



PATIENT

Dexter Pelavas

SPECIES

Canine

BREED

Poodle mix

SEX

Neutered male

AGE

12 years

WEIGHT

11.5 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Trudeau

HOSPITAL NAME

Petworks VH

REFERRING VET

Dr. Trudeau

INVOICE

42910

DATE

2/21/23

PRESENTING CLINICAL SIGNS

History: Not himself the last week. Episode of vomiting and did yelp when client touched his belly. Over the past few months has been PU/PD, more ravenous/hungry, a few vomits and some weight loss. On exam : Gr 3/6 cardiac murmur (historical); did cry repeatedly when tried to palpate mid to cranial abdomen

Abnormal PE/Chem/CBC/UA Results: Rads - enlarged liver +++ -gas in SI and stomach -loss of detail in cranial abdomen- mass effect? due to hepatomegaly? splenic mass? -BW- positive CPL -ALP too high to read, ALT mild to mod elevation

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate (neutered) is normal in size, echotexture and echogenicity for a neutered male.

Left kidney is normal is size (4.98 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal is size (5.39 cm),shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.52 cm at cranial pole and 0.59 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.49 cm at cranial pole and 0.43 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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 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 mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge



PATIENT	and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.
Dexter Pelavas	
SPECIES	<i>Gastrointestinal</i>
Canine	The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.
BREED	
Poodle mix	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.
SEX	
Neutered male	The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.
AGE	
12 years	<i>Pancreas</i>
WEIGHT	
11.5 kg	The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.
INTERPRETED BY	<i>Free Abdomen</i>
Beth Johnson, DVM DACVIM	There is no evidence of free peritoneal effusion noted in these images. There is no apparent lymphadenopathy noted in these images.
IMAGING PERFORMED BY	ULTRASONOGRAPHIC FINDINGS
Dr. Trudeau	Primary Findings
HOSPITAL NAME	1. Emerging mucocele – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.
Petworks VH	2. 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.
REFERRING VET	
Dr. Trudeau	Secondary Findings
INVOICE	
42910	1. Pancreatic age-related remodeling – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
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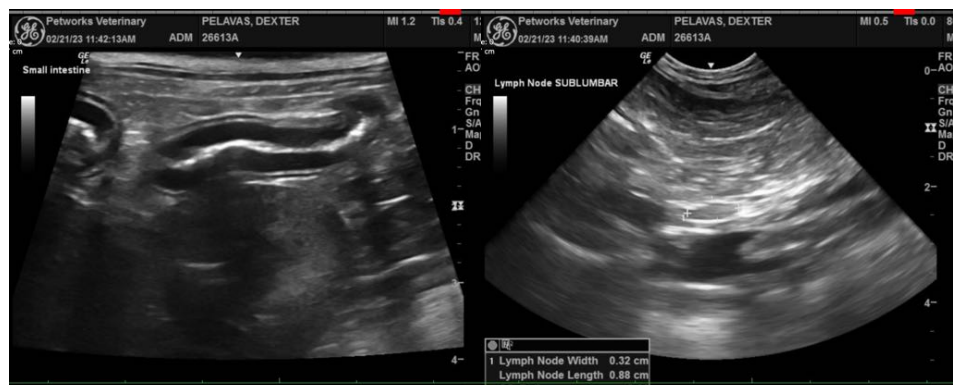
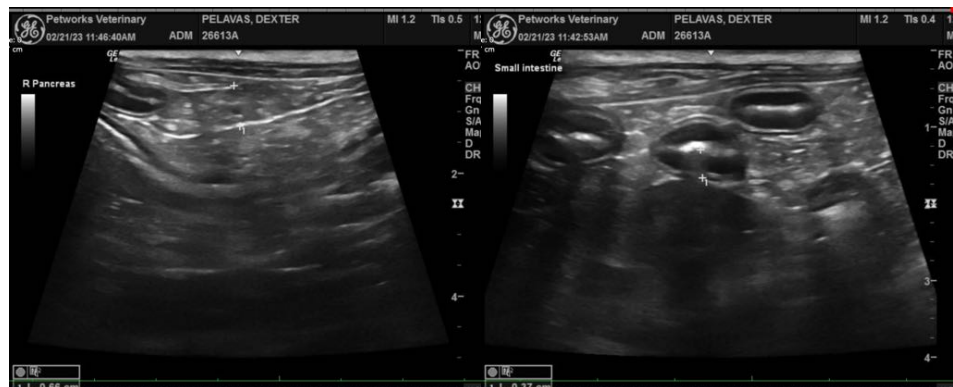
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no ultrasonographically visible evidence of active pancreatitis at this time. However, that does not rule it out. What is concerning given the patient's reported abdominal pain and liver enzyme changes is cholangitis/emerging gallbladder mucocele. Recommendations include either a conservative approach beginning with Ursodiol and broad spectrum antibiotics with monitoring of liver enzymes for improvement. If they improve antibiotics should be continued until they normalize or plateau with recheck levels in 2 weeks. However, if improvement is not noted and/or clinical signs progress then exploratory laparotomy for planned gallbladder evaluation and possible cholecystectomy may be recommended. If surgery is elected a liver biopsy should be obtained at the same time.

Prior to surgery:

- Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

The reported polyuria and polydipsia, etc. may be secondary to hyperadrenocorticism which is often associated with gallbladder mucocele. However, further evaluation of hyperadrenocorticism is not recommended in the face of concurrent illness due to the result of false positive results. Therefore, further evaluation of hyperadrenocorticism should be postponed until when/if clinical signs persist beyond medical management of the pain, nausea, etc.





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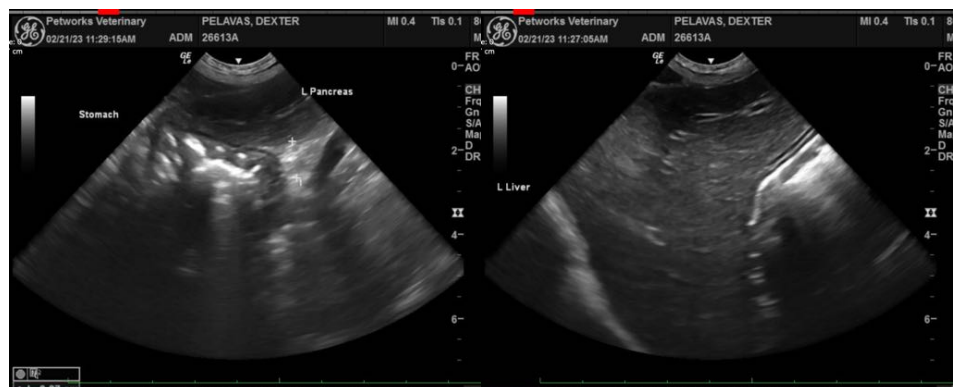
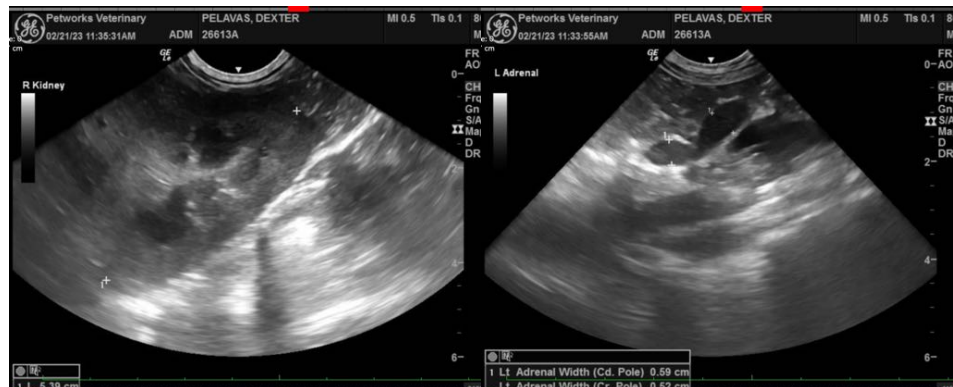
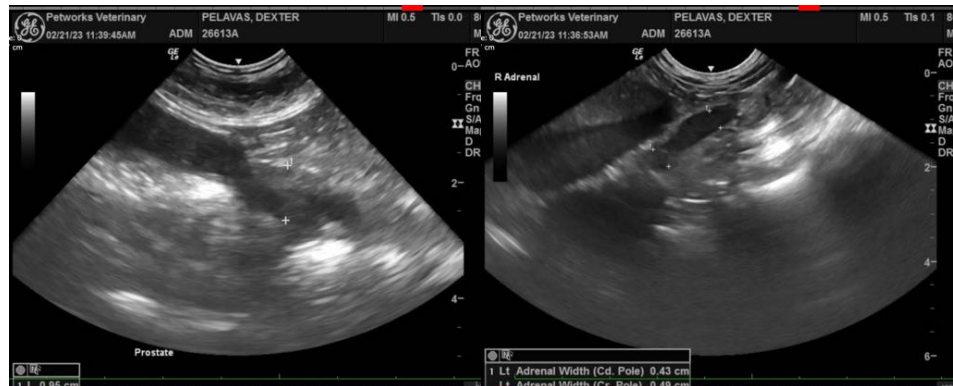
Dr. Trudeau

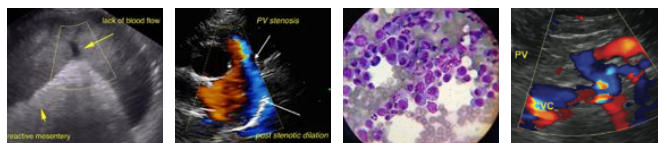
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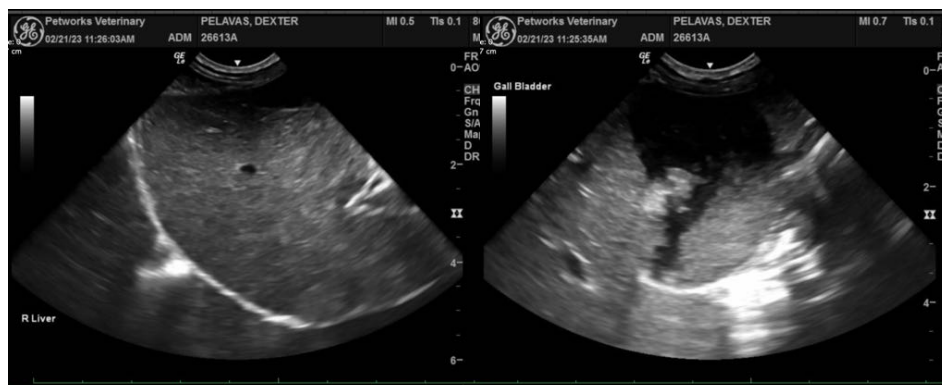
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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