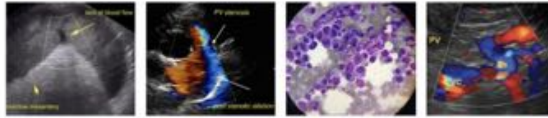


PATIENT

Lola Roberson

SPECIES

Canine

BREED

Terrier mix

SEX

Female, spayed

AGE

5/1/2013

WEIGHT

26.2 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Brighton AH

REFERRING VET

Dr. Wetzel

INVOICE

12882

DATE

1/19/22

PRESENTING CLINICAL SIGNS

The patient presented with a history of suspected pancreatitis. More recently decreased appetite an abdominal discomfort. No recent vomiting but has had some diarrhea and hematochezia in the past. CBC from December shows elevated NRBC, normal hematocrit, normal platelets, normal white count. 4DX negative.

Chemistry panel- AlkP 543, lipase 508, T4 normal.

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 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 in size (4.67 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.

The right kidney is normal in size (5.37 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 normal size (0.32 cm at cranial pole) (0.48 cm at caudal pole) (1.67 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.

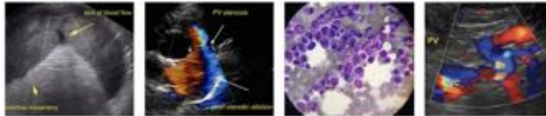
The right adrenal gland is normal size (1.80 cm at cranial pole) (0.63 cm at caudal pole) (1.28 cm in length) with a slightly irregular shape. The parenchyma is subtly heterogeneous in appearance with some loss of glandular detail. No distinct focal lesions are observed. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.93 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 swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. the portal vein: caudal vena cava ratio is approximately 1:1. The gallbladder is of normal contours and



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contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric wall is mildly thickened (up to 0.49 cm) with apparent retention of the normal layering pattern. The gastric lumen is mildly fluid distended. 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 ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The left limb of the pancreas is prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. There Is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gastric wall changes are most consistent with an inflammatory process with a lower possibility of emerging neoplasia.
- Age-related pancreatic remodeling +/- fibrosis. Concurrent low-grade pancreatitis is also possible, particularly if the patient exhibits discomfort on cranial abdominal palpation.

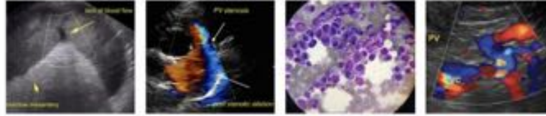
Secondary Findings:

- 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.
- Gallbladder debris- Incidental.
- Bilateral, age-related renal changes with dystrophic mineralization.
- The right adrenal changes are most consistent with hyperplastic change.

*It is unclear if the patient's clinical signs are secondary to mild pancreatitis flare ups or if there is a concurrent disease process (i.e., microscopic gastrointestinal disease or underlying metabolic issue).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the GI signs, consider the following:
  1. Malabsorption panel including serum cobalamin, folate, TLI and PLI.



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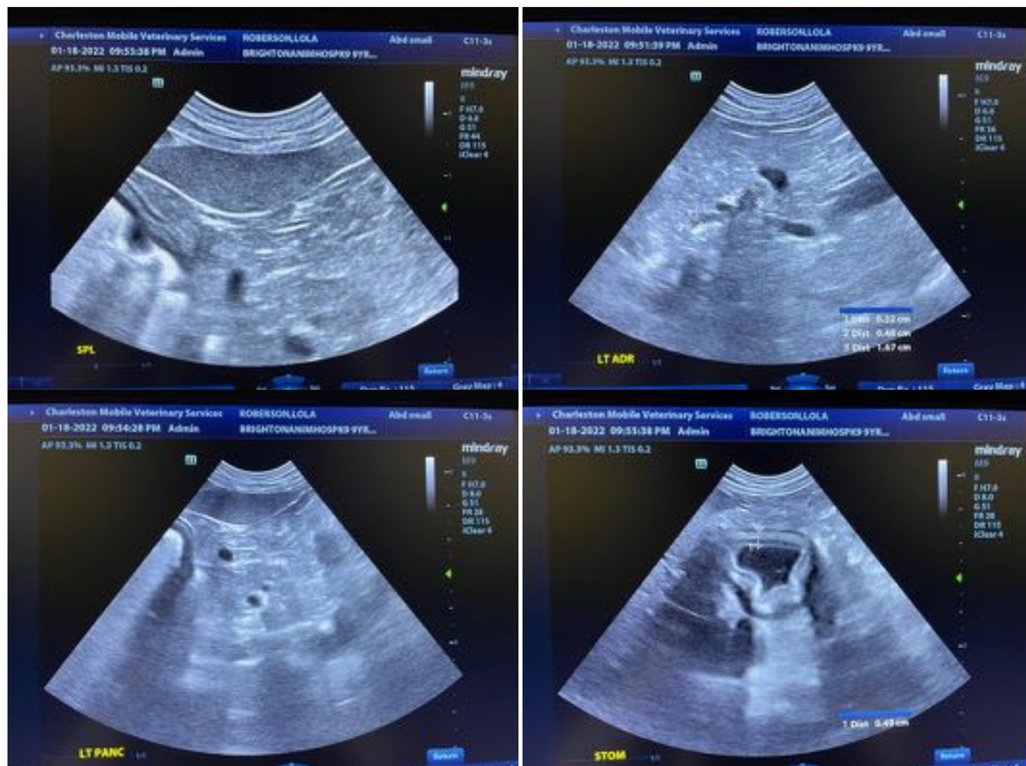
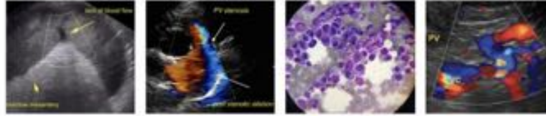
2. A fecal evaluation for ova/Giardia
3. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
4. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended
5. A 6-week limited antigen diet trial to assess for food allergies

- Thorough orthopedic and neurologic evaluations are recommended to assess for non-abdominal causes of pain.
- Ultimately, endoscopic or surgical gastrointestinal biopsies may be necessary to rule out underlying gastrointestinal disease.
- Given the patient's age, three-view thoracic radiographs are recommended prior to any anesthetic event.





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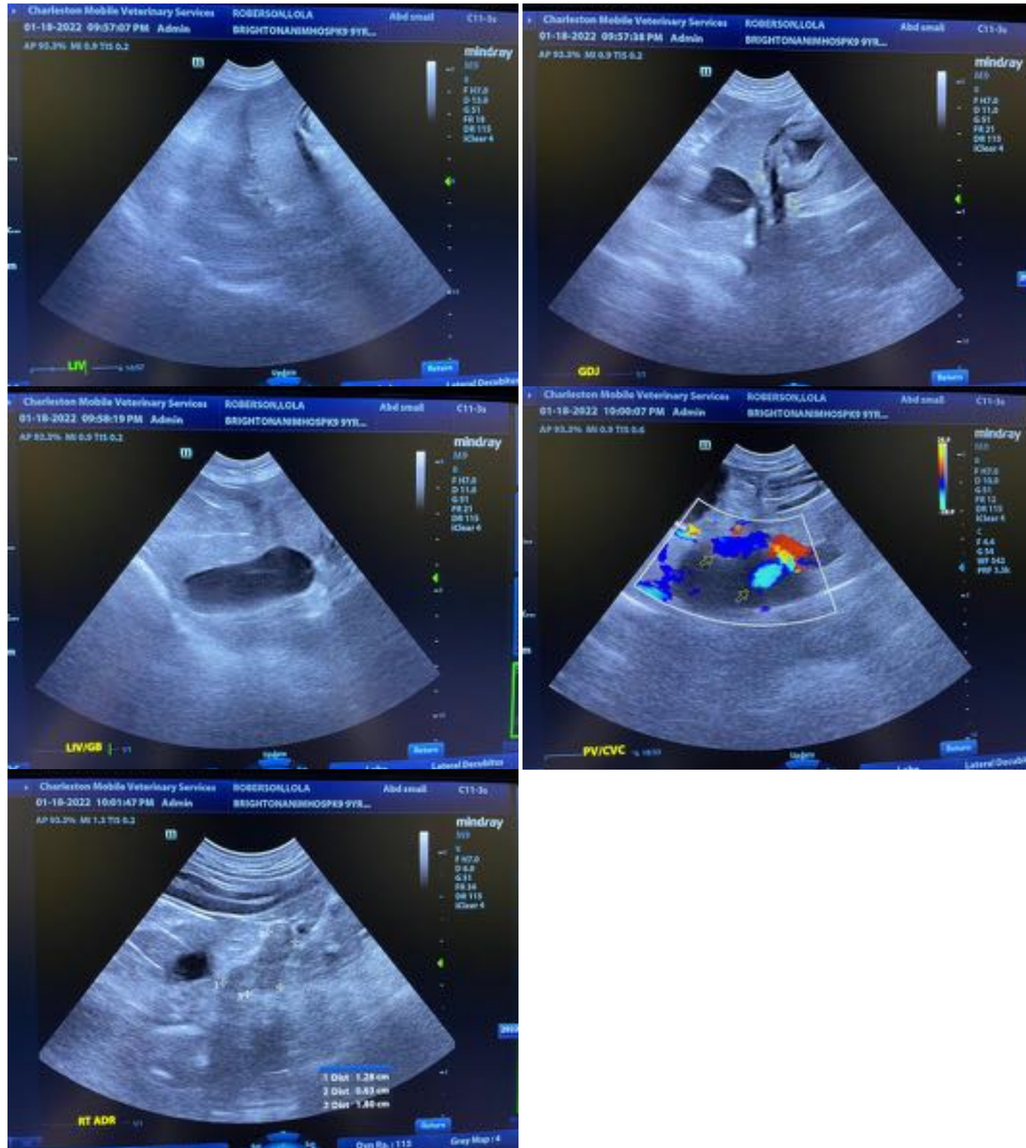

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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@CharlestonMobile.net