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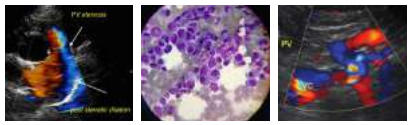
IntraPet.com



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DATE

9/24/21

PATIENT

Cash King

SPECIES

Canine

BREED

Maltese

SEX

Male Neutered

AGE

9/23/06

WEIGHT

19.7 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Martinolli

INVOICE

11899kk

PRESENTING CLINICAL SIGNS

History: Date: 09-23-2021 Notes: Saw regular veterinarian today; diagnosed with pancreatitis. Referred here for continued care; owner had a dog pass away from pancreatitis a couple years ago and it was not that old so he is very concerned about Cash. Full bloodwork done at rDVM today; not sent over (going to get send over in morning) but relayed from rDVM - BUN 36, x-rays - NSF, SNAP Lipase - Abnormal Assessment: r/o pancreatitis, neoplasia Plan: admit to hospital - IV fluids, Metronidazole, GI protectants, anti-nausea, ok'd AUS tomorrow.

Current Medications: Metronidazole 125 mg BID; Maropitant 9 mg IV q 24 hr; Protonix 9 mg IV q 24 hr. (started 9/23).

Lab Results: BUN 36.

Radiographs: NSF.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Sedation not required for scan.

Stat Report: STAT report not requested by the veterinarian.

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 is distended. A small amount of suspended, echogenic 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 2 cm, are normal.

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

The left kidney is normal size (5.53 cm in length) with a slightly irregular shape. The cortex is variably thickened and heterogeneous in appearance with numerous, varying-sized cortical cysts. There is poor corticomedullary distinction. Hyperechoic, shadowing, diverticular foci are present. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

The right kidney is normal size (5.82 cm in length) with a slightly irregular shape. The cortex is variably thickened and heterogeneous in appearance with numerous, varying-sized cortical cysts. There is poor corticomedullary distinction. Hyperechoic, shadowing, diverticular foci are present. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.64 cm at cranial pole) (0.63 cm at caudal pole) (1.46 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 (0.79 cm at cranial pole) (0.71 cm at caudal pole) (2.43 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 (0.99 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. An ill-defined, 0.70 cm hyperechoic focus is observed near the caudal aspect. Splenic vasculature is normal.

Liver
The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen. A 4.73 x 3.79 cm irregular multi-cystic mass is observed deep in the right liver. The remaining parenchyma is subtly heterogeneous in appearance. Hepatic vasculature and intrahepatic 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, suspended 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 is normal to mildly thickened (up to 0.44 cm) with a normal layering pattern and appropriate mural detail. There is slight disruption in the normal 1:3 muscularis to mucosal ratio in some segments. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas
The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen
There is no evidence of free fluid. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis, or chronic pancreatitis.
- Cystic hepatic mass. This lesion may represent a benign process; alternatively, neoplasia may be present.

Secondary Findings:

- Gall bladder sludge, non-mucocele.
- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.
- 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.
- Mild, bilateral adrenomegaly.

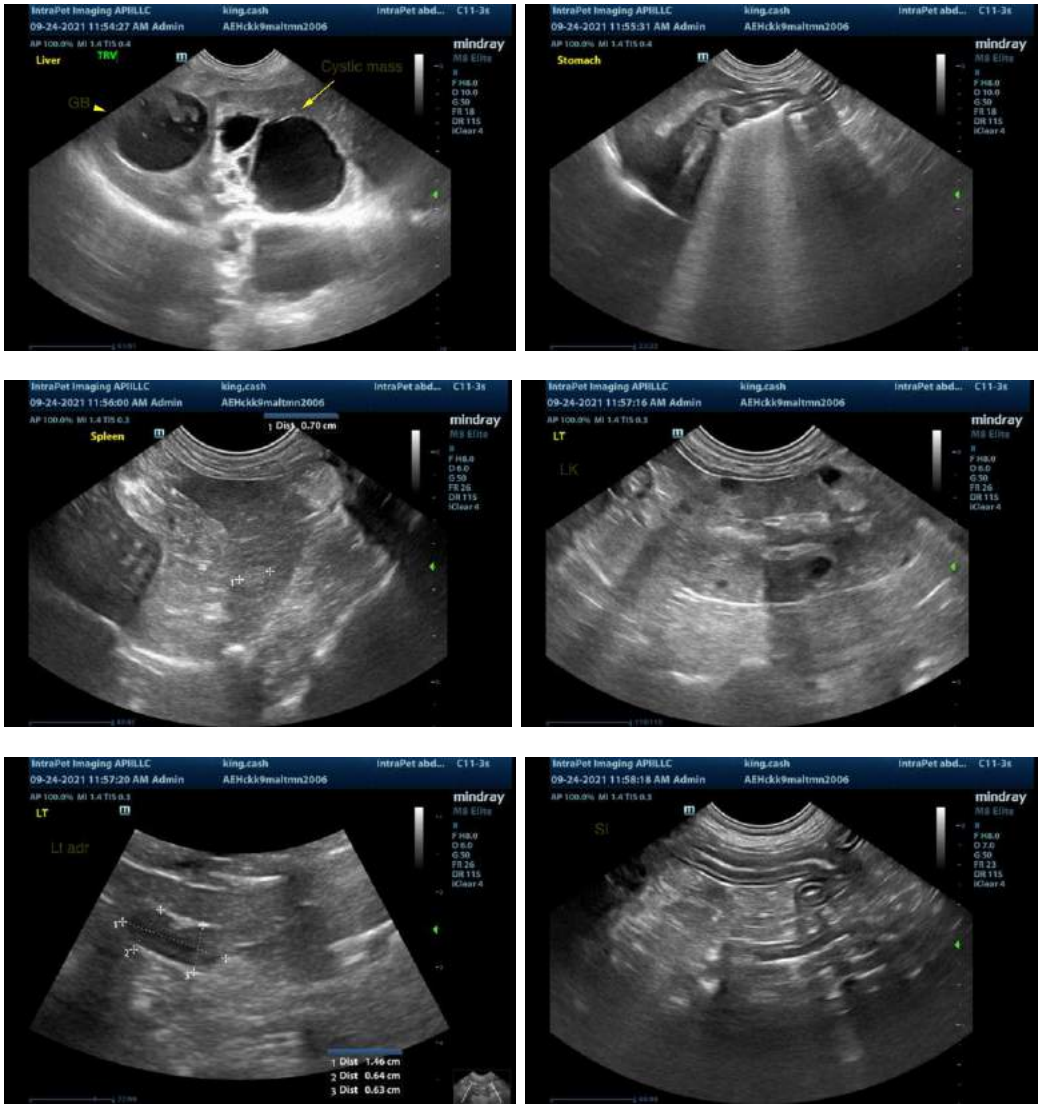
- The bilateral renal changes are consistent with a chronic nephropathy with cortical cysts and dystrophic mineralization.

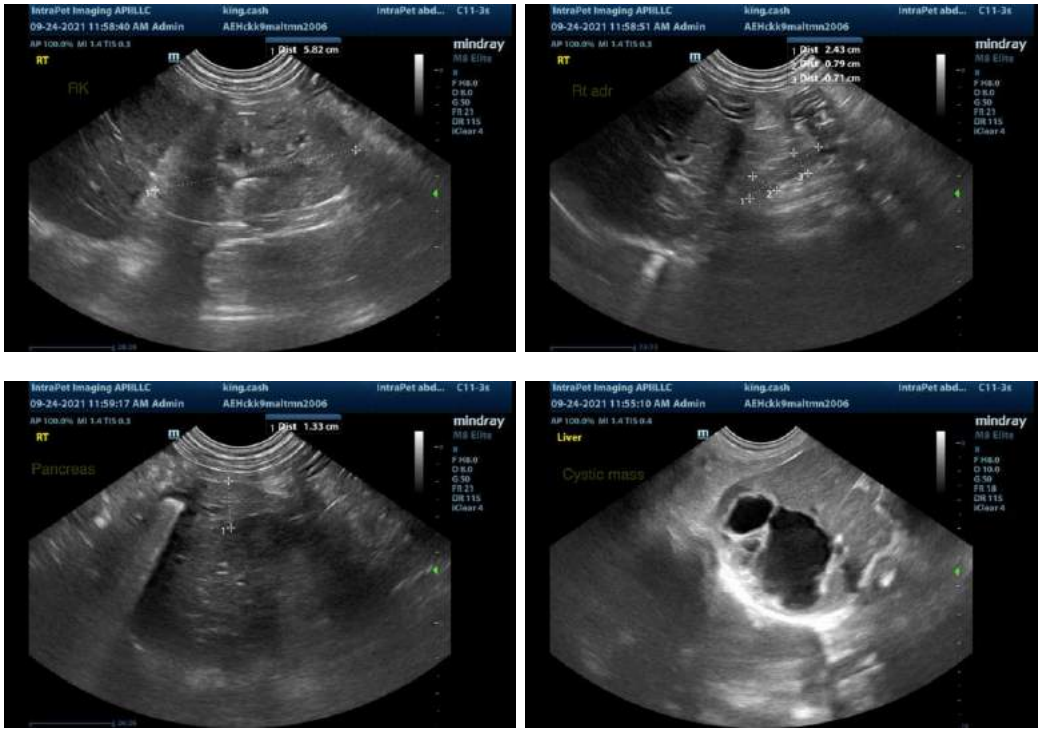
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.

2. If a conservative approach is desired, consider non-invasive testing (i.e., malabsorption panel, fecal evaluation for ova and Giardia, pre- and post-prandial serum bile acids, +/- initiation of a low-fat, hypoallergenic diet trial).

3. If a more aggressive approach is desired, consider an abdominal exploratory with hepatic mass removal and gastrointestinal biopsies.





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.

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