

**DATE**

10/25/2021

PATIENT

Jezebel Patch

SPECIES

Canine

BREED

Labrador Retriever mix

SEX

Female, spayed

AGE

1/11/2011

WEIGHT

92 lbs.

INTERPRETED BY
 Andrea Nicastrò, DVM,
 Diplomate ACVIM
 (*Small Animal Internal
 Medicine*)
HOSPITAL NAME

Eastern AH

REFERRING VET

Dr. Bottaro

INVOICE

12413

PRESENTING CLINICAL SIGNS

History: Hx of dilated common bile duct with impinging or tethering pancreatic tissue, nonspecific changes to the liver, etc. P is showing symptoms similar to what was going on in January - painful abdomen, heavy panting, ADR, soft stools) O is concerned she is having a 'flare up' again. O is also concerned for pleural effusion (she stated that previous U/S showed fluid in her lungs which I was unable to find on any other reports)

Current Medications: Pred 20mg PO q 24 hours. Amantadine 100mg - 2 capsules PO q 12 hours. Codeine 30mg - 3 tabs PO q 8-12 hours PRN pain. Denamarin Advanced large.

Lab Results: Not provided by the veterinarian.

Date of Previous IntraPet Ultrasound: 8-2-21, 1-14-21.

Sedation: Not needed.

Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with mostly anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (7.37 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (7.04 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.44 cm at cranial pole) (0.78 cm at caudal pole) (2.42 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in length with a flattened contour (0.41 cm at cranial pole) (0.60 cm at caudal pole) (3.40 cm in length). The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size with a normal capsular contour. There is appropriate echogenicity and echotexture. Several small hyperechoic nodules are observed throughout the organ. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hyperechoic relative to the spleen and mottled in appearance. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is normal in thickness. A moderate amount of mostly gravity-dependent echogenic debris is observed within the lumen. Luminal contents are anechoic. The common bile duct is moderately dilated (up to 0.75 cm). 1-2 choledocoliths are suspected in the dilated region. The common bile duct then tapers to normal diameter as it extends towards the duodenal papilla.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is minimally distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with slightly irregular peripheral contours. The parenchyma is subtly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is slightly hyperechoic.

Free Abdomen

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

Other

A brief echocardiogram reveals no evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Mild acute or chronic active pancreatitis is suspected. Regional peritonitis is present.
- Possible choledocoliths with moderate focal common bile duct dilation (dilation has improved since the previous sonogram).

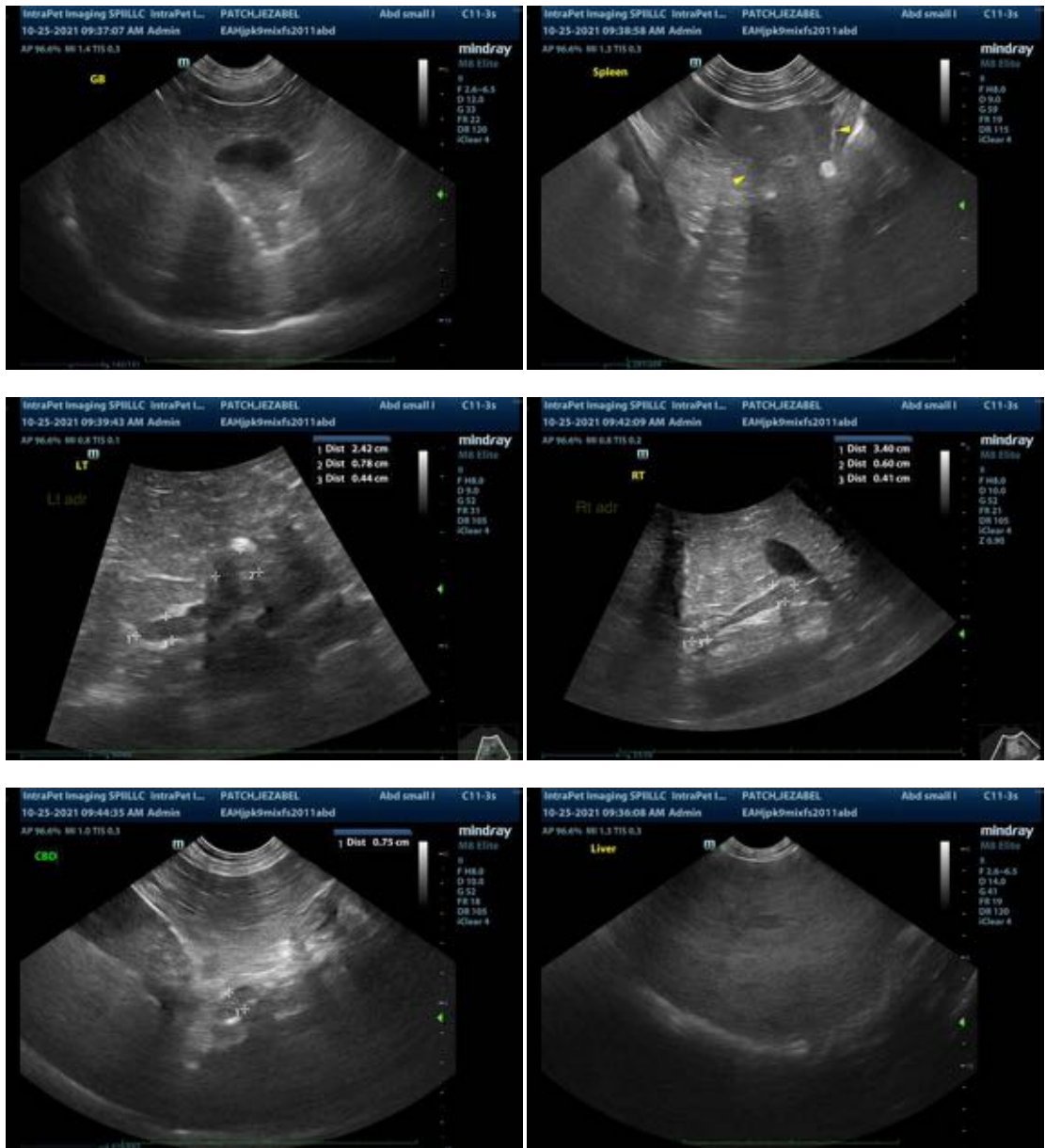
Secondary Findings:

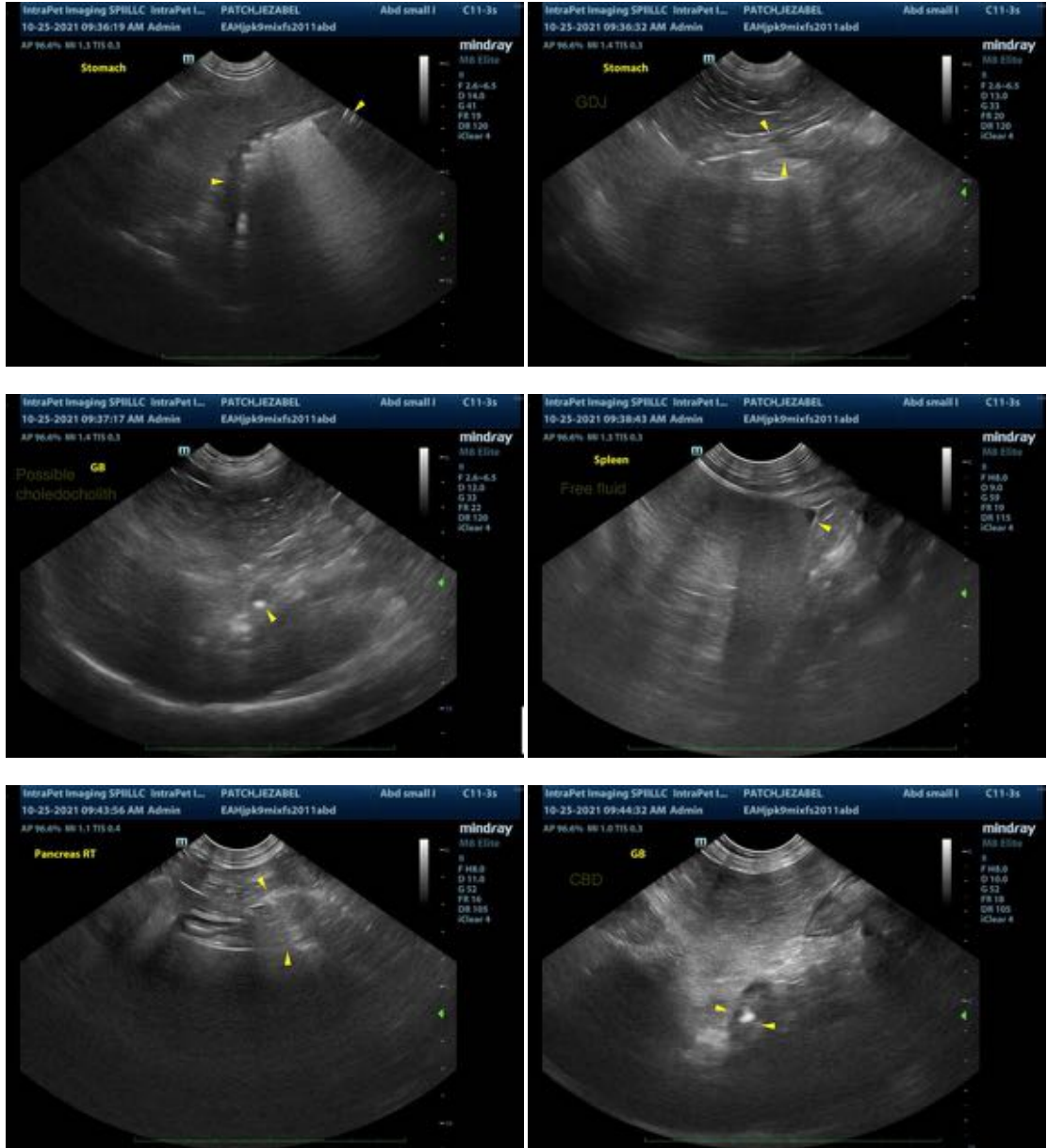
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- The hyperechoic lesions adjacent to the splenic vessels are most consistent with myelolipomas. Although a neoplastic process within the spleen cannot be excluded, it is considered unlikely in this patient.
- The flattened right adrenal gland may be a normal variant for this patient or may represent early atrophy (i.e., secondary to hypoadrenocorticism).
- Minor age-related renal pathology.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma.
- Baseline labwork including a CBC chemistry panel, urinalysis and T4 is recommended to assess overall metabolic function, if not already performed.

- Also consider three-view thoracic radiographs to assess for cardiopulmonary disease.
- If the above diagnostics are inconclusive and the patient does not respond to supportive care, a more advanced GI workup may be warranted.





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.

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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