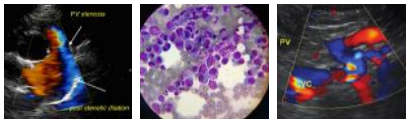
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

3/8/23

PATIENT

Bella Swann

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

11/21/15

WEIGHT

10.19 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Westminster VH

REFERRING VET

Dr. Hall

INVOICE

21506

PRESENTING CLINICAL SIGNS

History: Pet has a history of chronic pancreatitis and ALP elevation. For the last couple of months pet will have episodes of shaking, licking herself uncontrollably, nausea and overall abnormal. Pet will sometimes eat on these occasions, sometimes she will not. When presented in January for this episode no abnormalities were noted on PE, pet was given fluids and Cerenia and started on gabapentin, pet seemed to do well. She had another episode on 2/28/23. Pet was started on Cerenia chronically at this time and repeat bloodwork revealed normal spec cPL and continued elevation in ALP. Pet has been continuing to lose weight--pet was switched to wet food only diet but acts ravenous at home. Recently started on dry food to compensate. Abdominal US was recommended for recheck of pet

Current Medications: Gabapentin 50mg PO BID started 01/2023, Cerenia 12mg PO SID PRN
Lab Results: 3/1/23: CBC: normal; Chemistry: Glucose: 121mg/dL (63-114); Phosphorus: 2.4mg/dL (2.5-6.1); ALP: 1,167U/L (5-160); Cholesterol: 357mg/dL (131-345). 1/11/23: snap cPL ABNORMAL
Date of Previous IntraPet Ultrasound: 6/8/22. See attached.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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.

Left kidney is normal is size (3.74 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 (3.65 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 (1.52 cm long x 0.64 cm at cranial pole and 0.65 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.35 cm long x 0.65 cm at cranial pole and 0.72 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 (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with fluid, as well as some echogenic non-shadowing luminal contents and gas consistent with normal ingesta and chyme. 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. 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 and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic pancreas – This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present.

- Hyperechoic hepatomegaly – This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible but considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

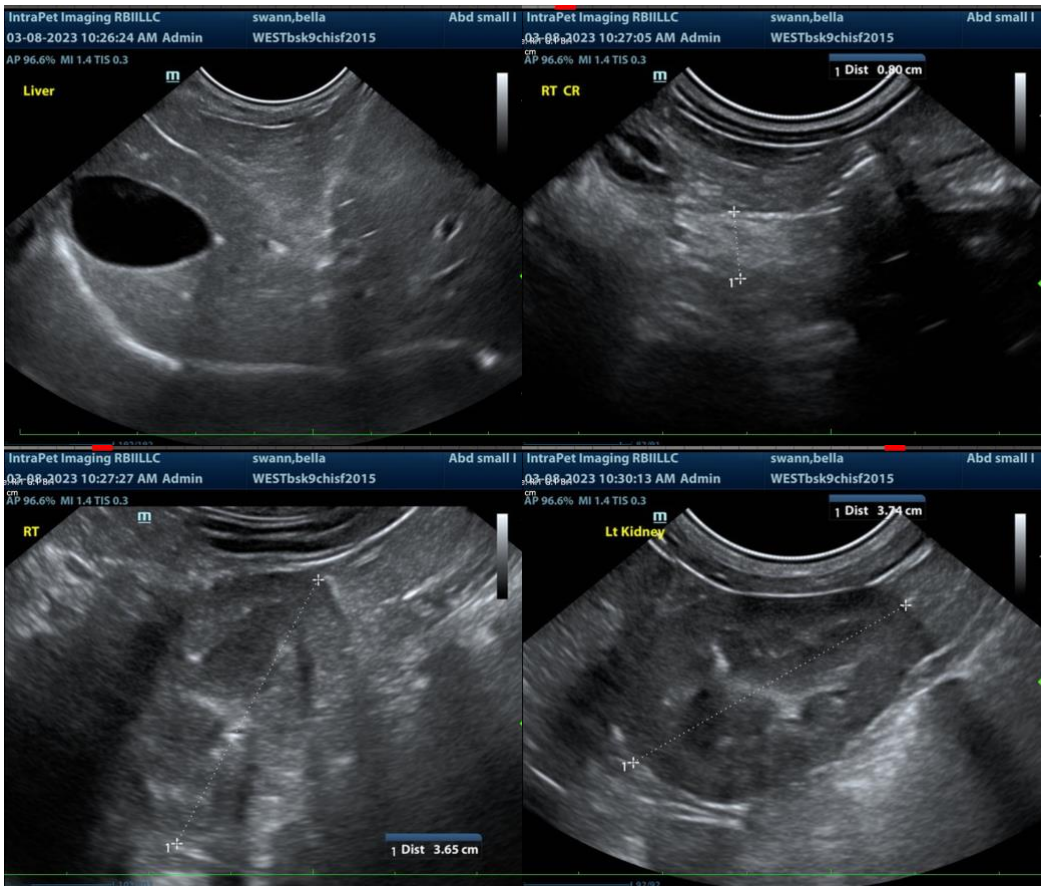
Given the appearance of the pancreas, combined with this patients reported weight loss, despite a ravenous appetite, further evaluation for possible exocrine pancreatic insufficiency, as well as further evaluation of gastrointestinal function, is recommended with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

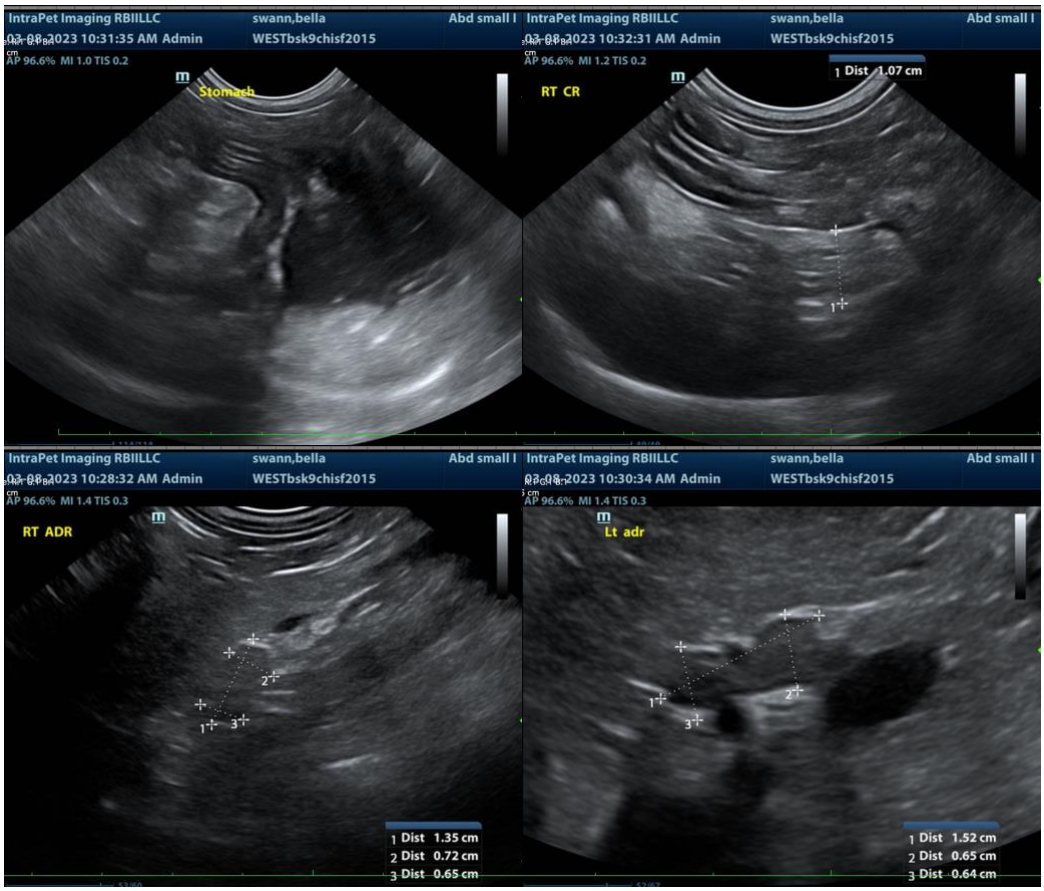
The reported intermittent episodes of shaking, ADR, etc., could be related to abdominal pain caused by pancreatitis flair-ups, however, other considerations should be given to possible orthopedic and/or neurologic painful episodes. Regardless, pending GI panel results, if tolerated, transition to a low fat diet could be considered to see if that helps alleviate episodes.

Differentials for a primary cholestatic liver enzyme pattern (increased ALP) are vast and non-specific. Differentials include, but are not limited to, benign nodular hyperplasia which occurs in 70% of older dogs

and often does not result in an abnormal ultrasound, reactive or idiopathic/vacuolar hepatopathy, cholestasis and/or hyperadrenocorticism as well as many chronic non-hepatobiliary diseases such as chronic infections/inflammation from dental disease, IBD, neoplasia, hyperlipidemia, hypothyroidism, chronic pancreatitis, chronic stress, etc.

There is no ultrasonographic evidence of cholestasis. Adrenocortical testing such as a low dose dexamethasone suppression test could be considered if clinical signs of hyperadrenocorticism are present. Ursodiol could be considered if gallbladder sludge is noted. A fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate. Otherwise, recommendations include addressing any other concurrent disease and monitoring. If values are progressive, recheck imaging is recommended.





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.

Beth Johnson, DVM DACVIM
Beth.Johnson@SonoPath.com