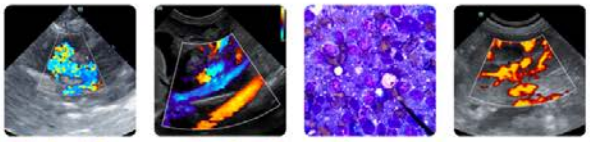


PATIENT

Frosty Nogues

SPECIES

Canine

BREED

Bichon

SEX

Neutered Male

AGE

11 Years

WEIGHT

16 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Byron Cabrera

HOSPITAL NAME

All Creatures Great & Small Denville

REFERRING VET

Dr. Silas Ashmore

INVOICE

72177

DATE

1/14/26

PRESENTING CLINICAL SIGNS

Emesis (many times) more than 15 times started yesterday, abdominal pain (cranial abdomen) lethargic, anorexia, no diarrhea, dehydration 7%

Abnormal PE/Chem/CBC/UA Results: TP 8.5 (HIGH) GLOB 4.9 (HIGH) ALT 800 HIGH (HIGH) ALK MORE THAN 2000 (HIGH) TBIL 2.8 (HIGH) WBC 19.61 (HIGH) NEU 16.38 (HIGH) MONO 2.17 (HIGH)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.50 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The area of the prostate is examined without evident prostatic pathology.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left measures 4.4 cm. Right measures 5.0 cm.

Adrenal Glands

While the adrenal glands measure technically normal in size, they are subjectively plump for a small dog. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. A hyperechoic nodule is noted in the cranial pole of the left adrenal gland. Nodule does not disrupt normal shape and/or architecture. Visible surrounding vasculature appears normal. Left measures 0.67 cm at the cranial pole and 0.56 cm at the caudal pole. Right measures 1.0 cm at the cranial pole and 0.67 cm.

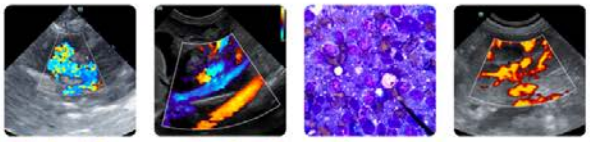
Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion

Gallbladder is moderately overdistended with organized, aggregated and centralized non-gravity dependent sludge. Striations of sludge separated by anechoic areas are noted extending from the lumen to the luminal wall. The wall is mildly thick, irregular and hyperechoic. There is no evidence of CBD dilation.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is moderately distended with a large amount of fluid. There are no echogenic contents, shadowing, etc. to indicate an obstruction, although the pylorus is difficult to fully visualize.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted.

Free Abdomen

There is a trace amount of anechoic free fluid primarily adjacent to the pancreas.

There is no apparent pathologic lymphadenopathy noted in these images.

There is a large amount of enhanced hyperechoic mesenteric fat throughout the cranial abdomen, surrounding both the pancreas and the neck of the gallbladder.

PRIMARY FINDINGS

- Moderate to severe acute pancreatitis with changes consistent with inflammation around bot the pancreas and the neck of the gallbladder.
- Gallbladder mucocele.
- Moderately heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Subjectively mild bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.

SECONDARY FINDINGS

- Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- Age related kidney changes.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, this patient appears to have significant pancreatitis, a gallbladder mucocele, and likely an underlying endocrinopathy (possible hyperadrenocorticism). It is difficult to say based on ultrasound whether patient's reported clinical signs are secondary to the pancreatitis alone, or the pancreatitis + the mucocele. Therefore, further treatment recommendations (if a more conservative approach is elected) would include:

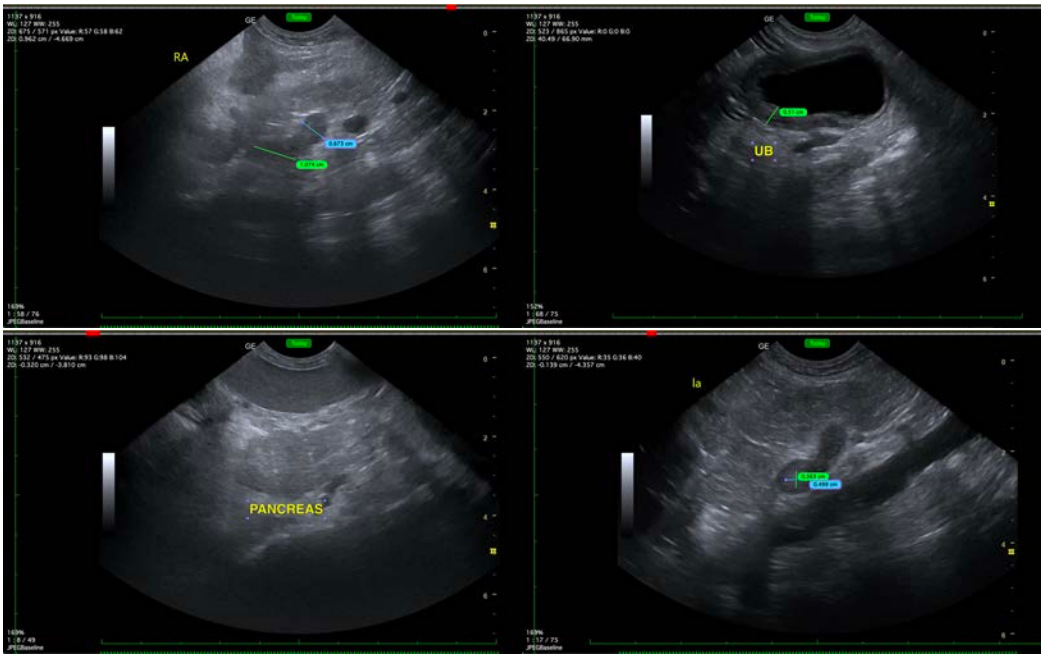
Medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. If possible, a fresh frozen plasma transfusion and hyperbaric oxygen therapy (HBOT) could be beneficial. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.

At the same time, empirical hepatic nutraceuticals including Ursodiol are recommended.

If not recently evaluated, a quantitative PLI is recommended if not already evaluated.

If patient does not improve and/or a more aggressive approach is elected sooner to prevent possible progression of the mucocele and/or even rupture, an exploratory laparotomy could be considered for planned liver biopsy and cholecystectomy, with the knowledge that ongoing medical management of pancreatitis will be warranted during and following surgery.

Future workup may involve evaluating for underlying endocrinopathy, but this should be last resort and pursued only in the face of appropriate clinical signs.



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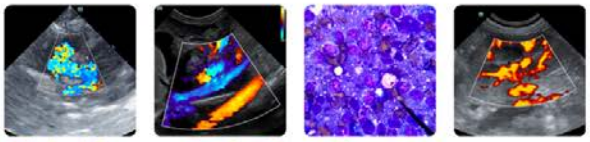

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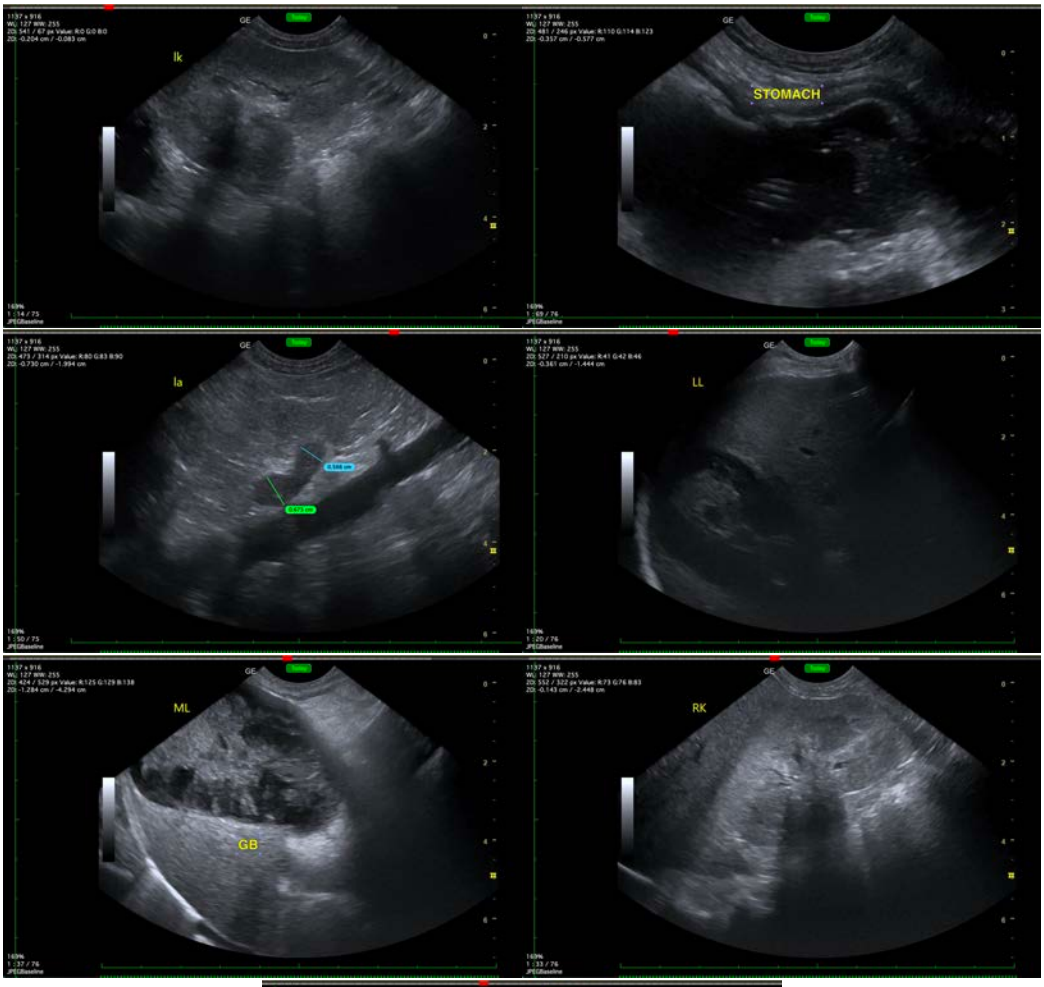

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM info@sonopath.com