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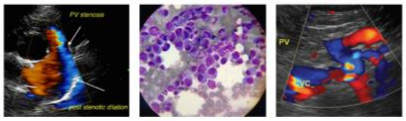
SVS IMAGING



SonoPath
Clinical Sonography & Telecytology
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PATIENT

Captain Miller

SPECIES

Canine

BREED

Terrier Mix

SEX

Neutered Male

AGE

7 years

WEIGHT

17.8 lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

New Berlin AH, Dr. Sobon

INVOICE

10720

DATE

4/8/22

PRESENTING CLINICAL SIGNS

History: Diabetic patient, vomiting, cranial ab pain, ketones in urine (not getting insulin due to vomiting) and now a fever of 103.6

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are 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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.70 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney presented normal size (6.13 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 presented normal size (5.21 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 mildly enlarged (0.44 cm at cranial pole) (0.66 cm at caudal pole) (1.92 cm in length); 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 mildly enlarged (0.53 cm at cranial pole) (0.61 cm at caudal pole) (1.80 cm in length); 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

The spleen is normal in size (1.57 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.52 cm irregular, hypoechoic nodule is visualized at the craniolateral aspect. 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 portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

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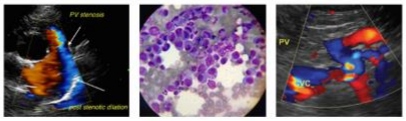

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Gastrointestinal

The gastric lumen is mildly distended with ingesta. 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 is normal in thickness with a normal layering pattern. There is evidence of mucosal speckling in some segments. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The body/right limb is enlarged with swollen peripheral contours. The parenchyma is heterogenous in appearance. No distinct focal lesions are observed. surrounding mesentery is hyperechoic

Free Abdomen

Trace free fluid is observed. A 1.50 cm medial iliac lymph node is visualized. A 0.66 cm gastric lymph node is also seen, as well as a 1.41 cm mesenteric node.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are consistent with moderate to severe pancreatitis with regional peritonitis.

Secondary Findings

- The bilateral renal changes are consistent with a diabetic nephropathy. The trace pyelectasia may be secondary to fluid therapy, PU/PD, and/or pyelonephritis. Correlation with clinical findings is recommended.
- Mild, bilateral adrenomegaly
- The splenic nodule could be consistent with a benign process (i.e., focus of lymphoid hyperplasia, extramedullary hematopoiesis or splenitis). Alternatively, an emerging tumor is possible.
- The small intestinal mucosal speckling can be associated with enteritis. However, correlation with the patient's clinical history should be considered.
- 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

- Supportive care for diabetic ketoacidosis and pancreatitis is recommended, including fluid therapy, regular insulin, gastric protectants, antiemetics, pain medication, +/- fresh frozen plasma. Consider initation of trickle feeling, as soon as the patient will tolerate it as this will help to maintain enterocyte health.
- Given the diabetic ketoacidotic status, also consider a urine culture and sensitivity.
- Three-view thoracic radiographs should also be considered as pancreatitis can have pulmonary effects.

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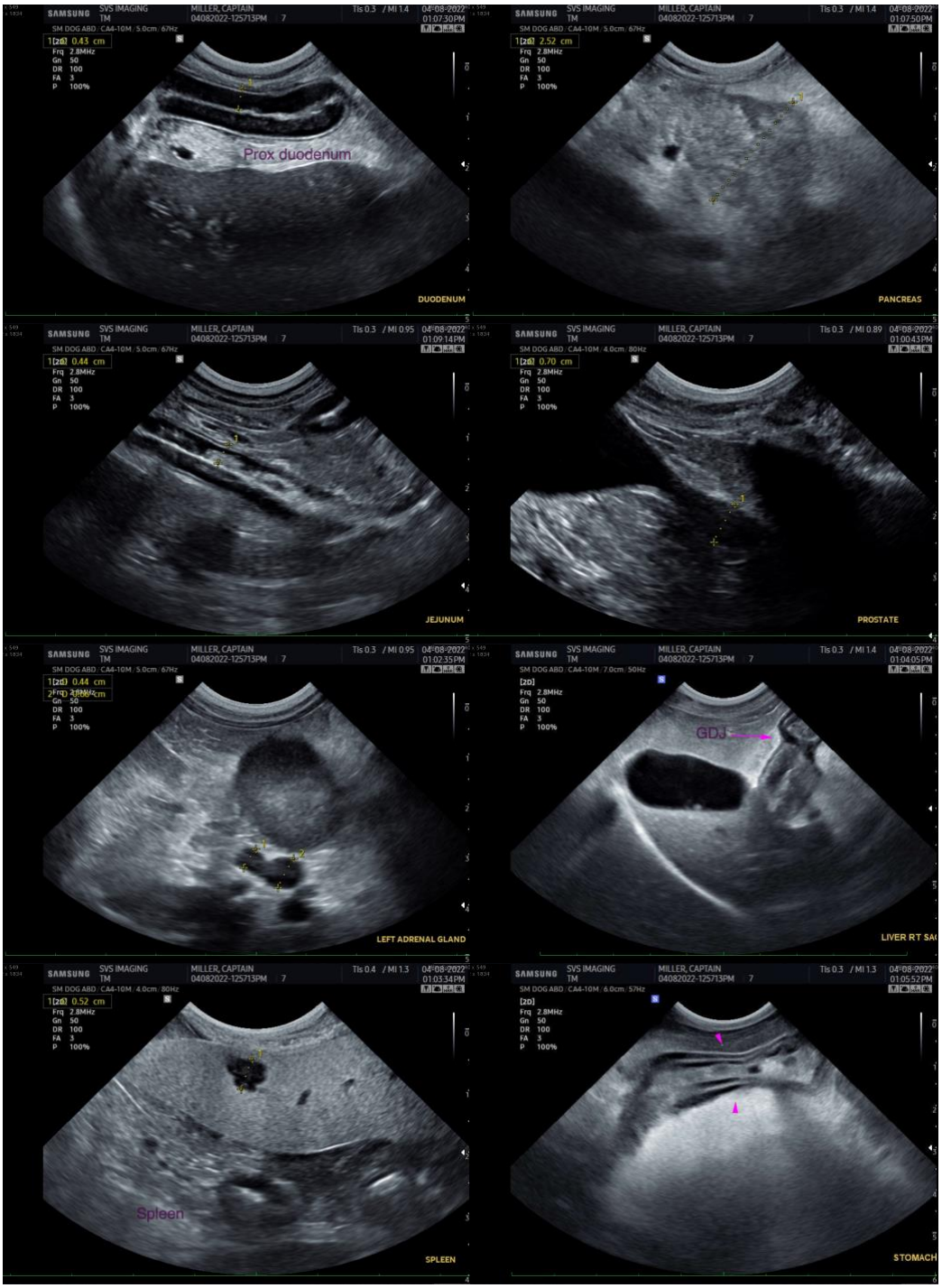
- Regarding the splenic nodule, serial sonographic monitoring (i.e., every 2-3 months) is recommended to assess for growth.



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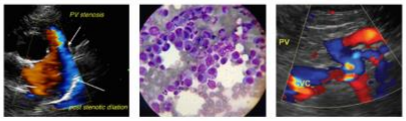

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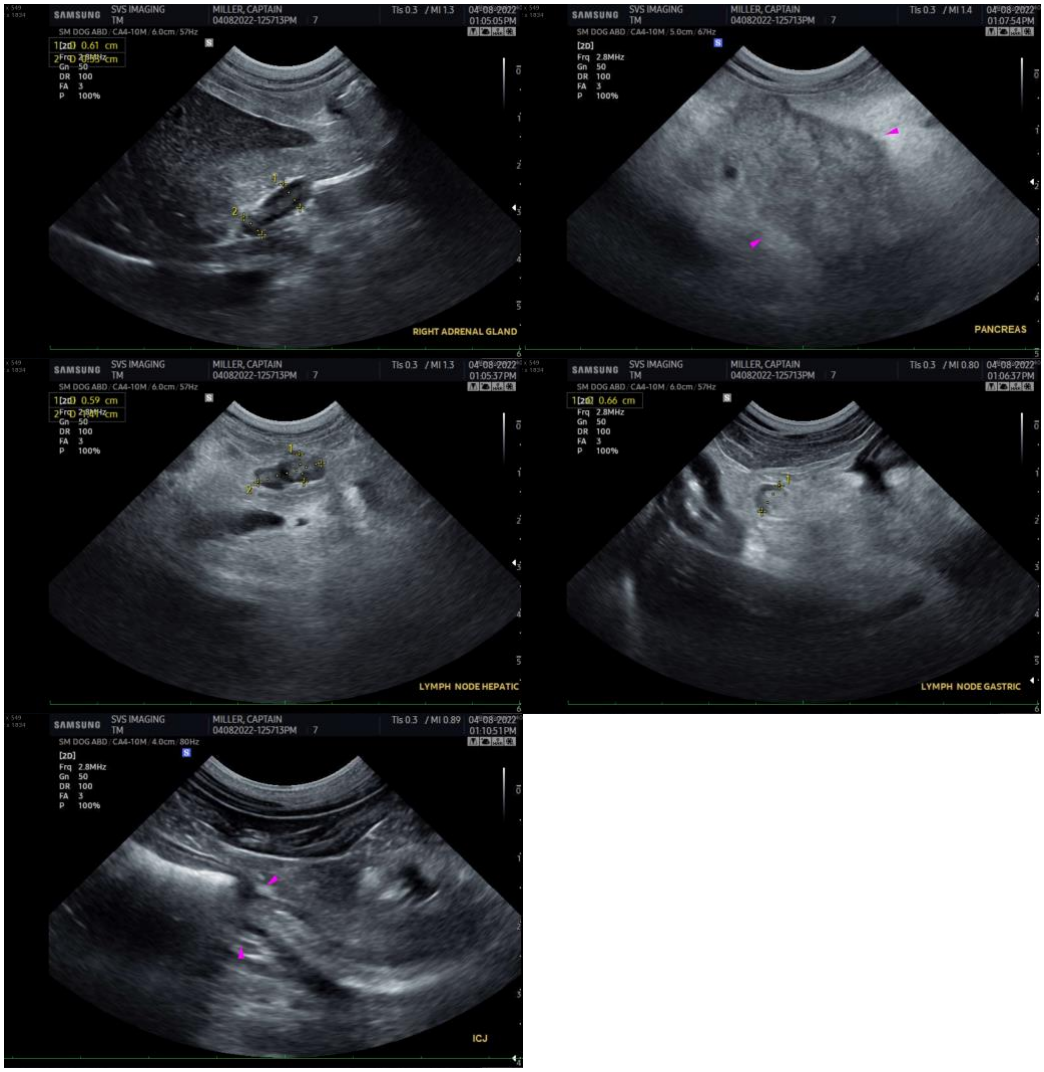

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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