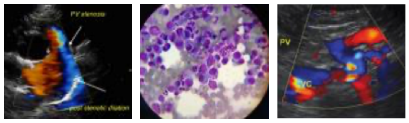
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

3.9.23

PATIENT

Sadie Harkins

SPECIES

Canine

BREED

Pitbull

SEX

Spayed Female

AGE

4/9/2012

WEIGHT

72.1lbs

INTERPRETED BY

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

HOSPITAL NAME

Animal EH

REFERRING VET

Dr. Saubier

INVOICE

12378

PRESENTING CLINICAL SIGNS

Owner adopted approx. 4 years ago. History of weakness in hind end. Two weeks ago seen at rDVM - BW, X-rays and ACTH stim performed. Diagnosed with arthritis, Cushing's disease. Low potassium Vetoryl K low - Rena- Plus Galliprant Episode of vomiting with aspiration around same time - treated for pneumonia. Had been improving and last several days seemed brighter able to stand / walk. This evening acutely down in hind end and able to walk. Has historically been eating well up until this evening.

Current Medications: None listed.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

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 distended with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (6.98 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The right kidney is normal in size (6.40 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

Adrenal Glands

The left adrenal gland is enlarged (1.22 cm at cranial pole) (1.59 cm at caudal pole) (3.85 cm in length) with a slightly irregular 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 mildly enlarged (0.88 cm at cranial pole) (1.08 cm at caudal pole) (3.29 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 subjectively normal in size (1.66 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is of appropriate echogenicity with a slightly mottled appearance and a coarse echotexture. No distinct focal lesions are observed. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature 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 moderate to large amount of aggregated echogenic, partially dependent sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. 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 enlarged with an irregular shape. The parenchyma is hypoechoic relative to surrounding omental fat and slightly mottled in appearance. A 2.67 cm round, anechoic structure is arising from the base/right limb and appears adhered to the gastric wall. The mesentery surrounding the pancreas is hyperechoic to saponified.

Free Abdomen

There is no obvious evidence of free fluid. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Moderate to severe pancreatitis. The anechoic area parenchyma could be consistent with a pancreatic abscess or cyst. Adjacent peritonitis is present.

Secondary Findings

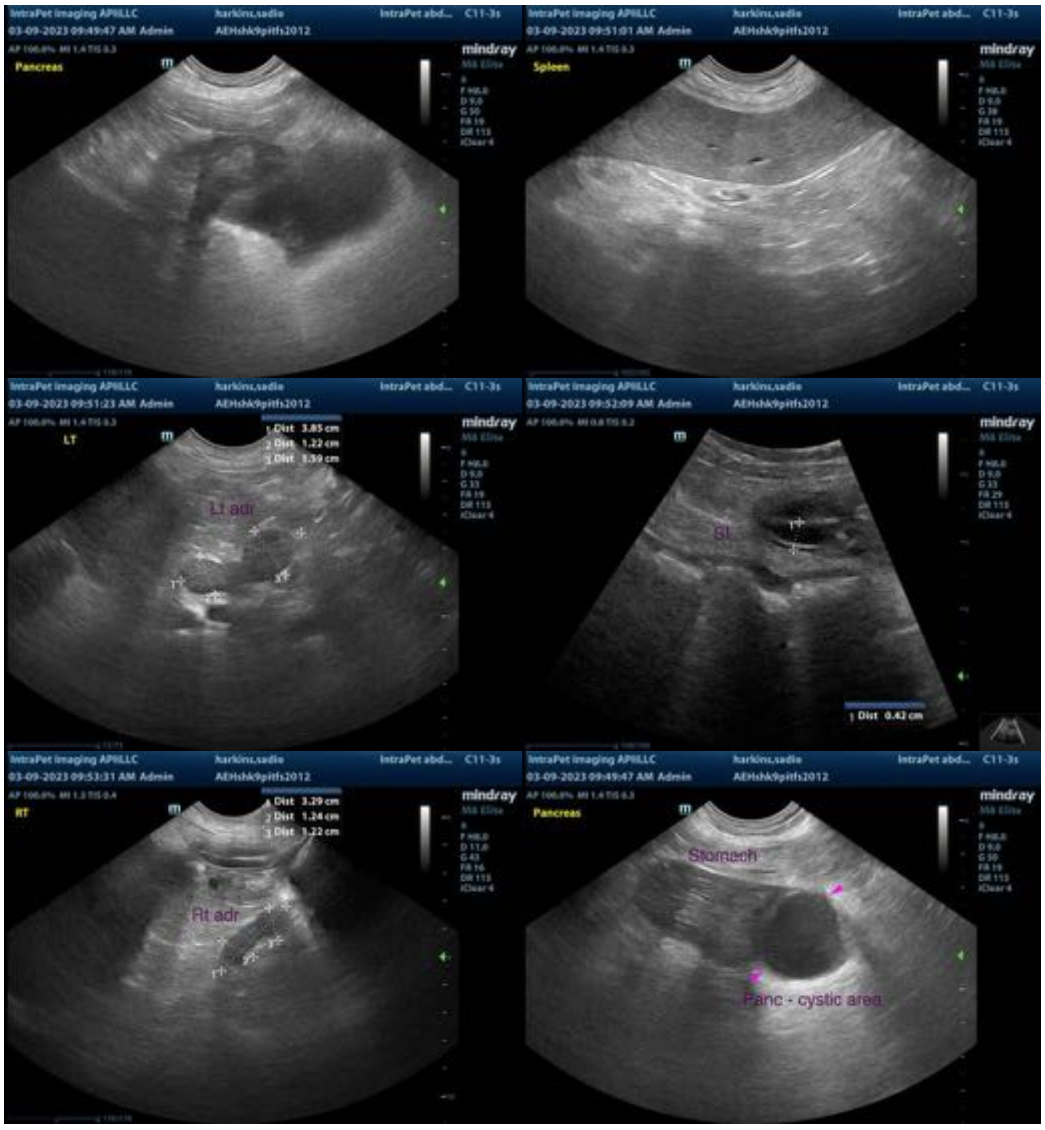
- The bilateral adrenomegaly is consistent with the previous diagnosis of pituitary-dependent hyperadrenocorticism.
- Mild bilateral age-related renal changes with dystrophic mineralization
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- 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. Correlation with the patient's liver values is recommended.

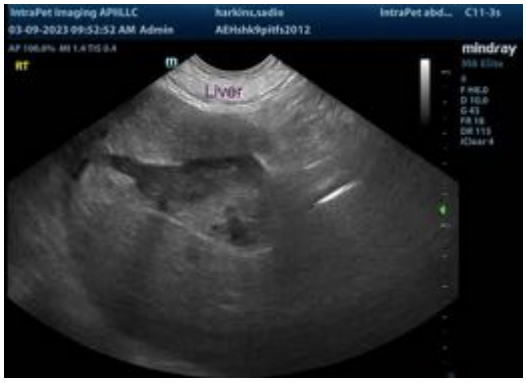
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a fine-needle aspirate of the anechoic structure in the pancreas, if accessible and if clotting status is appropriate. A 25-gauge needle should be used. Samples should be submitted for cytology along with aerobic and anaerobic bile cultures. If aspiration is not performed at this time, serial sonographic monitoring (i.e., daily) of the pancreas is recommended to assess for progression.

- Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma. Nutritional support (i.e., trickle feeding) should be initiated, when tolerated. If available, hyperbaric oxygen therapy may be beneficial in reducing pancreatic inflammation.

- Thoracic radiographs are recommended to assess cardiopulmonary status.





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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