



PATIENT PRESENTING CLINICAL SIGNS

Jack Jack Vincent

History: Presented for acute vomiting and lethargy. Patient is diabetic, clinical signs seem well controlled at home per owner. Has lost 3lbs in past 8 months. On exam he was BAR, TPR within normal. Est 5% dehydrated. Normal stool on rectal. No pain on abdominal palpation. Snap CPL normal. Lepto panel pending. Started on Clavamox 15mg/kg BID and Baytril 11mg/kg SID.

SPECIES

Canine

BREED

Mini Pinscher

SEX

Neutered Male

AGE

6 years

WEIGHT

13 lbs

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 prostate is normal in size (0.63 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 (5.00 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. An ill-defined hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (4.82 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. An ill-defined hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is enlarged (0.47 cm at cranial pole) (0.71 cm at caudal pole) with a prominent caudal pole. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is upper limits of normal size (0.46 cm at cranial pole) (0.53 cm at caudal pole) 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.

Spleen

The spleen is normal in size (1.05 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 prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is distended. The wall is thickened (up to 0.25 cm) and slightly irregular. A large amount of echogenic-to-mineralized, consolidated sludge with some linear striations is observed within the lumen. Most of the sludge is suspended, and some is adhered to the luminal surface. A 0.42 cm cholelith is also seen. The mesentery surrounding the gallbladder is hyperechoic. The cystic and common bile ducts are normal/not seen.

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Falmouth AH

REFERRING VET

Jennifer Switzer,
DVM

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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly to moderately 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 segmentally dilated with chyme. 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. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

There is no obvious evidence of free fluid. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gallbladder changes could be consistent with an emerging mucocele or cholestasis. A nonobstructive cholelith is also present. Concurrent cholecystitis is suspected with adjacent peritonitis.
- The hepatic parenchymal changes are nonspecific and may be secondary to an inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, chronic hepatitis), copper hepatotoxicosis, regenerative nodular hyperplasia, vacuolar hepatopathy, other hepatopathy, or some combination thereof.

Secondary Findings

- Mild bilateral adrenomegaly
- Bilateral chronic renal changes
- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A cholecystectomy with submission for histopathology as well as aerobic and anaerobic bile cultures can be considered. Liver biopsies should also be obtained if surgery is pursued. Clotting times and three-view thoracic radiographs are recommended prior to anesthesia.
- If a more conservative approach is desired at this time, consider empirical treatment for bacterial cholangiohepatitis/cholecystitis (broad-spectrum antibiotics, Denamarin, Ursodiol therapy) with close monitoring of the patient's gallbladder to assess for progression to a fully-formed mucocele. Serial monitoring of the patient's liver values is also recommended to assess liver enzyme trends. If liver values do not improve with medical therapy, surgery should be reconsidered.
- 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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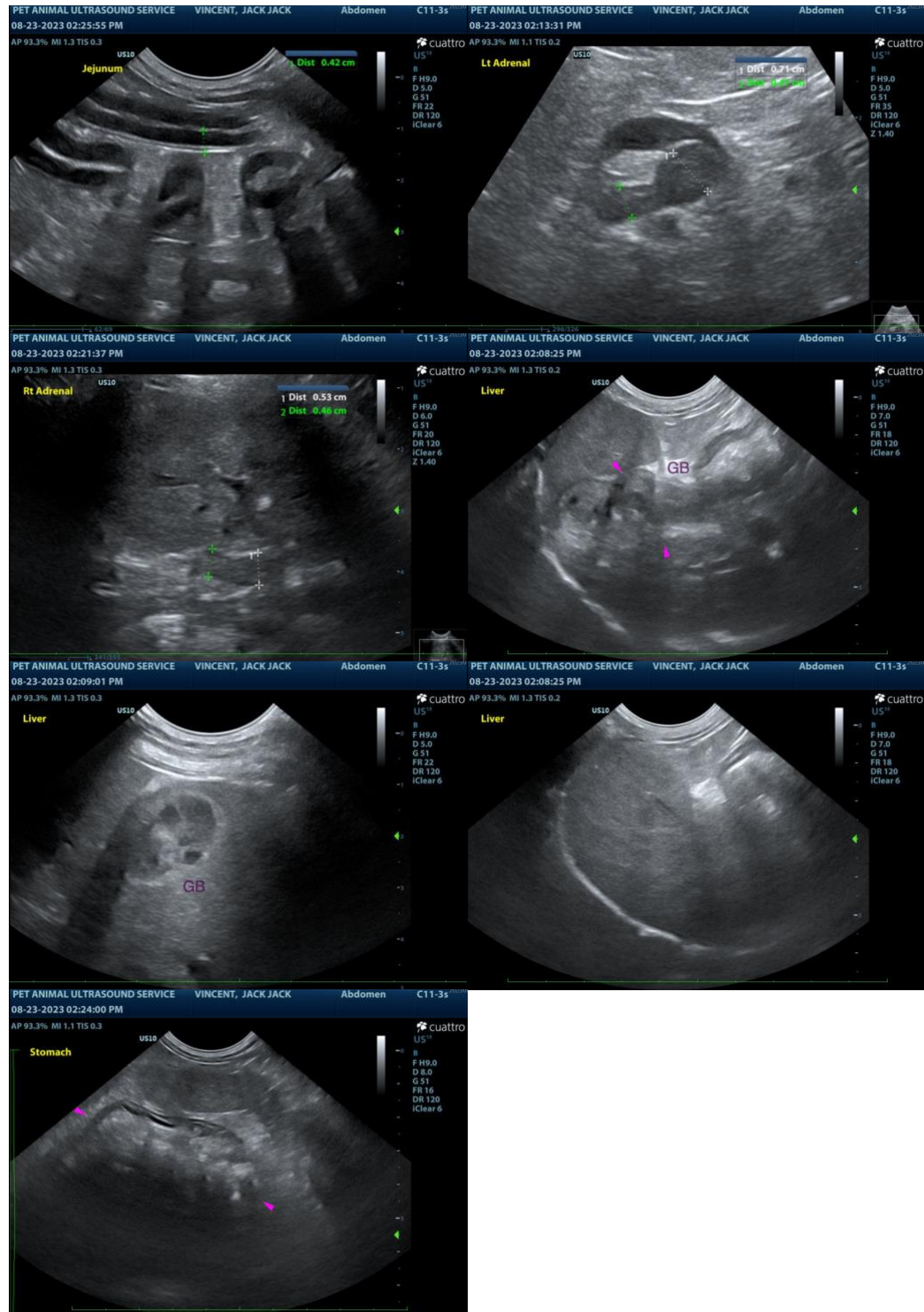
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.



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