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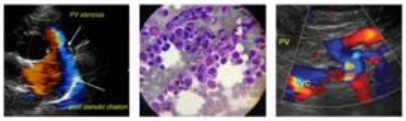
svsimagingqc.net 309-737-3070



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Livie Dudzek 278175

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Spayed

AGE

10 years

WEIGHT

8.7 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC- Dr. Mayhew

INVOICE

11573

DATE

9.1.22

PRESENTING CLINICAL SIGNS

History: Concern for pancreatitis- was hospitalized this past weekend and discharged to home care- now having diarrhea and intermittent hyporexia. Initially presented for vomiting on 8/26.

Abnormal PE/Chem/CBC/UA Results: Bloodwork from 8/27: 1. CBC: Lymphocyte 0.76 (0.83 - 4.91) L Eosinophil 0.01 (0.04 - 1.62) L Neutrophil% 89.2 (52.0 - 81.0) H Lymphocyte% 8.0 (12.0 - 33.0) L Eosinophil% 0.1 (0.5 - 10.0) L MCHC 38.4 (30.0 - 38.0) H PLT 56 (117 - 490) L - suspect false due to clumping 2. CBC Diff: PCV 48 (35 - 54) WNL TP 5.6 (5.8 - 7.0) L, hemolyzed plasma Lymphocyte 0.47 (1.0 - 4.9) L Eosinophil 0 (0.10 - 1.49) L MCH 20 (12.5 - 17.5) H Plt 3 (7 - 12) L Large amount of platelet clumping 3. Comp/lytes: TP/globulins would not read Creatinine 0.3 (0.4 - 1.4) L Calcium 8.9 (9.0 - 12.2) L Glucose 139 (75 - 125) H Lipase 378 (0 - 225) H Magnesium 1.3 (1.5 - 2.4) L Na/K ratio 37 Bloodwork today is pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** 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 (4.23 cm in length); with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few pinpoint hyperechoic foci are observed within the cortex. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The **right kidney** is normal size (4.77 cm in length); with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is mildly enlarged (0.42 cm at cranial pole) (0.68 cm at caudal pole) (1.58 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.

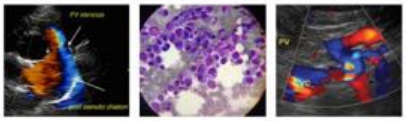
The **right adrenal gland** is normal size (0.47 cm at cranial pole) (0.44 cm at caudal pole) (2.31 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (1.58 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 normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. No focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.



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The **gall bladder** lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated, echogenic, gravity dependent 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 mildly 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 not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction is normal. The colonic wall is normal to mildly thickened (up to 0.42 cm) with retention of the normal layering pattern. There is no obvious evidence of an obstructive pattern.

Pancreas

The **pancreas** is diffusely prominent to enlarged with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is slightly hyperechoic.

Free Abdomen

Trace free fluid is observed. The medial iliac **lymph nodes** are visualized, the left measuring 1.77 x 0.51; the right 1.57 cm x 5.41. The nodes are normal in shape and echogenicity. A prominent gastric lymph node is also seen (0.63 x 0.52). A few enlarged mesenteric lymph nodes are also visualized, the largest measuring 3.98 cm in length. Two to three prominent lymph nodes are also observed in the right cranial quadrant, one of which is cystic in nature.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are consistent with mild acute on chronic active pancreatitis.
- The trace ascites is likely secondary to pancreatitis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

Secondary Findings

- The colonic wall changes are most consistent with inflammation with a lower possibility of emerging neoplasia.
- Minor, age-related chronic renal changes with dystrophic mineralization.
- The mild left adrenomegaly may be a normal variant for this patient or may represent early hyperplastic change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Supportive care for pancreatitis is recommended, including fluid therapy, gastric protectants, antiemetics and pain medication as needed.

If the patient fails to respond to medical therapy, consider a repeat abdominal ultrasound to assess for the progression of the pancreatitis.

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Also consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI to further evaluate for concurrent maldigestion/malabsorption.

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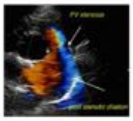
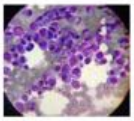
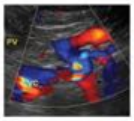

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com