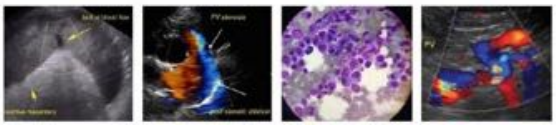


PATIENT

Molly Edwards

SPECIES

Canine

BREED

Terrier X

SEX

Spayed Female

AGE

10 years

WEIGHT

8.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Hamilton Region VEC

REFERRING VET

Rosca

INVOICE

12917

DATE

5.1.23

PRESENTING CLINICAL SIGNS

History: Admitted for treatment of DKA *Since admission glucose values ranging in teens, 17-13. *Cysto 420 mLs urine at 5:45 am to relieve as not urinating outside, no suspicion of obstruction. *Temps in the 39.2 range overnight. *Previous pancreatitis, hepatomegaly, stifle degeneration (possible cruciate); lymphopenia, increased bilirubin and cholesterol. *Management of pancreatitis to help regulate diabetes, painful abdomen therefore CRI fentanyl *Recommend abdominal ultrasound available Mond Current Medications HMED Pantoprazole 2023-04-29 Mirtazapine 15mg 2023-04-29 HMED Ampicillin 1g 2023-04-29 Fentanyl Injection per 1mL 2023-04-29 Cerenia (Maropitant) Injection per mL 2023-04-29 Vitamin B12 Inj 5000mcg 1mL 2023-04-29 Methadone HCL (Comfortan) Inj per 1 mL 2023-04-29

Abnormal PE/Chem/CBC/UA Results: please see attached labs and rads.

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. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (5.96 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.60 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. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.49 cm at cranial pole) (0.55 cm at caudal pole) (2.09 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 appears normal.

The right adrenal gland is in normal size (1.53 cm at cranial pole) (0.54 cm at caudal pole) (1.68 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 appears normal.

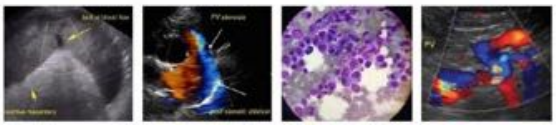
Spleen

The spleen is subjectively normal in size with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively enlarged with slightly swollen 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 lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of aggregated, echogenic, gravity-dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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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 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 with irregular peripheral contours. The parenchyma is hypoechoic and edematous. The pancreatic duct is not overtly dilated. The surrounding mesentery is hyperechoic to saponified.

Free Abdomen

The mesentery throughout the abdomen is hyperechoic. A small amount of free fluid is observed. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are most consistent with moderate to severe acute pancreatitis Regional peritonitis is present.

Secondary Findings

- The hepatic parenchymal changes are most consistent with a diabetic hepatopathy. However, inflammatory disease or infiltrative neoplasia cannot be completely excluded. Correlation with the patient's liver values is recommended.
- Bilateral chronic age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Supportive care for diabetic ketoacidosis and acute pancreatitis is recommended, including regular insulin, IV fluid therapy, pain management, gastric protectants, +/- fresh frozen plasma. If available, hyperbaric oxygen therapy may be useful in reducing pancreatic inflammation. Nutritional support (i.e., via trickle feeding) should be initiated as soon as the patient will tolerate it, as this will help to maintain enterocyte health.
- Three-view thoracic radiographs are recommended to assess cardiopulmonary status, as moderate to severe cases of pancreatitis can result in pulmonary/pleural pathology.
- Serial sonographic monitoring (i.e., daily) of the patient's pancreas is recommended to assess for the development of abscesses.
- Close monitoring of the patient's organ function is also recommended to assess for the development of metabolic dysfunction.

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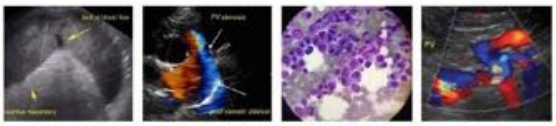

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IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

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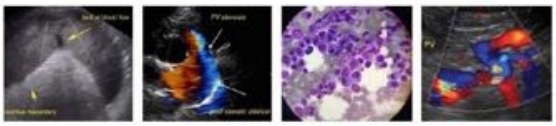
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance, please contact me.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com