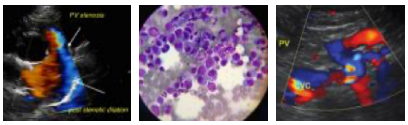
IMAGING PERFORMED BY

IntraPet.com



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DATE
8/22/23

PATIENT

Charlie Delbrook

SPECIES

Canine

BREED

Australian shepherd

SEX

Male, neutered

AGE
9/22/2010

WEIGHT

70.5 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Hicks

INVOICE

15209

PRESENTING CLINICAL SIGNS

O reports that on Friday night P did not eat all of his dinner, O had started Gabapentin due to mobility issues. Saturday P did not eat or drink, O tried to give Gabapentin in baby food but P vomited up the baby food and Gabapentin. O syringe feeding broth and water, wouldn't take anything else.
Sunday P was drinking on his own but started with diarrhea. Ate chicken on Sunday but had diarrhea overnight night. Hx pancreatitis, & hypothyroid (thyro tabs 0.8mg BID) - on meds - on Previcox for arthritis - rDVM directed to discontinue - last dose given Friday.

Current Medications: Proviabel, Buprenorphine, Cerenia, Ondansetron, Entyce.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Patient sedated with Torbugesic.
ALT 155, CBC WNL
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 is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.90 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (7.50 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. The cortex is isoechoic relative to the spleen with pinpoint hyperechoic foci. There is 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 size (7.22 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. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.39 cm at cranial pole) (0.61 cm at caudal pole) (2.47 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 normal size (0.68 cm at cranial pole) (0.62 cm at caudal pole) (2.90 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 (2.37 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 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 gall bladder lumen is moderately distended. The wall is thin and

smooth. A moderate amount of aggregated echogenic partially dependent to suspended debris in a partially stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 thickness is normal. There is disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion. See *Other.*

Free Abdomen

Trace free fluid is observed. A 1.96 x 0.79 cm sublumbar lymph node is visualized. The node is normal in shape and echogenicity.

Other

A 9.06 x 8.51 cm septated cystic mass is observed in the left cranial to mid-abdomen. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Left cranial to mid cystic mass, the origin of which is unclear. It may be arising from pancreas, mesentery, lymph node, spleen (less likely), other. Differentials include cystic or necrotic tumor, abscess, benign cyst, other. Adjacent peritonitis is present.

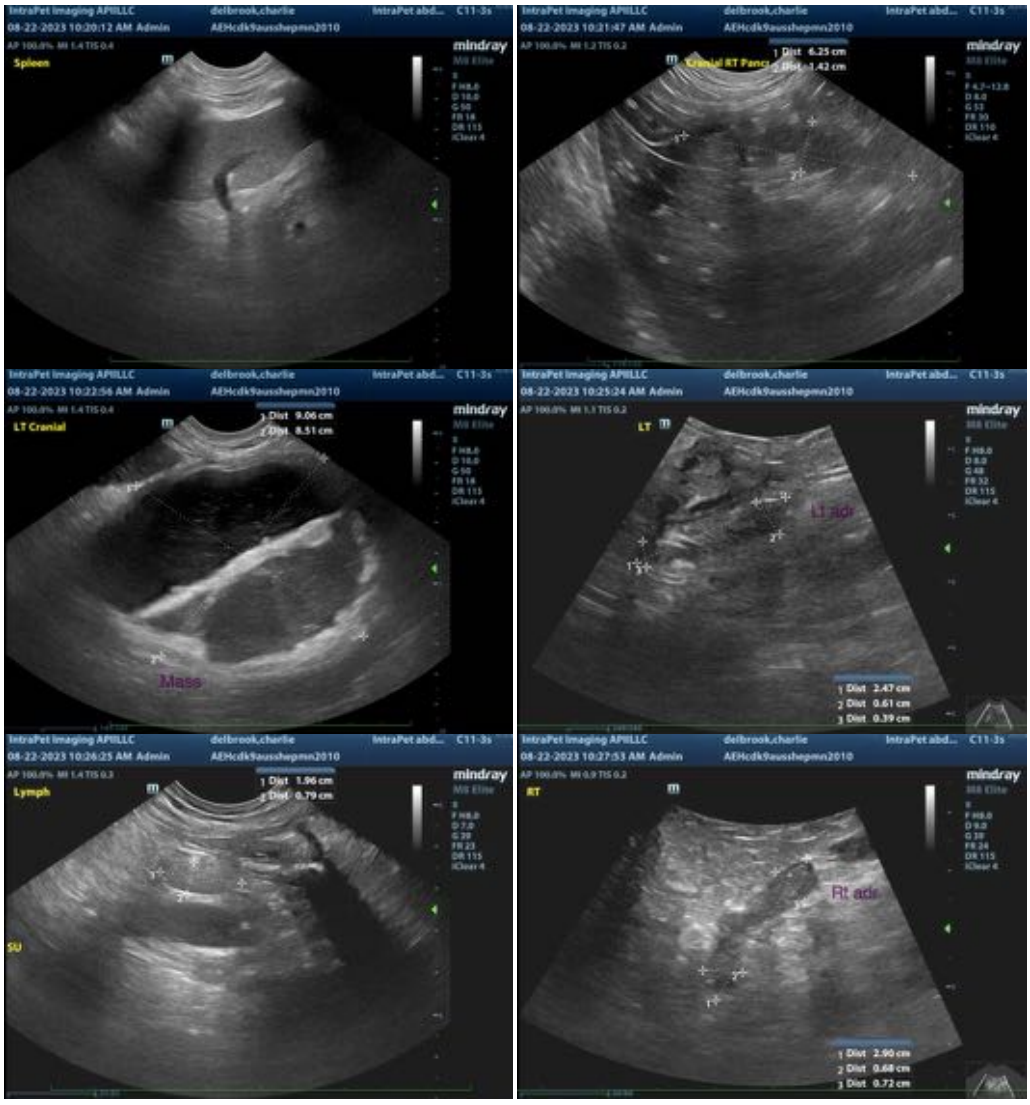
Secondary Findings:

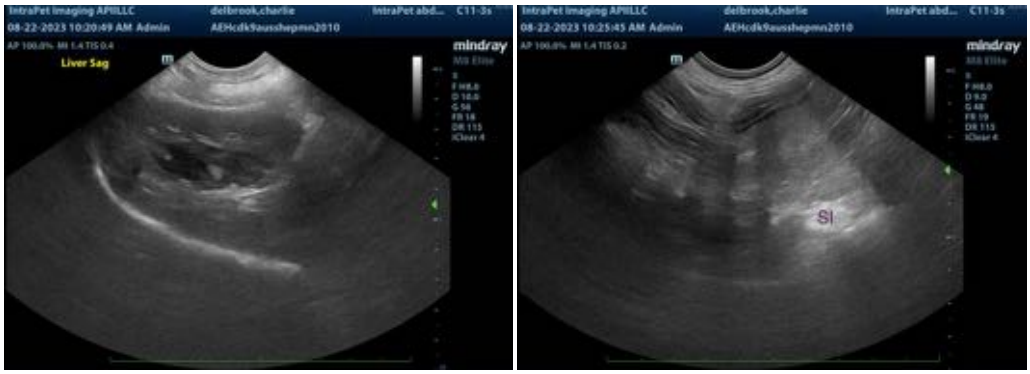
- Bilateral chronic age-related renal changes with subtle dystrophic mineralization.
- The gallbladder changes are consistent with an emerging mucocele.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The small intestinal wall changes could be consistent with inflammatory bowel disease or may be a normal variant for this patient. Correlation with the patient's clinical history is recommended.
- The prominent sublumbar lymph node is likely reactive with a lower possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

- Consider an abdominal CT scan to better characterize the abdominal mass. Alternatively, an abdominal exploratory with mass removal and submission for histopathology and cultures (aerobic and anaerobic) can be considered. If surgery is pursued, the gallbladder should be assessed for a mucocele +/- removed. If a cholecystectomy is not performed, consider initiation of Ursodiol therapy with serial sonographic monitoring (i.e., every 6-8 weeks) to assess for a progression to a fully formed mucocele.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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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