



PATIENT

Gypsy Williams

SPECIES

Canine

BREED

Boston Terrier

SEX

Female

AGE

10 years

WEIGHT

6.5 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Kalenius

HOSPITAL NAME

Wilvet Salem

REFERRING VET

Dr. Kalenius

INVOICE

42688

DATE

11/24/22

PRESENTING CLINICAL SIGNS

History: P has been intermittent vomiting for 6-8 weeks, some bile, sometimes with food content after eating. P had blood in vomit this morning, has not had blood present before today. P has been lethargic and sleeping a lot more than normal and O has noticed decrease in weight. P has not eaten anything today, last ate part of a cheeseburger yesterday. P had softer stool this morning, usually harder in appearance. P is not on any medications. P eats a grain free dry kibble 1 cup spread over TID and some treats. P is up to date on vaccines.

Abnormal PE/Chem/CBC/UA Results: Chronic vomiting / diarrhea - worse today with some hematemesis (frank, not digested) EPOC Bicarb 29.2, tCO2 29.4, GLU 137 other values wnl. CBC = mild neutrophilia (13.66 k/ul), otherwise NSF. CHEM 17 ALT 135, otherwise wnl. AFAST - mild gastric distension with fluid, enlarged epigastric and mesenteric LNN. Thickened stomach wall. r/o LSA vs IBD vs other __ Pending diagnostics 1. ABD US submitted to Sonopath STAT 2. Fecal to IDEXX 3. LN cytology (abdominal) to Idexx - history for submission: Pet presents for 6 weeks vomiting and recent soft stool. US findings include thickened stomach wall and mesenteric / epigastric lymphadenopathy. EPOC Bicarb 29.2, tCO2 29.4, GLU 137 other values wnl. CBC = mild neutrophilia (13.66 k/ul), otherwise NSF. CHEM 17 ALT 135, otherwise wnl.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The right kidney measured 4.4 cm.

Adrenal Glands

The left adrenal gland was slightly swollen at the caudal pole measuring 0.7 cm, 0.37 cm at the cranial pole and 2.15 cm in length. The right adrenal gland was largely normal and measured 2.64 x 0.8 cm at the cranial pole and 0.75 cm at the caudal pole. However, the right phrenic vein appeared to be occupied to approximately 0.5 cm towards the vena cava; yet the vena cava was free of evident invasion. This is consistent with thrombosis or possible emerging right adrenal tumor.

Spleen

The **spleen** in this patient was mildly enlarged with uniform parenchyma and was folded upon itself. This is a positional variant and is not pathological. There was no evidence of significant disease.



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Liver

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The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

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The **stomach** presented concentric mild mural thickening. Enhanced mesentery was noted around the stomach. The gastric fundus was particularly thickened with loss of mural detail. The gastric wall measured up to 1.6 cm. The small intestines and colon were unremarkable. The mesenteric lymph nodes were enlarged, rounded and hypoechoic measuring 1.0 cm.

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Pancreas

Regional inflammation was noted around the **pancreas** and was primarily associated with the gastric fundus. The pancreatic remodeling was minor and appeared to be secondary given the gastric presentation.

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ULTRASONOGRAPHIC FINDINGS

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Gastritis pattern with potential underlying gastric carcinoma.

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Concentric gastric wall thickening. Moderate to severe gastritis versus gastric carcinoma.

Mesenteric lymphadenopathy.

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Right phrenic vein occupation. Thrombosis versus underlying carcinoma or pheochromocytoma.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Full thickness gastric biopsies are indicated. I recommend serial blood pressure measurements in this patient. If hypertension is present then urine catecholamine is indicated. Gastroscopy with gastric biopsies is indicated or full thickness gastric and mesenteric lymph node biopsies +/- right adrenal removal. Guarded prognosis. If empirical measures are to be utilized only then aggressive GI protectant protocol such as the following should be considered with a recheck sonogram in 7-10 days.

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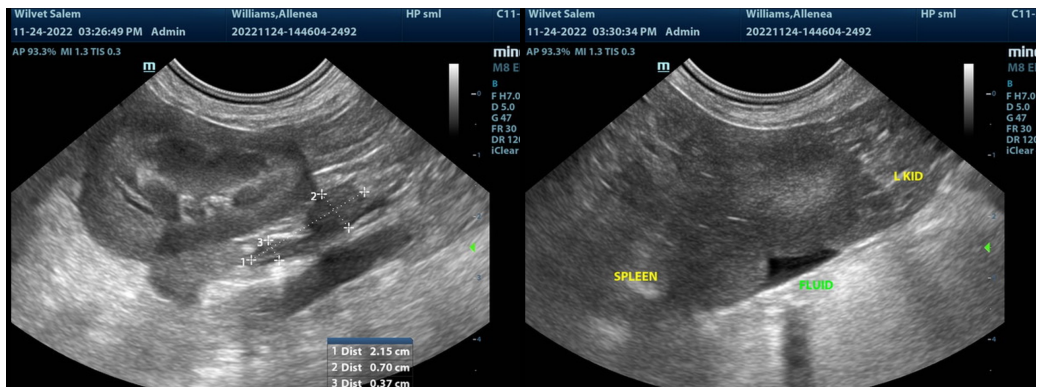
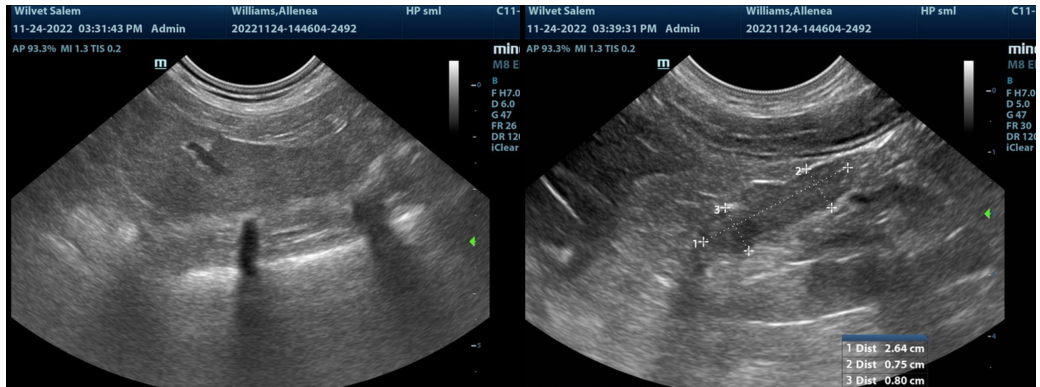
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.



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Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
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