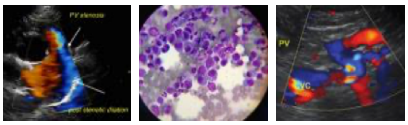
IMAGING PERFORMED BY

IntraPet.com



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

DATE

9/15/21

PATIENT

Murphy Schaeffer

SPECIES

Canine

BREED

Yorkshire terrier

SEX

Male, neutered

AGE

11/9/2008

WEIGHT

4 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Timonium AH

REFERRING VET

Dr. Gernhart

INVOICE

12097

PRESENTING CLINICAL SIGNS

History: Pancreatitis, anorexia 1 week duration.

Current Medications: Metronidazole 4.5mg IV BID, Ampicillin 36mg IV BID, Cerenia 1.8mg SID IV, Pantoprazole 1.2mg IV, Ursodiol 50mg 1/2tab, Vetmedin 2.5mg 1/4tab.
Lab Results: Not provided by the veterinarian.
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: 5-27-2021.
Sedation: not needed
Stat Report: not requested

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with mostly 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 prostate is not definitively visualized due to its pelvic location.

The left kidney is normal size (3.26 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. A few nephroliths are present. There is no evidence of pyelectasia, infarcts or hydroureter. 3 small cortical cysts are observed at the caudal aspect. Renal vasculature is normal.

The right kidney is normal size (2.97 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. Several nephroliths are visualized. Mild pyelectasia is present (0.14 cm in the transverse plane). There is no evidence nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.54 cm at cranial pole) (0.50 cm at caudal pole) (1.28 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 (0.54 cm at cranial pole) (0.51 cm at caudal pole) (1.36 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 (0.67 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few ill-defined hyperechoic nodules are observed throughout the organ. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen and subtly mottled 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 distended. The wall is mildly thickened (up to 0.24 cm), hyperechoic and irregular. A small to moderate amount of echogenic debris is observed within the lumen, some of which is gravity-dependent and some of

which is adhered to the mucosal surface. The mesentery surrounding the gallbladder is reactive. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric wall is subjectively thickened, however the wall thickness is difficult to measure due to the presence of rugal folds. The layering pattern appears to be intact. The gastric lumen is not dilated. The pyloric outflow tract is patent. The small intestinal wall is normal to borderline thickened (up to 0.40 cm) with a normal layering pattern. There is evidence of mild mucosal speckling in some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

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

Free Abdomen

The mesentery in the cranial abdomen is hyperechoic. A small amount of echogenic free fluid is visualized. . The abdominal lymph nodes are normal/not visible.

Other

A brief echocardiogram reveals no evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gallbladder changes are consistent with cholecystitis with regional peritonitis.
- The pancreatic changes could be consistent with acute or chronic, active pancreatitis.

Secondary Findings:

- The gastric and small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with the possibility of emerging neoplasia.
- The hepatic parenchymal changes could be consistent with inflammatory/immune mediated disease, hepatotoxicosis (i.e., copper), infiltrative neoplasia (less likely) +/- concurrent age-related pathology.
- The hyperechoic lesions adjacent to the splenic vessels are most consistent with myelolipomas. Although a neoplastic process within the spleen cannot be excluded, it is considered unlikely in this patient.
- Bilateral age-related renal changes with non-obstructive nephroliths.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Baseline labwork including a CBC chemistry panel, urinalysis and T4 is recommended if not already performed.
- While awaiting test results, empirical treatment for cholecystitis and pancreatitis is recommended.

- If possible, a sample of abdominal fluid should be collected and submitted for fluid analysis and cytology.
- Three-view thoracic radiographs are also recommended to assess cardiopulmonary status.
- Also consider a malabsorption panel.

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, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)
Andrea.nicastro@sonopath.com