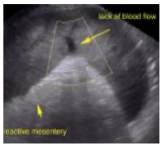
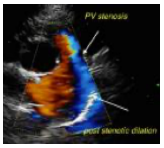
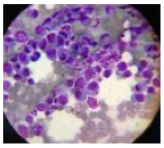
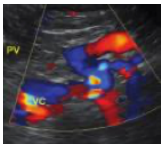
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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1-800-838-4268 info@sonopath.com

PATIENT
Scout Culp

SPECIES
Canine

BREED
Border Collie Mix

SEX
Neutered Male

AGE
10 years

WEIGHT
70 lbs

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

IMAGING PERFORMED BY
Anna Wepprich

HOSPITAL NAME
Wilvet Salem

REFERRING VET
Dr. Anna Wepprich

INVOICE
11351

DATE
8.8.22

PRESENTING CLINICAL SIGNS

History: Started phenobarbital 2wk ago for worsening focal facial seizures, Added keppra 1 wk ago. On 8/6 pt presented to rDVM for restlessness, panting, and not eating for 1-2 days. tense painful abdomen, anxious

Abnormal PE/Chem/CBC/UA Results: CBC - leu 16k, neut 13k, mono 0.85 - consistent with stress/ inflammation chem - per rDVM no abnormalities, in house chem pending VBG - wnl cPL – abnormal

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 1-2 cm, are normal.

The **prostate** is not definitively visualized due to its pelvic location.

The **left kidney** is normal size (6.78 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The **right kidney** is normal size (7.17 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of 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 (0.63 cm at cranial pole) (0.53 cm at caudal pole) (3.47 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 caudal pole of the **right adrenal gland** is well visualized and is normal in size (0.48 cm in width); normal shape, glandular echogenicity and detail. Surrounding vasculature appears normal.

Spleen

The **spleen** is normal in size (1.60 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few, small, ill-defined myelolipomas are observed in the region of the hilus. 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 mostly gravity dependent, echogenic debris/sludge 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 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, particularly the left limb, hypoechoic and edematous. The peripheral margins are irregular.

Free Abdomen

The **mesentery** throughout the abdomen, particularly in the cranial aspect, is hyperechoic. A small amount of free fluid is present. A 1.72 cm medial iliac **lymph node** is visualized. The node is normal in shape and echogenicity. A 1.17 gastric lmph nodes is also seen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are consistent with severe, acute pancreatitis with secondary peritonitis +/- saponification of fat. Pancreatic neoplasia cannot be completely excluded. However, given the acute nature of the gastrointestinal signs, pancreatitis is favored.

Secondary Findings

- Minor, bilateral age-related renal changes
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely. However, correlation with the patient's liver values is recommended
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

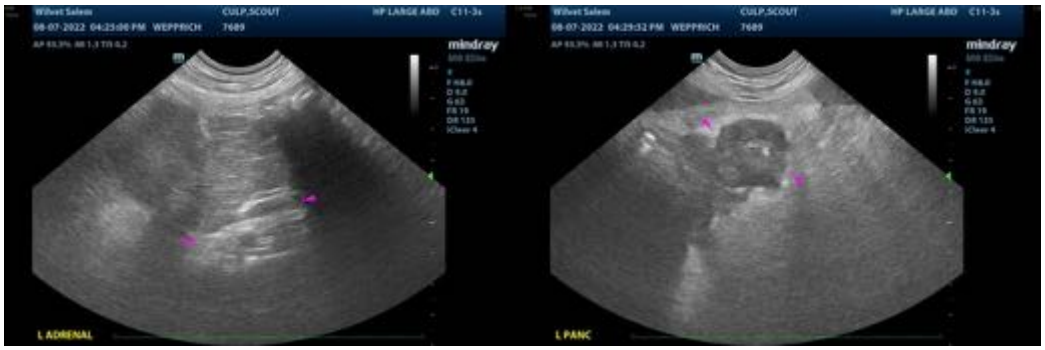
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

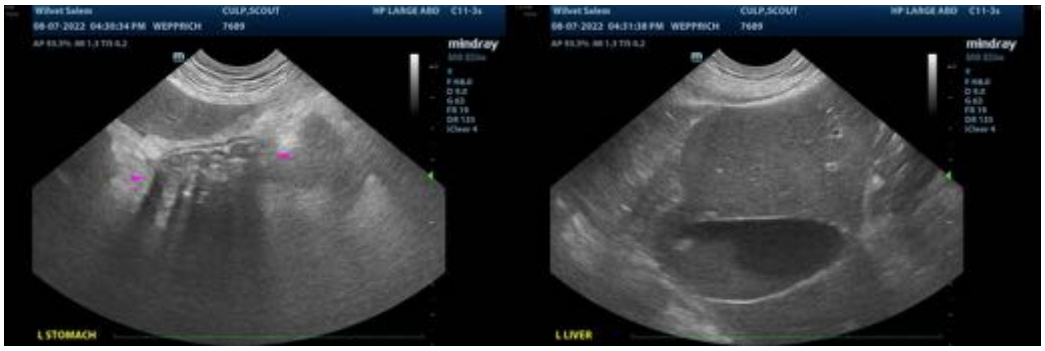
A fine-needle aspirate of the pancreatis can be considered to help evaluated for pancreatic neoplasia. Clotting times (i.e., PT/PTT platelet count) should be evaluated prior to aspiration. A 25-gauge needle should be used.

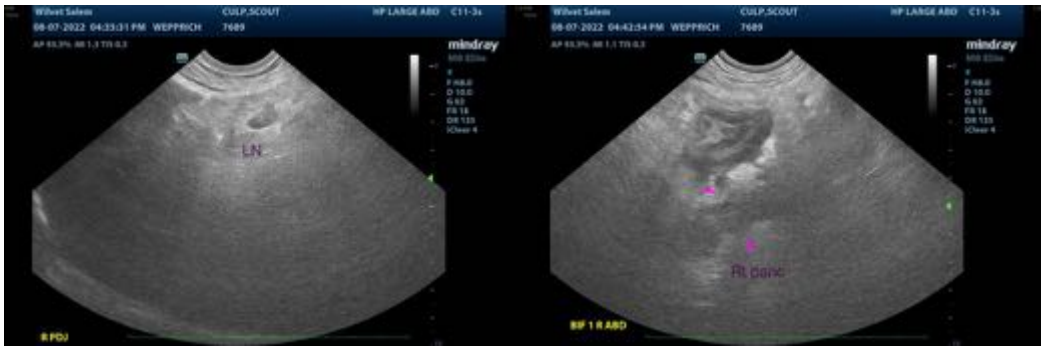
Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma. If available, hyperbaric oxygen therapy may be beneficial in reducing pancreatic inflammation. Initiation of trickle feeding is also recommended as soon as the patient will tolerate it, as it can help to maintain enterocyte health.

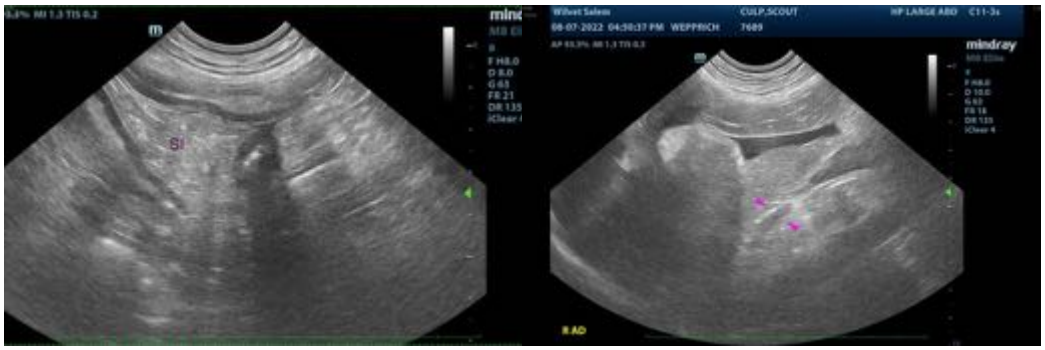
Three-view thoracic radiographs are recommended as severe pancreatitis can have pulmonary/pleural effects.

Serial monitoring of the patient's liver and kidney values is also recommended to monitor metabolic functions.









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)
info@SonoPath.com