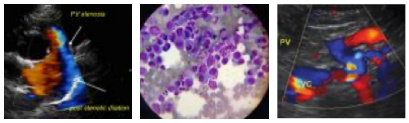
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

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DATE

3.6.23

PATIENT

Lennon Shipley

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

1/1/2014

WEIGHT

7.3 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal EH

REFERRING VET

Dr. King

INVOICE

12342

PRESENTING CLINICAL SIGNS

Vomiting, not eating, not drinking. Rads-- Mass effect in region of pancreas-- necrotizing vs mass vs other. Labs, hyperglycemia with large ketones, Azotemia BUN 66, creat __2.7__ phos 12.3, increase amyl/lipase, ALT 158, ALKP 328, Neutrophils only 1000, Increase in Monocytes. Severe DKA, pancreatitis, possible mass effect, and azotemia, Trace ketones --- slim chance of transient DM due to severe pancreatitis. Discussed This will require extensive treatment and time in hospital, possible that the pancreatitis and/or possible even mass will make management impossible. difficult to regulate, long term needs injections BID, and folllow up care with RDVM

Current Medications: Humulin R, Baytril, Cerenia, Protonix, Ampicillin, Buprenorphine.
Lab Results: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested by DVM.
Imaging Performed By: Andi Parkinson, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small to moderate amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. The region of the trigone is normal.

The left kidney is normal in size (4.76 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A few small cortical cysts are seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (4.41 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A few small cortical cysts are seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.59 cm at cranial pole) (0.54 cm at caudal pole) (1.76 cm in length) with a normal shape and 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 in normal size (0.66 cm at cranial pole) (0.45 cm at caudal pole) (1.49 cm in length) with a normal shape and 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

The spleen is normal in size (0.56 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 enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of mostly gravity dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. 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. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely enlarged with irregular peripheral contours. The parenchyma is heterogenous with several cystic to multi-septated cystic lesions throughout the organ, particularly in the left limb Surrounding mesentery is hyperechoic.

Free Abdomen

A small amount of free fluid is suspected. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes could be consistent with severe pancreatitis and/or pancreatic neoplasia. The cystic pancreatic lesions may represent benign cysts, necrotic areas or abscessed regions.

Secondary Findings

- The hepatic parenchymal changes are most consistent with a diabetic hepatopathy. However, inflammatory disease, hepatotoxicosis (i.e., copper), infiltrative neoplasia (i.e., lymphoma), other hepatopathy, cannot be excluded. Correlation with the patient's liver values is recommended.

- Mild bilateral age-related renal changes with cortical cysts

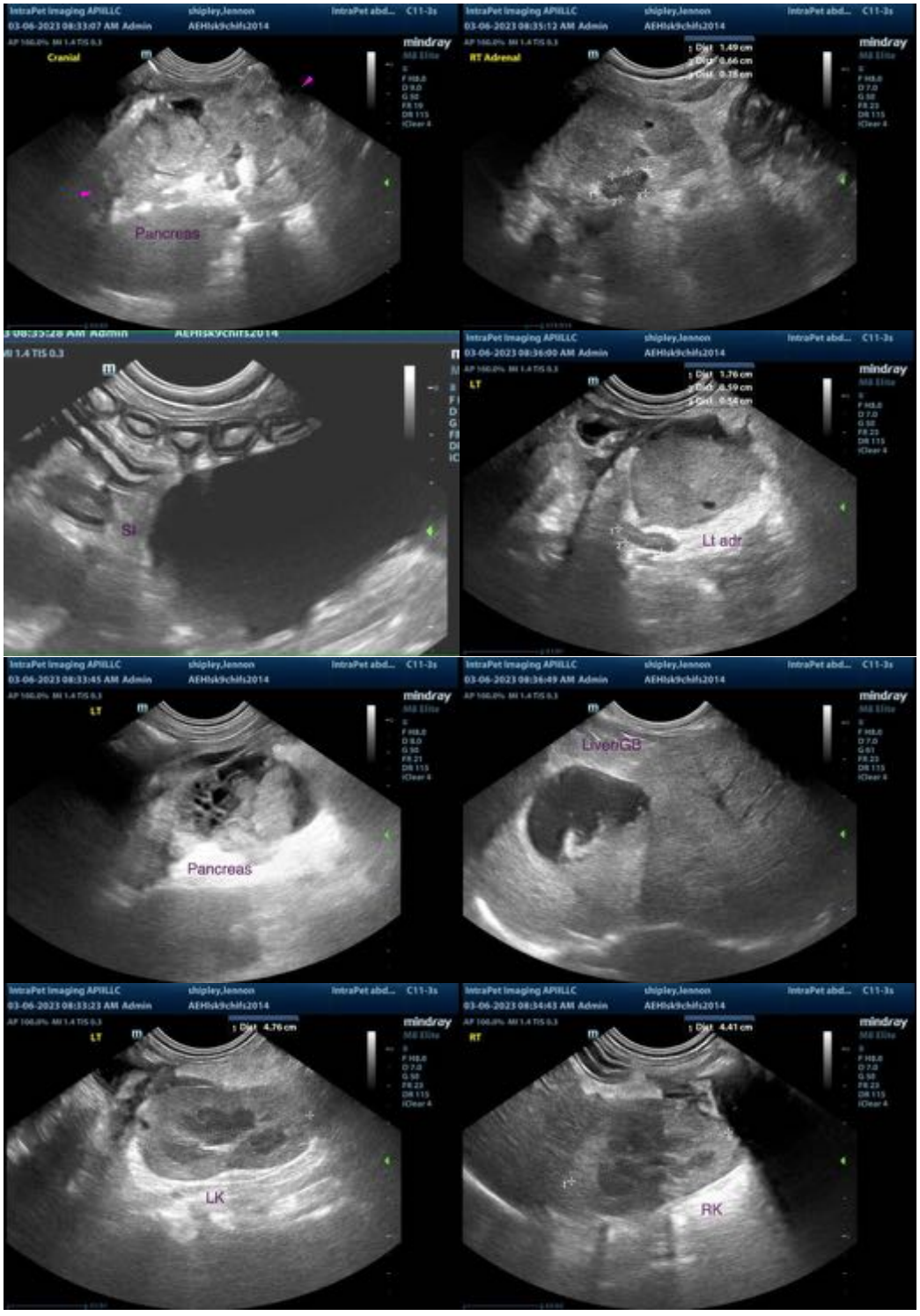
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Thoracic radiographs are recommended to assess cardiopulmonary status, particularly given the presence of severe pancreatitis and potential for secondary pulmonary/pleural pathology.

- Consider a fine-needle aspirate of the pancreas (if clotting status is appropriate). A 25-gauge needle should be used. Cytology and cultures should be submitted.

- Given the azotemia, a urinalysis with culture and sensitivity should also be considered with close monitoring for worsening renal values.

- Supportive care for diabetic ketoacidosis/severe pancreatitis is recommended while awaiting test results. IV fluid therapy, regular insulin, pain medication, GI protectants, +/- fresh frozen plasma should be administered. Also consider hyperbaric oxygen therapy (if available), as this may help to reduce pancreatic inflammation. Nutritional support (i.e., via trickle feeding) is also strongly recommended.


Cranial
Pancreas
RT Adrenal
SI
LT
Lt adr
Pancreas
LiverGB
LK
RK

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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