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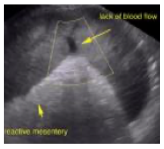
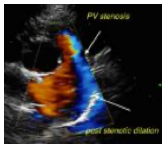
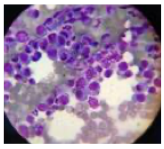
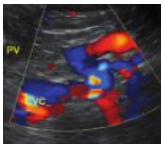
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Bella Wilson

SPECIES
Canine

BREED
Shih Tzu

SEX
Spayed Female

AGE
12 years

WEIGHT
8.6 kg

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

IMAGING PERFORMED BY
Erin Wicks

HOSPITAL NAME
Shores Veterinary EC

REFERRING VET
Dr Miller

INVOICE
12729

DATE
4.10.23

PRESENTING CLINICAL SIGNS

History: Presented at our hospital for vomiting; stumbling/unsteady after vomiting. Restless, panting, abdominal pain. Possible ate rabbit feces in yard yesterday.
Previous Health Concerns: IVDD surgery 3 years ago, pancreatitis

Abnormal PE/Chem/CBC/UA Results
Abdominal: Tender on palpation
cPL – strongly abnormal
EPOC – Lactate (3.23)
Liver – ALT (>1000) ALP (>993) GGT (51)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A 0.53 cm cystic calculus is observed within the lumen, along with a scant amount of suspended echogenic debris. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.70 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Several nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.29 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Several nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.74 cm at cranial pole) (0.84 cm at caudal pole) (2.58 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 mildly enlarged (1.35 cm at cranial pole) (0.79 cm at caudal pole) 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.

Spleen

The spleen is normal in size (1.29 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few small, ill-defined myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is prominent in size with normal curvilinear peripheral contours. The parenchyma is isoechoic 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 is distended. The wall is normal in thickness. A moderate to large amount of aggregated, echogenic suspended sludge in a partially stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen. The mesentery surrounding the gall bladder is hyperechoic/reactive.

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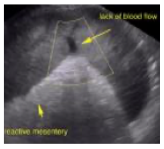
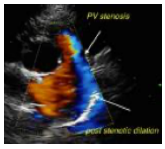
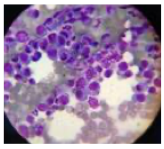
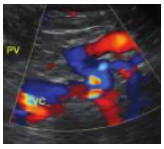

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Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is minimally fluid-distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness 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 base/right limb is prominent in size with irregular peripheral contours. The parenchyma is hypoechoic-to-heterogenous and mottled in appearance. The pancreatic duct is not overtly dilated. Surrounding mesentery is mildly hypoechoic.

Free Abdomen
The mesentery in the cranial abdomen is hyperechoic. Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gall bladder changes are consistent with a mucocele with adjacent peritonitis. Concurrent cholecystitis is suspected. There is no obvious evidence of rupture. However, previous rupture cannot be completely excluded.
- The hepatic parenchymal changes are nonspecific and could be secondary to inflammatory disease (i.e., bacterial cholangiohepatitis, chronic hepatitis), hepatotoxicosis (i.e., copper), vacuolar hepatopathy, other hepatopathy.
- The pancreatic changes are suggestive chronic active pancreatitis.
- Cystic calculus

Secondary Findings

- Mild bilateral adrenomegaly
- Bilateral chronic renal changes with nonobstructive nephrolithiasis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- An abdominal exploratory with cholecystectomy and liver biopsies should be considered (if the patient's clinical condition is stable). Thoracic radiographs and clotting times should be performed prior to anesthesia. If surgery is not pursued at this time, empirical treatment for cholecystitis/cholangiohepatitis/pancreatitis/gall bladder mucocele is recommended, including broad-spectrum antibiotics, hepatic antioxidants and Ursodiol therapy, with close sonographic monitoring of the gall bladder to assess progression. If the patient's clinical signs and/or liver values do not improve with supportive measures, surgery should be considered. If surgery is pursued, a cystotomy with stone removal, analysis and culture is recommended.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.

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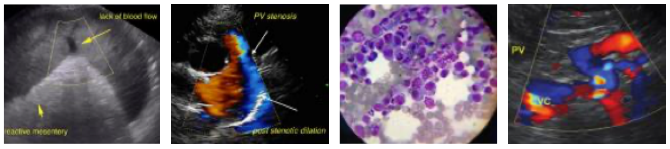

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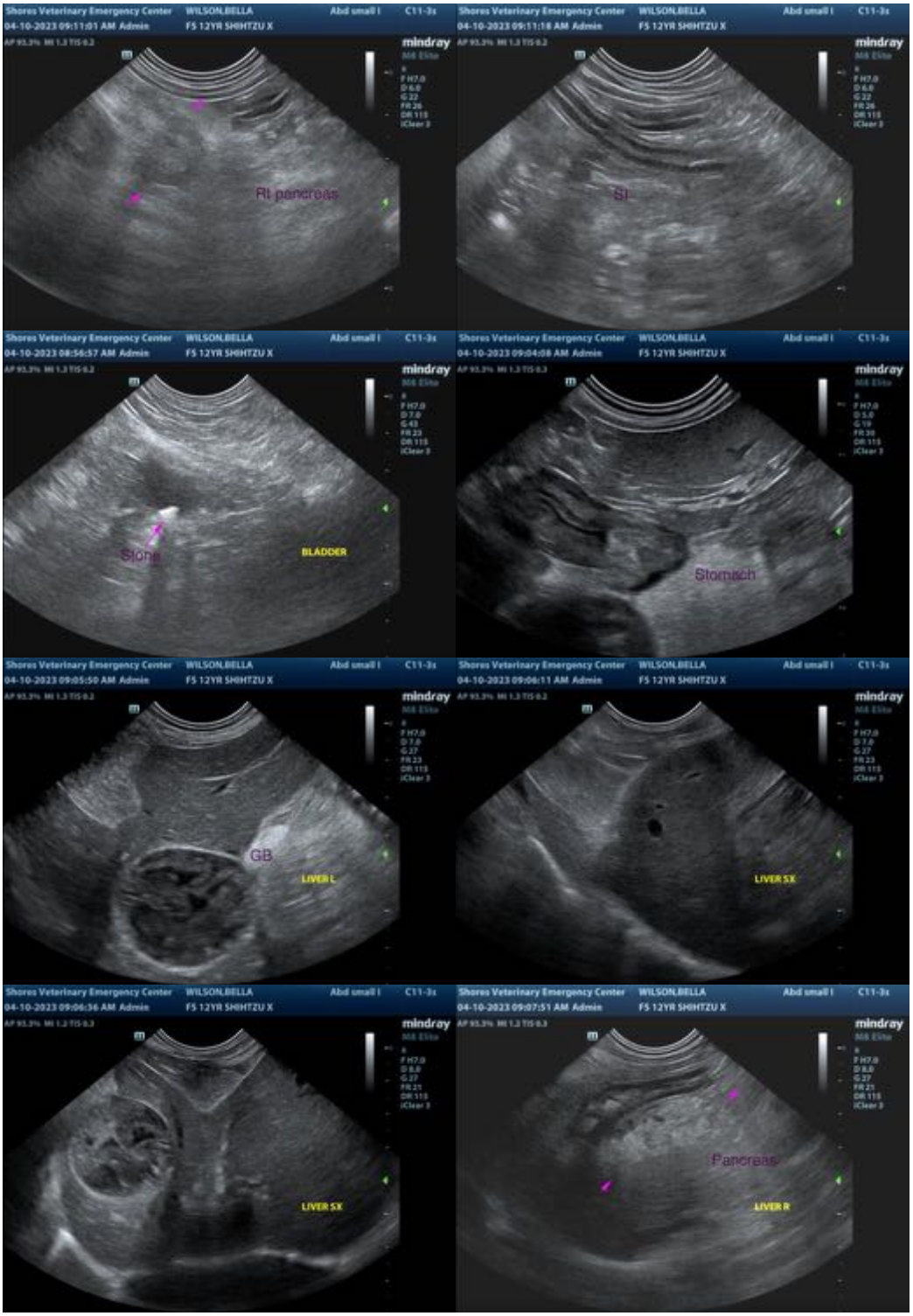

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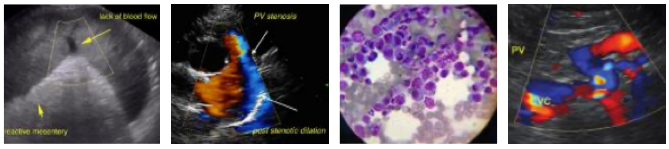

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com