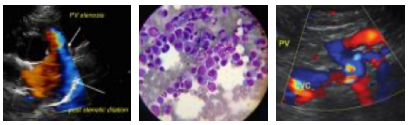
IMAGING PERFORMED BY

IntraPet.com



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Clinical Sonography & Telecytology
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**DATE**
8/30/22

**PATIENT**
Mae Lassahn

**SPECIES**
Canine

**BREED**
Westie

**SEX**
Female, spayed

**AGE**
8/1/2009

**WEIGHT**
23 lbs.

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

**HOSPITAL NAME**
Chadwell AH

**REFERRING VET**
Dr. Gold

**INVOICE**
13892

## PRESENTING CLINICAL SIGNS

Addison's dz for her entire life. Diabetes last 2 years.

Current Medications: Vetsulin 6 units BID, Pred susp 0.33mL BID.
Lab Results: Blood- elevated pancreatic enzyme. BUN 46, creat 1.7
Radiographs: Very enlarged cranial abdominal mass +/- distended stomach, evaluate liver.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed By: Rachel Brilhart, RDMS.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder wall is 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 left kidney is normal size (4.87 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.

The right kidney is normal size (5.19 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with poor corticomedullary distinction. Trace pyelectasia is present (0.10 cm in the transverse plane). A few non-obstructive nephroliths are visualized. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is normal size (0.70 cm at cranial pole) (0.42 cm at caudal pole) (2.10 cm in length) with a slightly prominent cranial pole. At the cranial aspect, a 0.69 x 0.42 cm irregular hyperechoic nodule is visualized. The glandular echogenicity and detail at the caudal aspect are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.71 cm at cranial pole) (0.45 cm at caudal pole) (2.12 cm in length) with a normal shape and smooth peripheral contours. A 1.25 x 0.62 cm hyperechoic nodule is observed at the cranial to mid-aspect. The glandular echogenicity and detail at the caudal aspect are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

### *Spleen*

The spleen is normal in size (1.55 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 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 moderate amount of aggregated echogenic to mineralized debris/sludge is observed within the lumen, most of which is gravity dependent and some of which is suspended. The cystic and common bile ducts are normal/not seen.

### *Gastrointestinal*

The gastric lumen is moderately to severely fluid distended and hypomotile. 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. No obstructive disease is noted.

### *Pancreas*

The base/right limb of the pancreas is enlarged with irregular peripheral contours. The parenchyma is heterogeneous in appearance. The pancreatic duct is not overtly dilated. Surrounding mesentery is hyperechoic.

### *Free Abdomen*

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

### *Other*

A brief echocardiogram reveals no obvious evidence of pericardial effusion.

## ULTRASONOGRAPHIC FINDINGS

**Primary Findings:**

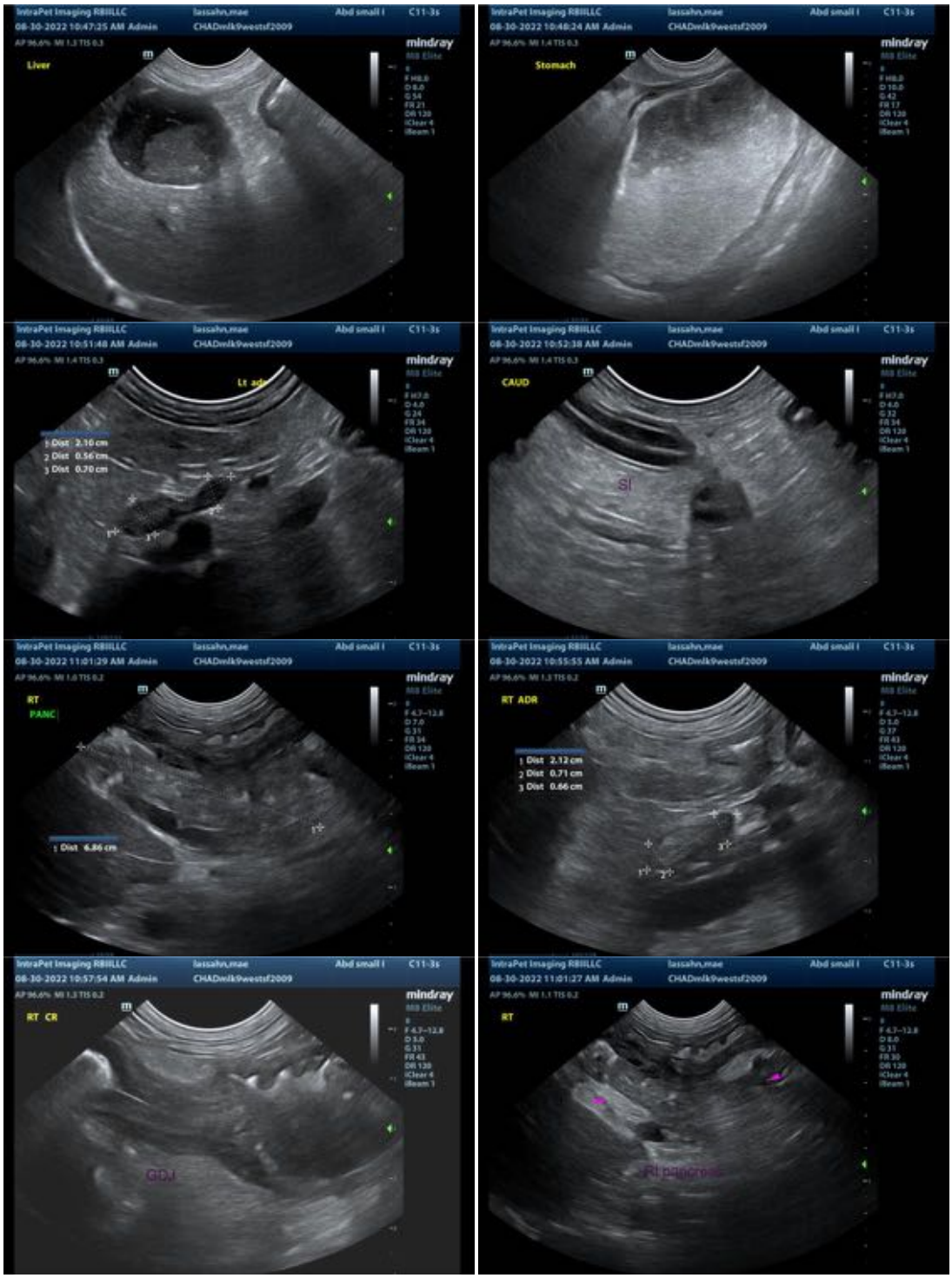
- The pancreatic changes are consistent with moderate to severe pancreatitis with adjacent peritonitis.
- Gastric ileus is present, likely secondary to pancreatitis.

**Secondary Findings:**

- Bilateral, degenerative renal changes with non-obstructive nephrolithiasis and pyelectasia.
- The bilateral adrenal nodules trend toward the benign (i.e., benign nodular hyperplasia). However, emerging tumors cannot be excluded.
- The hepatic parenchymal changes are most consistent with a diabetic hepatopathy. However, inflammatory disease, hepatotoxicosis (i.e., copper), reactive hepatopathy or other pathology cannot be excluded.
- Gallbladder debris/sludge, non-mucocele.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma. Consider initiation of a pro-motility agent (i.e., Metoclopramide) to help address the gastric ileus. If available, hyperbaric oxygen therapy may be beneficial in reducing pancreatic inflammation. When the patient will tolerate it, consider initiation with trickle feeding to help maintain enterocyte health.
- Thoracic radiographs are recommended, as severe pancreatitis can have pulmonary/pleural effects.
- Serial monitoring of the patient's liver and kidney values is recommended to monitor progression of metabolic functions, which can deteriorate with severe pancreatitis.




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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