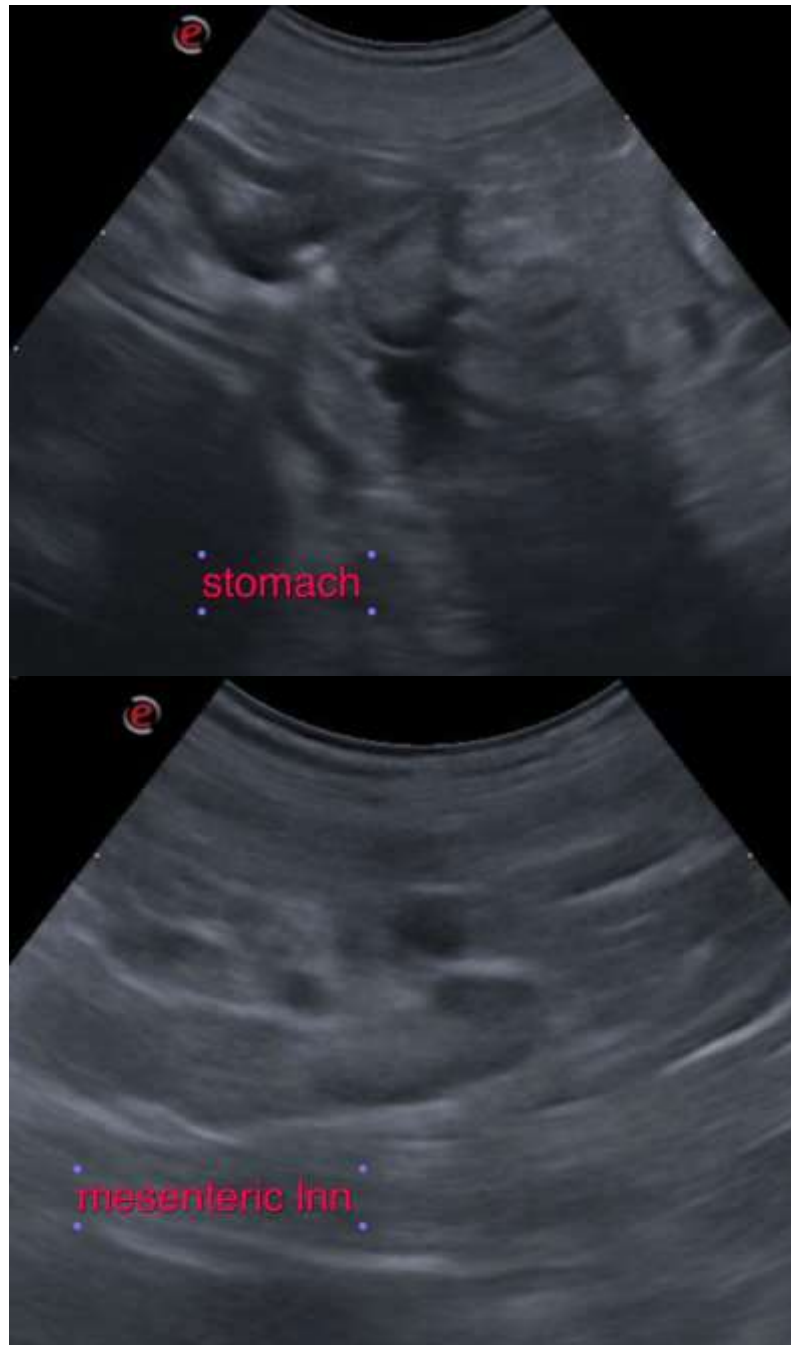
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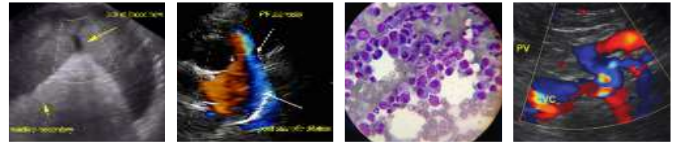
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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info@sonopath.com

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