SonoPath
Clinical Sonography & Telecytology
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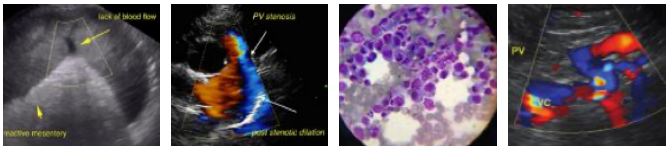


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Shenzi Waddell

SPECIES
Canine

BREED
Pinscher mix

SEX
Female, spayed

AGE
7 yrs.

WEIGHT
35 lbs.

INTERPRETED BY
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY
Amy Mayhew

HOSPITAL NAME
SVS Imaging Michigan

REFERRING VET
Dr. Richards

INVOICE
14581

DATE
2/14/23

PRESENTING CLINICAL SIGNS

History: Current Medications: RC GI LF Patient History: AUS and Texas A&M Maldigestion profile on 2/14/23. Re-occuring pancreatitis. Presented for discussion on poss chronic pancreatitis 1/24/23 P was seen here Jan 2022 and diagnosed/treated for pancreatitis and was seen at another vet with pancreatitis Dec 2022 (minimal MR received) - hx of vomiting, regurgitating food, poss distended abdomen at that time. Per O, P improved with fluids and meds. O scheduled appt today due to poss flare up of pancreatitis- P vomited, possible regurgitated a couple days ago. O gave famotidine and metronidazole left over from visit to prior vet and feels that P has improved P also has prior hx of getting into garbage, concerns for FB, but O has done a lot to reduce access to this and does not feel it is related to her recent episodes
Abnormal PE/Chem/CBC/UA Results: 1/24/23 Exam: On exam today, P BAR- very active, high energy Appears well hydrated Nonpainful on exam today No abdominal distention noted, nonpainful on ab palpation. No signs of nausea. Has been "gassy" per O P has always been lean, difficulty getting P to gain wt, extremely active. Was prev on Purina Sport diet due to this, but concerns this may be too rich for P. Suggest low fat food due to concern for chronic pancreatitis, but need to monitor wt closely IH BW CBC- leukopenia with neutropenia present, slightly elevated HGB Chems all wnl, including lipase. Normal protein (was low at prior clinic in last month) 4dx- neg x4 - has been off prevention, O plans to restart Reviewed that pancreatitis can become chronic issue, provided Plumbs Handout Discussed diet plays a big role, but rec ruling out other potential GI causes for vomiting, poss regurg, inappetance Rec checking AUS and Texas AM Malidigestive panel to monitor better- AP reviewed tx plan, O declined scheduling at this time Discussed trying antacid therapy

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (6.88 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

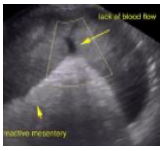
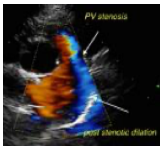
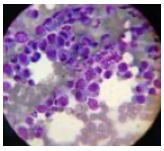
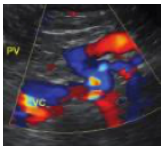
The right kidney is normal size (6.83 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.52 cm at cranial pole) (0.60 cm at caudal pole); 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 size (0.72 cm at cranial pole) (0.49 cm at caudal pole); 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.

Spleen

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The spleen is normal in size (1.51 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with fluid and shadowing chyme. 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 left limb is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

There is no obvious evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 2.88 cm in length. The nodes are normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

*An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include primary gastrointestinal disease (i.e., esophagitis, esophageal dysfunction, infectious/parasitic disease, inflammatory bowel disease, food allergy), mild chronic pancreatitis, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the history of possible regurgitation, consider a Barium esophogram, preferably via fluoroscopy to assess for esophageal dysfunction.
- A fecal evaluation for ova/Giardia.
- Resting cortisol level to screen for atypical hypoadrenocorticism.

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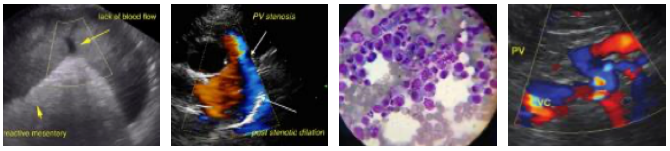

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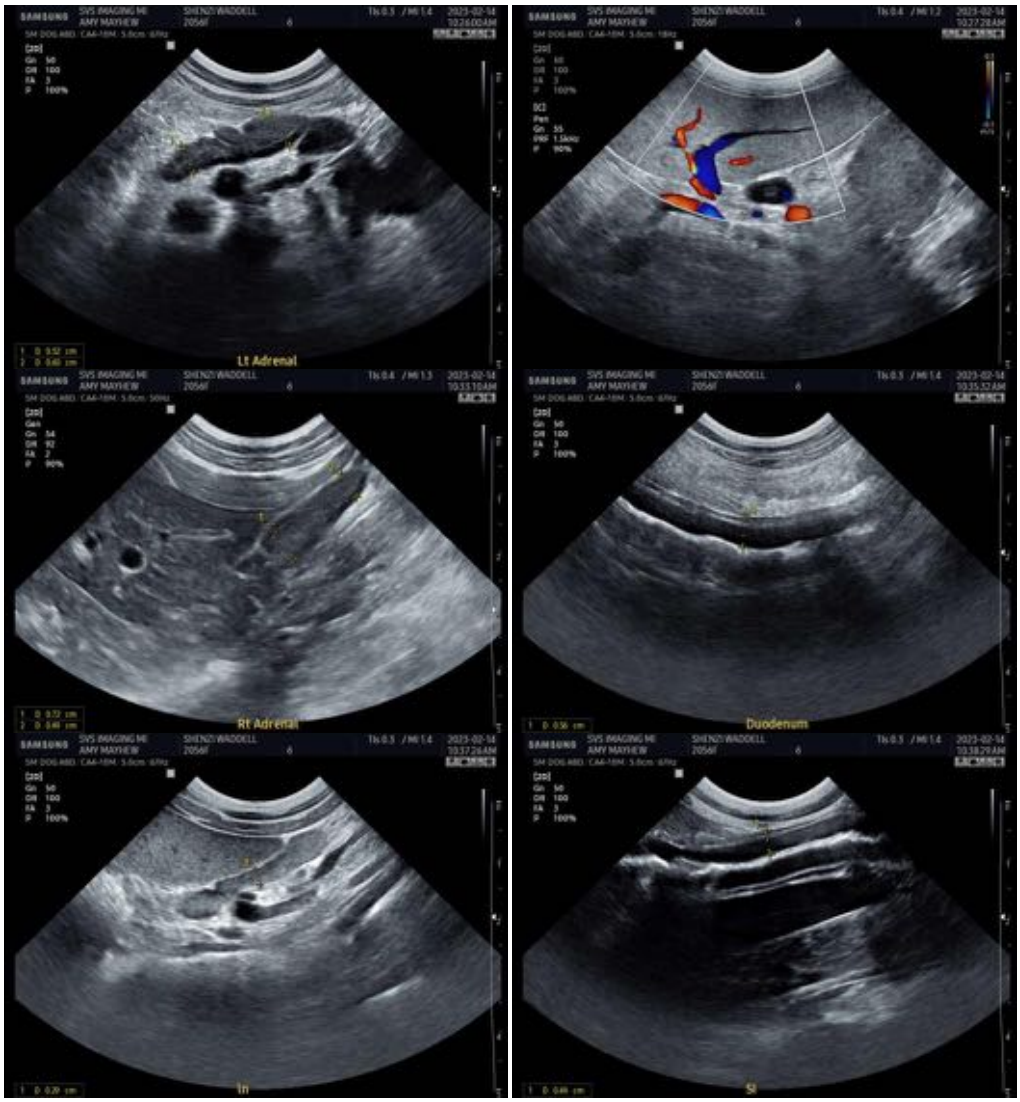
- 6 week limited antigen or hydrolyzed protein diet trial.
- Consider initiation of a probiotic.
- Depending on the results of the above diagnostics as well as the malabsorption panel, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis. Given the clinical history, an upper GI endoscopy is preferable to assess the esophageal mucosa and to evaluate for ulcers, etc.



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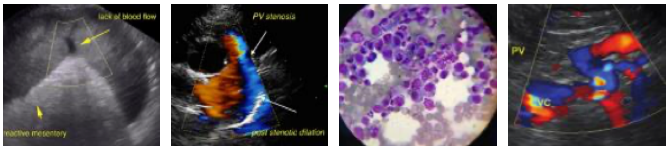

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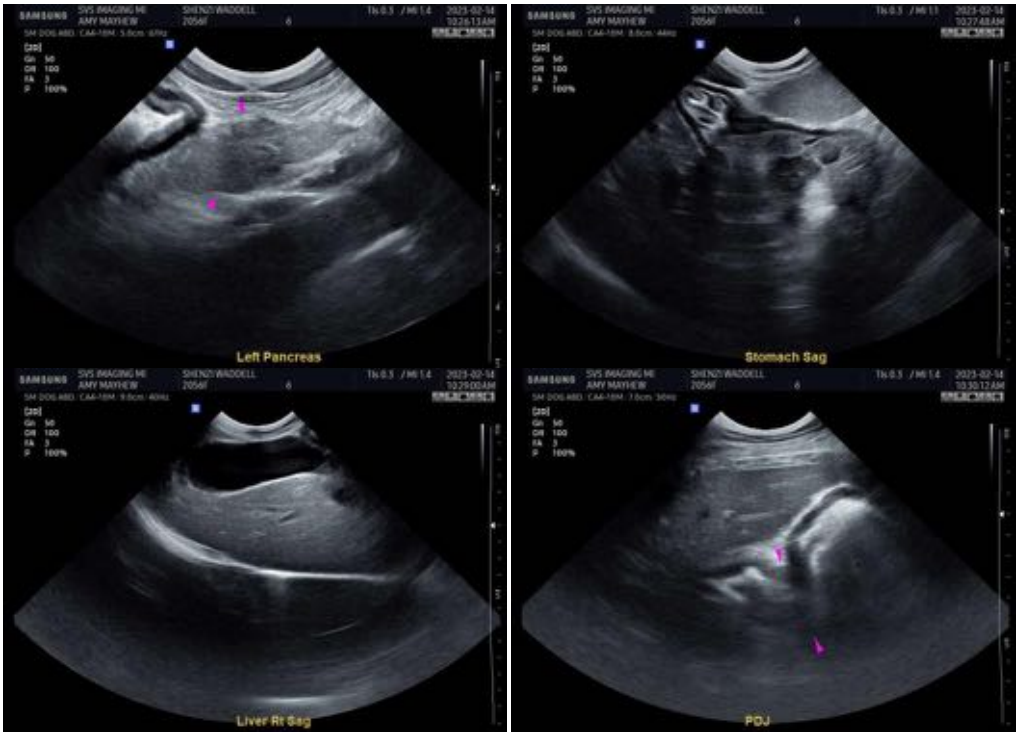

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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