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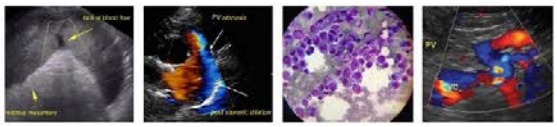


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Zoe Ferron

SPECIES

Canine

BREED

Cockapoo

SEX

Spayed Female

AGE

9 Years

WEIGHT

13.2 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Hamilton Region Vet Emergency Clinic

REFERRING VET

Dr. Wattson

INVOICE

45387

DATE

2/22/23

PRESENTING CLINICAL SIGNS

02/20: Owner concerned that she is lethargic, unable to move easily, exhibiting strange behavior Seen at HREVC ~ 1 week ago for pollakiuria and stranguria. Bloodwork, radiographs and urinalysis with urine culture was performed. Results were consistent with UTI. Mild elevation in ALKP. O concerned for tense abdomen and loose stool Not wanting to eat since yesterday morning Current diet: Urinary SO (recent change) Reports focal seizure. Pet described as twitching, no generalized tonic-clonic episode. Last seizure was >6 months ago. Not a recent epileptic patient. Current medications: Phenobarbital 60 mg PO BID, Gabapentin, Clavaseptin No known recent phenobarbital level No known ingestion of toxins or human medications 02/21: Returned for recheck as still not eating Current Medications Fortiflora, phenobarbital

Abnormal PE/Chem/CBC/UA Results: 2/12 - UTI and crystalluria on UA; E.coli on culture CBC - m1 leukocytosis (19.11) characterized by m1 neutrophilia (16.42) with left shift and m1 monocytosis (1.29) Chem 17 - m1 increased ALP (319) Lytes - wnl SDMA - wnl 02/20 Chem 10, lytes m1 hypokalemia (3.4) m1 increased ALT (141) m1 increased ALP (340) UA - resolved UTI - USG 1.024 please see attached rads

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

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. The right kidney measured 4.45 cm. The left kidney measures 5.28 cm.

Adrenal Glands

The right adrenal gland is normal in size (1.8 cm long x 1.52 cm at the cranial pole and 0.74 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

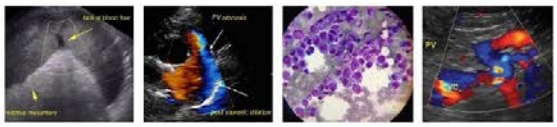
The left adrenal gland is normal in size (1.88 cm long x 0.61 cm at the cranial pole and 0.60 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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Gallbladder is moderately distended with anechoic bile as well as mild suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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. A small amount of anechoic free fluid is also noted. In the caudal left limb of the pancreas, there is a 1.0 cm x 2.5 cm hypo- to possibly anechoic structure that may represent a cyst or emerging abscess/necrosis, or even a concurrently enlarged lymph node cannot be definitively ruled out.

Free Abdomen

See pancreas.

PRIMARY FINDINGS

- Acute pancreatitis with possible emerging pancreatic cyst or abscess or lymphadenopathy in the area of the left limb.

SECONDARY FINDINGS

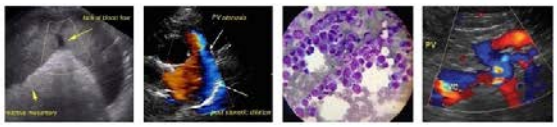
- **Mild gallbladder debris -** Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Given the concurrent neurologic signs, a blood pressure is recommended if not recently evaluated.

In the meantime, 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. If the left limb structure



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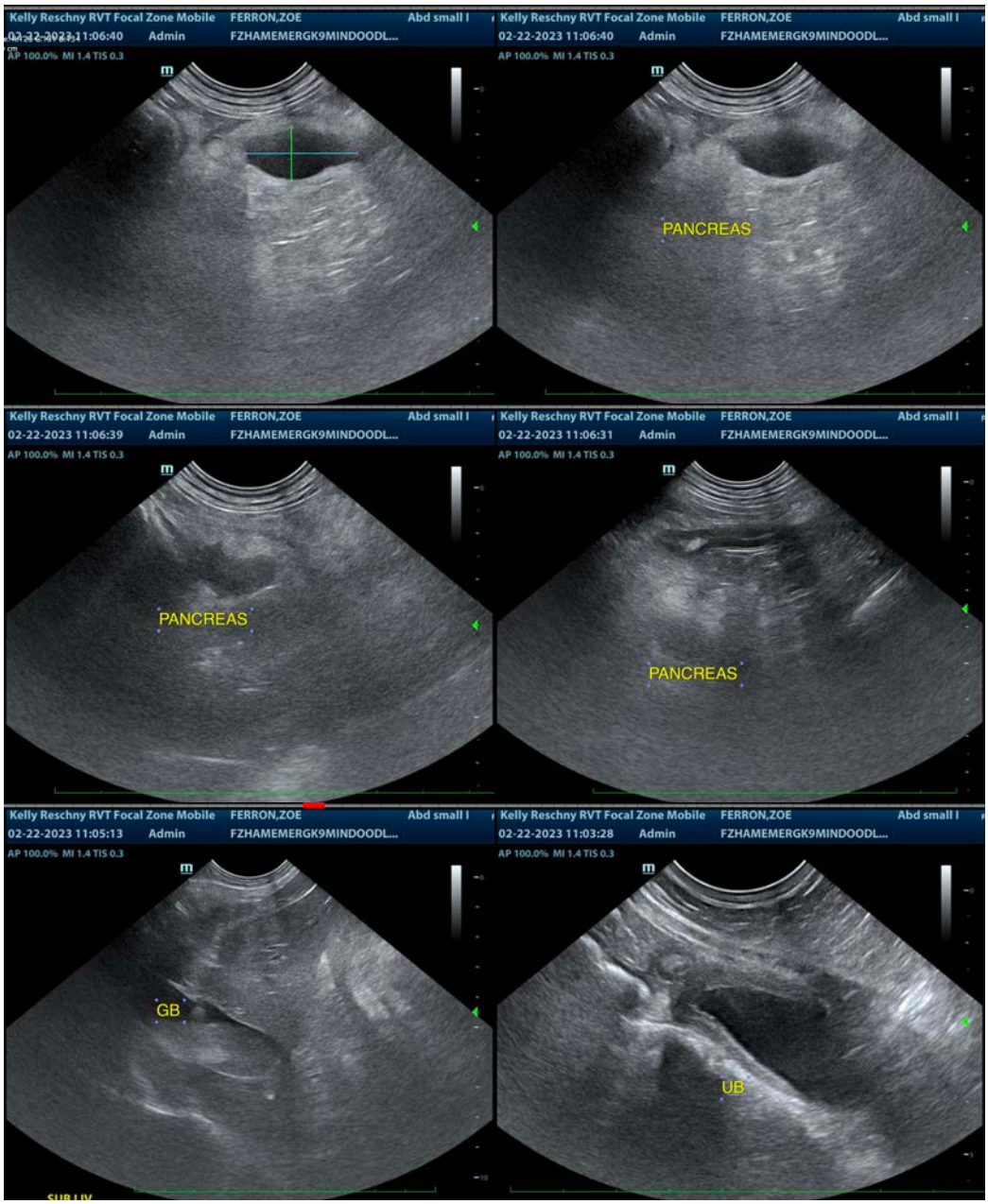
does not change in appearance and does not have evidence of blood flow while being monitored, a fine needle aspirate could be considered if patient's coagulation status is appropriate.



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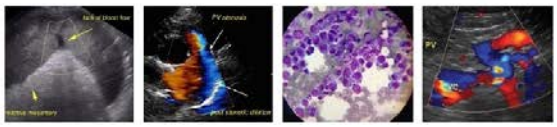

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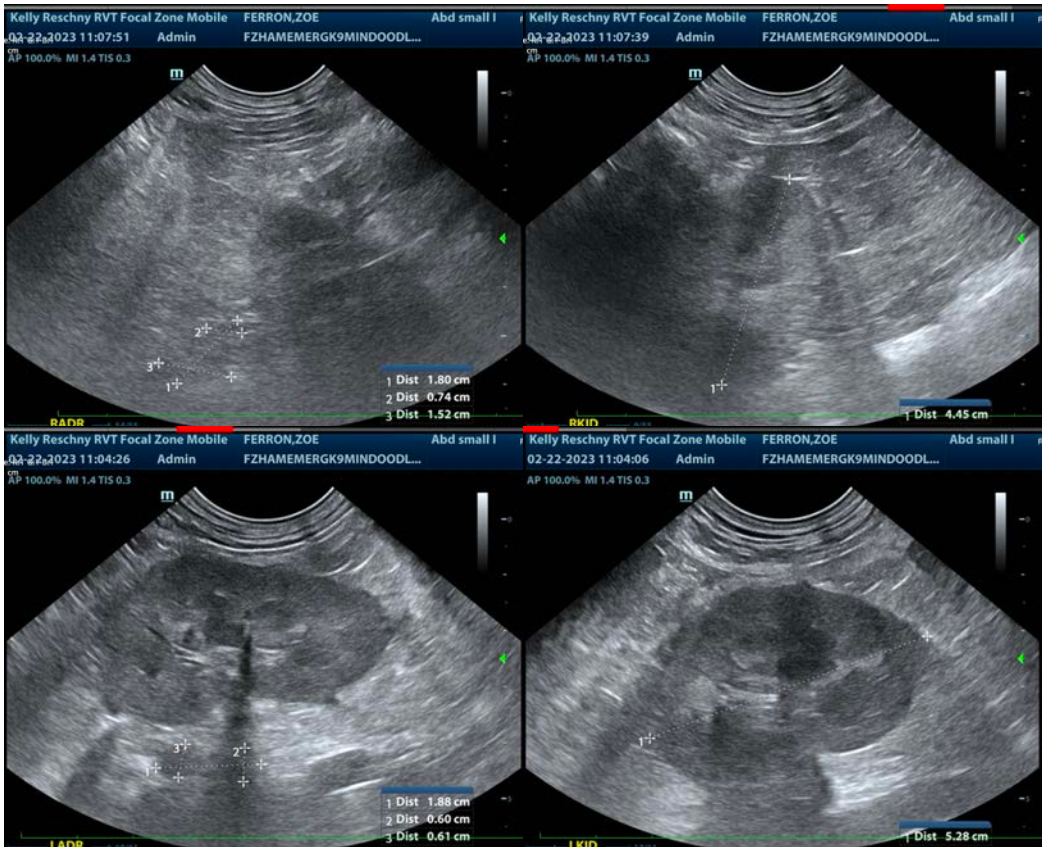

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com