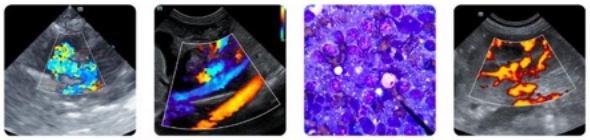

PATIENT

Charlie Dise

SPECIES

Canine

BREED

Yorki/Bichon

SEX

Male, neutered

AGE

5 Yrs.

WEIGHT

17.8 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Vincent Tavella

HOSPITAL NAME

Williamsburg VC

REFERRING VET

Dr. Vincent Tavella

INVOICE

13652

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PRESENTING CLINICAL SIGNS

History: Increased sleeping and drinking noted for a few weeks. No major changes to diet or environment. Abdomen painful to touch. Decreased weight (4 pounds) Abnormal PE/Chem/CBC/UA Results: PE: Abdominal Discomfort. Dehydration. Chem: PrecisionPSL is severely elevated at 598 U/L (Reference: 24-140). Amylase is also high at 1421 IU/L (Reference: 290-1125). These results are strongly supportive of a diagnosis of pancreatitis. Triglycerides are critically high at 1687 mg/dL (Reference: 29-291). Glucose is also very high at 382 mg/dL (Reference: 70-138 Liver Enzyme: Alk Phos is elevated at 192 IU/L (Reference: 5-131). Phosphorus is slightly high at 6.4 mg/dL (Reference: 2.5-6.0). Magnesium is high at 4.3 mEq/L (Reference: 1.5-2.5). Chloride is low at 99 mEq/L (Reference: 102-120), CBC: Total WBC is elevated at 16.2 x10^3 (Reference: 4.0-15.5). The Platelet Count is high at 578 x10^3 (Reference: 170-400), Urinalysis: Protein (3+) in the urine. USG 1.023. No glucosuria.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended. The wall is of appropriate thickness for the level of repletion. The mucosal surface is slightly irregular. Gravity-dependent mineralized sand with tiny calculi are observed within the lumen. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney is subjectively normal in size 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 hyperechoic medullary band is observed at the corticomedullary junction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.93 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 hyperechoic medullary band is observed at the corticomedullary junction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.58 cm at cranial pole) (0.56 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

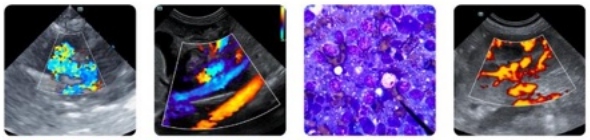
The right adrenal gland is mildly enlarged (0.77 cm at cranial pole) (0.57 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.23 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.



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

Gastrointestinal

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 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 pancreas is diffusely enlarged, particularly the left limb and base. The peripheral contours are swollen. The parenchyma is hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is not overtly dilated. Surrounding mesentery is hyperechoic to saponified. Peripancreatic effusion is observed.

Lymph nodes

2-3 prominent mid-abdominal lymph nodes are visualized, one of the nodes measuring 1.33 x 0.77 cm.

Free Abdomen

A small amount of free fluid is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pancreatic changes are consistent with severe acute pancreatitis with adjacent peritonitis+/- saponification of fat.
- Urinary bladder sand with tiny cystic calculi

Secondary Findings:

- The hepatic changes are most consistent with a diabetic hepatopathy. Other considerations include vacuolar hepatopathy, inflammatory disease, infiltrative neoplasia (less likely) and/or other hepatopathy.
- Gallbladder debris, non-mucocele
- Mild bilateral adrenomegaly
- Bilateral renal changes are most consistent with a diabetic nephropathy.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma +/- fuzapladib.
2. A repeat urinalysis is recommended to assess for glucosuria (and ketonuria), as the degree of hyperglycemia in conjunction with the absence of glucosuria represents discordant results. A

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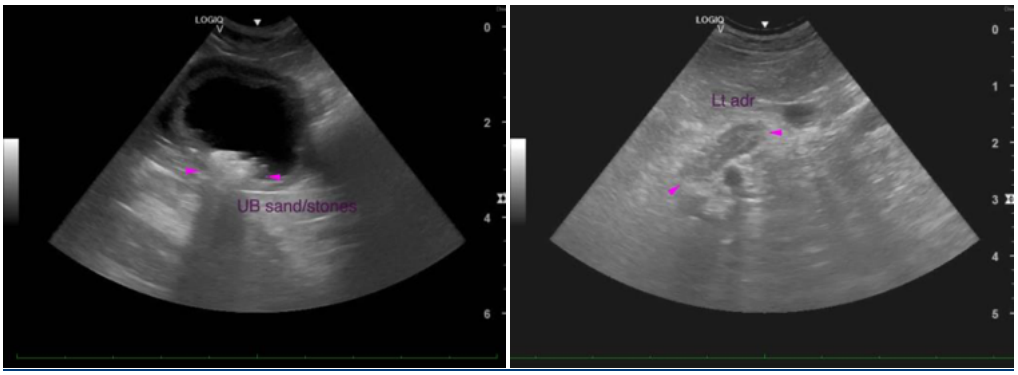
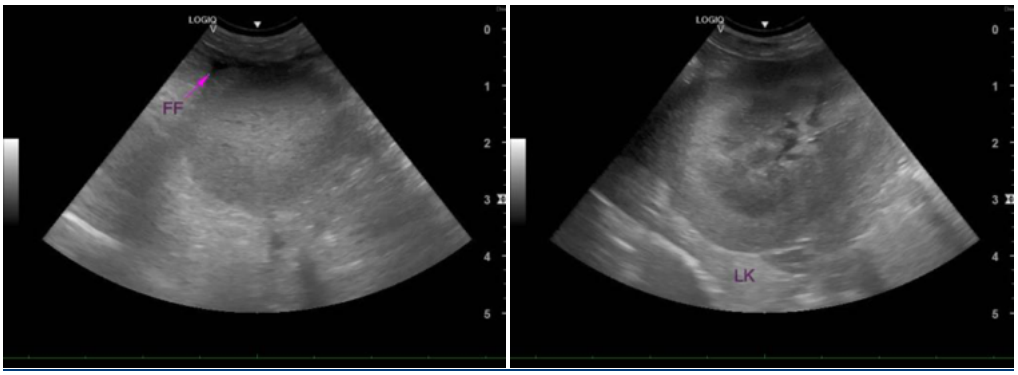
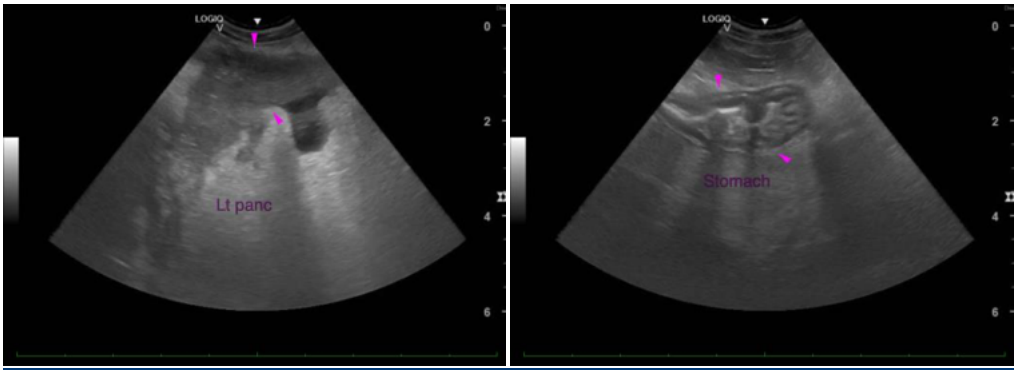
urine culture and sensitivity should also be considered to assess for occult infection.

3. Consider a UPC if proteinuria persists in the absence of infection.
4. Three-view thoracic radiographs are also recommended to assess cardiopulmonary status as pancreatitis can have systemic effects.
5. 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.
6. Regarding the urinary bladder stones/sand, consider a cystotomy with stone removal analysis and culture once the patient's current clinical condition has stabilized. Alternatively, an attempt at medical dissolution can be considered.







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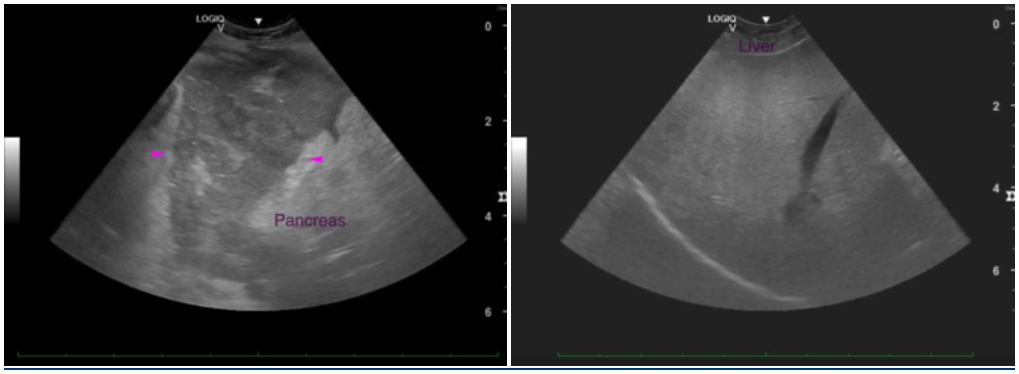

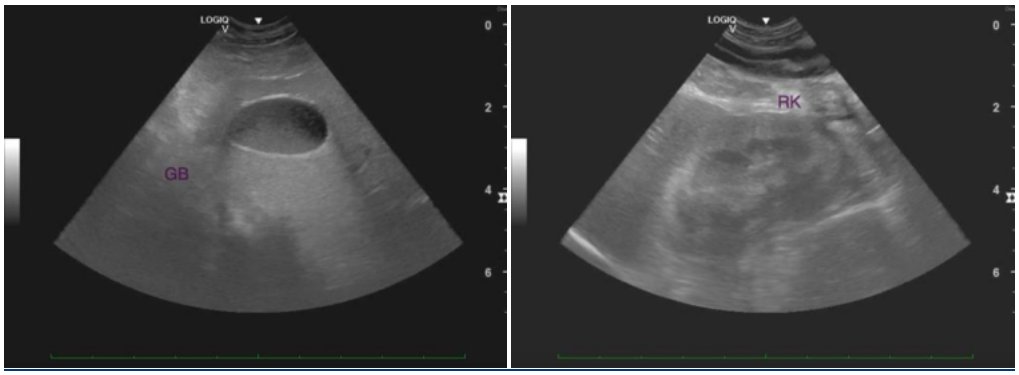

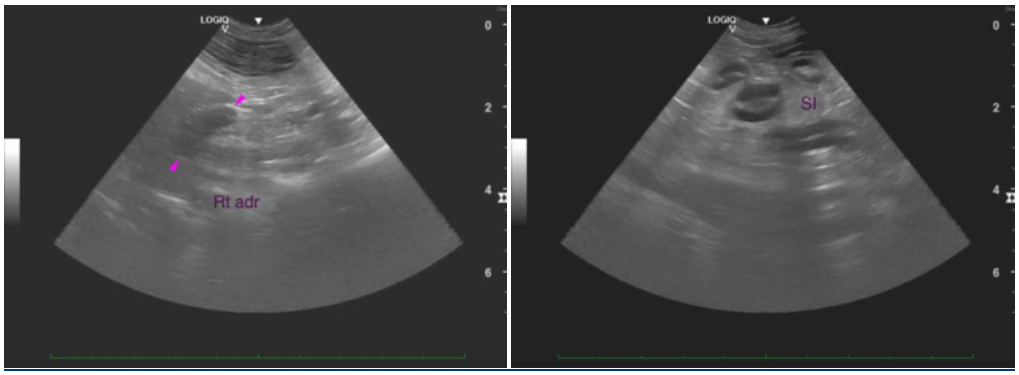

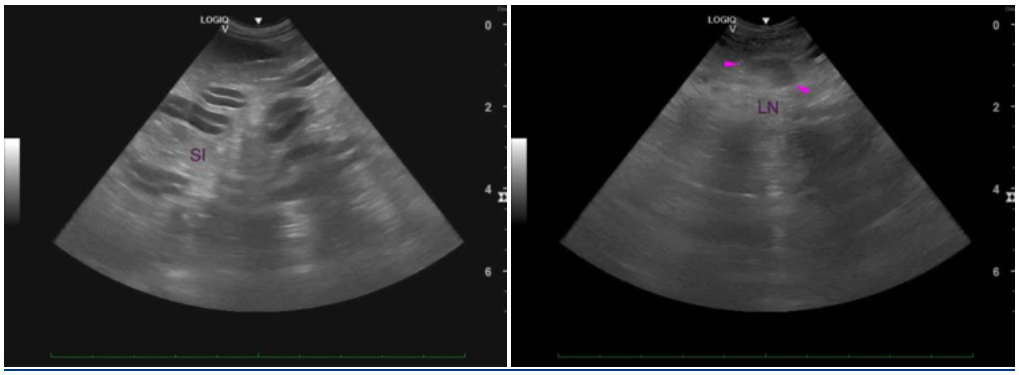

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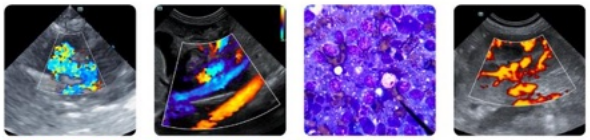

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Educational Teleconsultation Services™

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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