**DATE PRESENTING CLINICAL SIGNS**

8.26.2022 8/5/22: Poor appetite & vomiting for a few days; elevated liver values (will forward) & mild neutrophilia; treated with buprenex, prednisolone, cerenia & mirtaz. 8/5-8/19- improved a lot, ate well, no V, acting herself

**PATIENT**

8/19-8/25 (exam 8/25)- almost daily vomiting,

Grim Glenn-Campbell

Current Medications: 8/8-8/19: prednisolone-5mg sid x 7d, then 2.5mg sid x 7d, Buprenex 0.2ml orally bid x 5 d (0.3mg/ml) 8/8-8/12

**SPECIES**

Cerenia 16mg po-o not able to give

Feline

Lab Results: Neutrophilia 25320 (on 8/8: 13090), ALT 449 (was 641 on 8/8), TBil 1.3 (was 2.2 on 8/8), Fpl2 24.

**BREED**

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

DSH

Imaging Performed By: Andi Parkinson, BS, RDMS.

**SEX****ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

Spayed Female

**Urinary System**

The **urinary bladder** is normal in thickness and the mucosal surface is smooth. The bladder is mildly distended. A small amount of aggregated, echogenic, suspended debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1-2 cm, are normal.

**AGE**

8/5/2008

**WEIGHT**

15.18lbs

The **left kidney** is normal size (3.71 cm in length); normal shape and architecture with 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.

**INTERPRETED BY**

Andrea Nicastro,  
DMV, Diplomate  
DACVIM (Small  
Animal  
Internal Medicine)

The **right kidney** is normal size (4.09 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 width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

**HOSPITAL NAME**

Timonium AH

The **right adrenal gland** is normal size (0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

**REFERRING VET**

Dr. Kauder

**Spleen**

The **spleen** is normal in size (0.72 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.

**INVOICE**

11509

**Liver**

The **liver** is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. There is a subtle increase in portal markings. Intrahepatic biliary stones are present. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The **gall bladder** is moderately distended. The wall is normal in thickness. Luminal contents are mostly anechoic. The cystic and common bile ducts are thickened. The lumen is dilated. The common bile duct

measures 0.55 cm at the distal aspect. A 0.50 cm choledocholith is observed at the level of the duodenal papilla.

#### ***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 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 base and right limb of the **pancreas** are enlarged with irregular/rounded peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is dilated (up to 0.32 cm) and is filled with stones and mineralized debris. Surrounding mesentery is hyperechoic.

#### ***Free Abdomen***

The **mesentery** in the cranial abdomen is hyperechoic. There is no obvious evidence of free fluid. The abdominal **lymph nodes** are normal/not visible.

#### ***Other***

A 0.75 cm ill-defined mineralized focus is observed within the mesentery in the left midabdominal region

### **ULTRASONOGRAPHIC FINDINGS**

#### **Primary Findings**

- The pancreatic changes are consistent with moderate to severe pancreatitis, which may be acute or chronic and active in nature. Pancreatic stones are present. Regional peritonitis is present.
- The hepatic parenchymal and cystic and common bile duct changes are consistent with an inflammatory hepatopathy and cholangitis, respectively. A choledocholith is present at the duodenal papilla, resulting in at least partial obstruction of the common bile duct.
- Intrahepatic biliary stones (incidental)

#### **Secondary Findings**

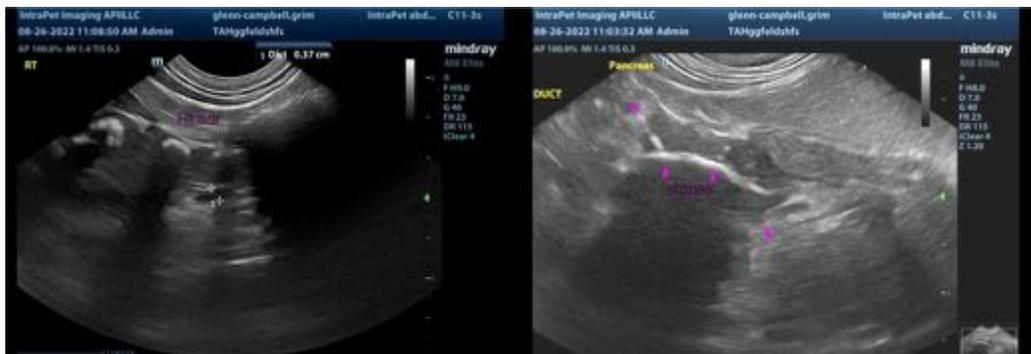
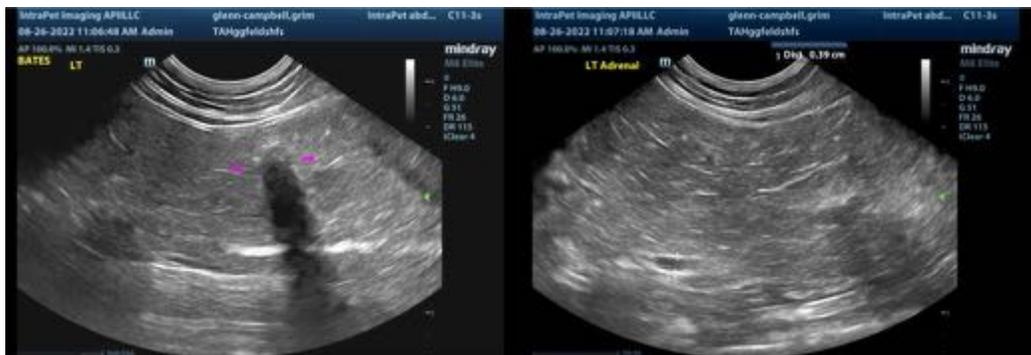
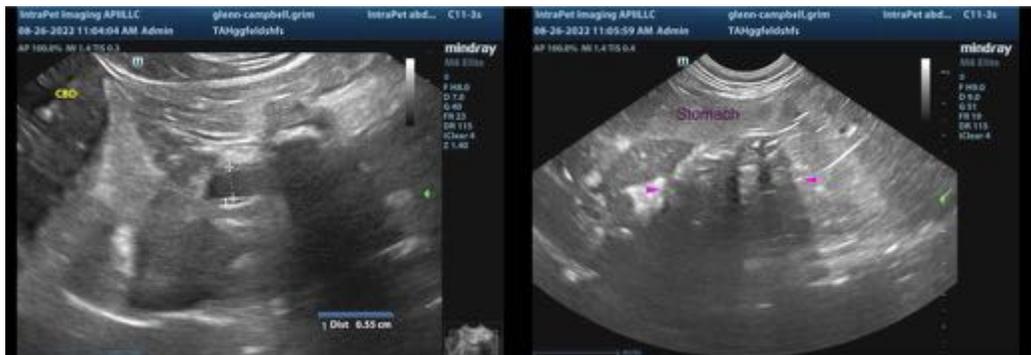
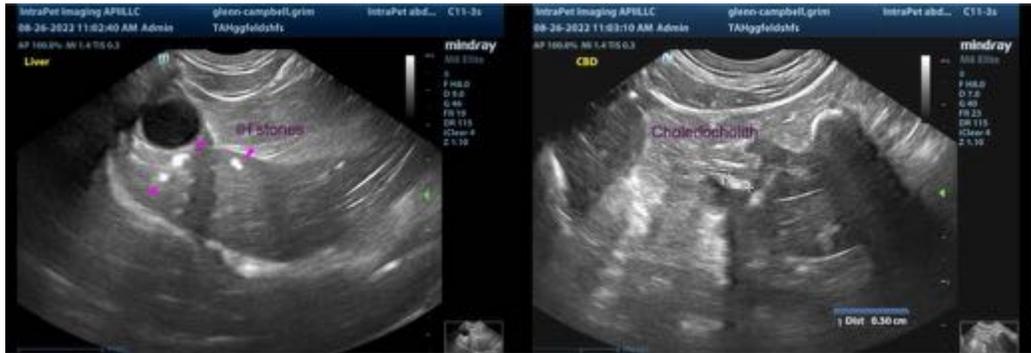
- Bilateral degenerative renal changes
- The mineralized focus in the left mid abdomen is consistent with a Bate's body (incidental)

### **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Supportive care for pancreatitis/cholangitis/cholangiohepatitis is recommended, including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, broad-spectrum antibiotics, +/- fresh frozen plasma. Nutritional support (i.e., temporary feeding tube) may be warranted if the patient's caloric intake is inadequate.

Thoracic radiographs are recommended to assess cardiopulmonary status, as pancreatitis can have pulmonary/pleural effects.

Serial monitoring of the patient's liver values is recommended. If the patient's total bilirubin increases substantially, an abdominal exploratory with a bile duct rerouting may be warranted.



**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)**  
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