



DATE	PRESENTING CLINICAL SIGNS
4/28/2028	Patient History: Anakin presents for pancreatitis diagnosed at Swan Creek yesterday Patient History: - Pancreatitis diagnosed yesterday at Swan Creek - Started vomiting Monday morning at 2:30 AM - Was normal Saturday, sleeping more Sunday - Last full meal was Saturday - Currently not eating or drinking well but walking around more - Has not vomited since 10:30 AM yesterday - History of eating rabbit feces and becoming ill from it previously - No other significant medical history, surgeries, seizures, or diabetes - Low-fat diet recommended by previous veterinarian.
PATIENT	
Anakin Zacerous	
SPECIES	Current Medications: None listed.
Canine	Labwork Results: Labwork not attached / pending.
BREED	Date of Previous IntraPet Ultrasound: No previous.
Pekingese Mix	Sedation: Not required to complete full diagnostic ultrasound.
SEX	Stat Report: STAT requested.
MN	Imaging Performed by: Rachel Brillhart, RDMS.
AGE	ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
14 years	Urinary System
WEIGHT	The 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.
22.8 lbs	Prostate is normal in size, echotexture, and echogenicity for a neutered male.
INTERPRETED BY	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 mineral or infarcts observed. Trace pyelectasia is noted bilaterally. Left kidney measures 5.46 cm and the right kidney measures 4.92 cm.
Beth Johnson, DVM DACVIM	Adrenal Glands
HOSPITAL NAME	Adrenal glands are bilaterally mildly plump in size for a small dog. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.
Animal Emergency Hospital	REFERRING VET
REFERRING VET	Left adrenal measures 0.88 cm at the cranial pole and 0.79 cm at the caudal pole. In the left adrenal gland, there is a discrete homogeneous non-capsular disrupting 0.5 cm x 0.7 cm hypoechoic nodule is noted in the cranial pole.
Dr. Willer	INVOICE
INVOICE	The right adrenal measures 1.0 cm at the cranial pole and 0.69 cm at the caudal pole. A hyperechoic nodule is noted in the cranial pole of the right adrenal. Nodule does not disrupt normal shape and/or architecture. The nodule in the right adrenal gland measures 0.7 cm in diameter.
11803	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). An approximately 1.1 cm x 0.74 cm non-capsular disrupting hypo- to anechoic nodule is noted near the cranial aspect of the spleen. 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.

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 and luminal wall. The wall is mildly subjectively thick, irregular, and hyperechoic measuring 0.38 cm thick with some edematous areas noted. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with 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. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in thickness except for a very mild, thick wall measuring 0.34 cm thick in the very distal descending colon. The lumen is mildly distended with soft stool.

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 no visible free peritoneal effusion noted in these images.

There is a mildly prominent hypoechoic lymph node adjacent to the pancreas.

Other

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

PRIMARY FINDINGS

- Mild to moderate acute pancreatitis, possibly a resolving acute on chronic low grade smoldering pancreatitis flare up is suspected.

- Mild mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- 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.
- Mildly reactive cranial abdominal/suspect pancreaticoduodenal lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- 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. With a hyperechoic adrenal nodule in the right adrenal gland– Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored. As well as a subtle hypoechoic nodule in the left adrenal gland with similar differentials.
- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions and cannot be ruled out.
- The mildly thick distal descending colon trends in appearance toward benign, as is seen with colitis, potentially secondary to other underlying metabolic disease versus parasitic, infectious, dietary related, inflammatory changes, etc. Infiltrative neoplasia is possible but considered less likely.

SECONDARY FINDINGS

- Age related kidney changes with trace pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

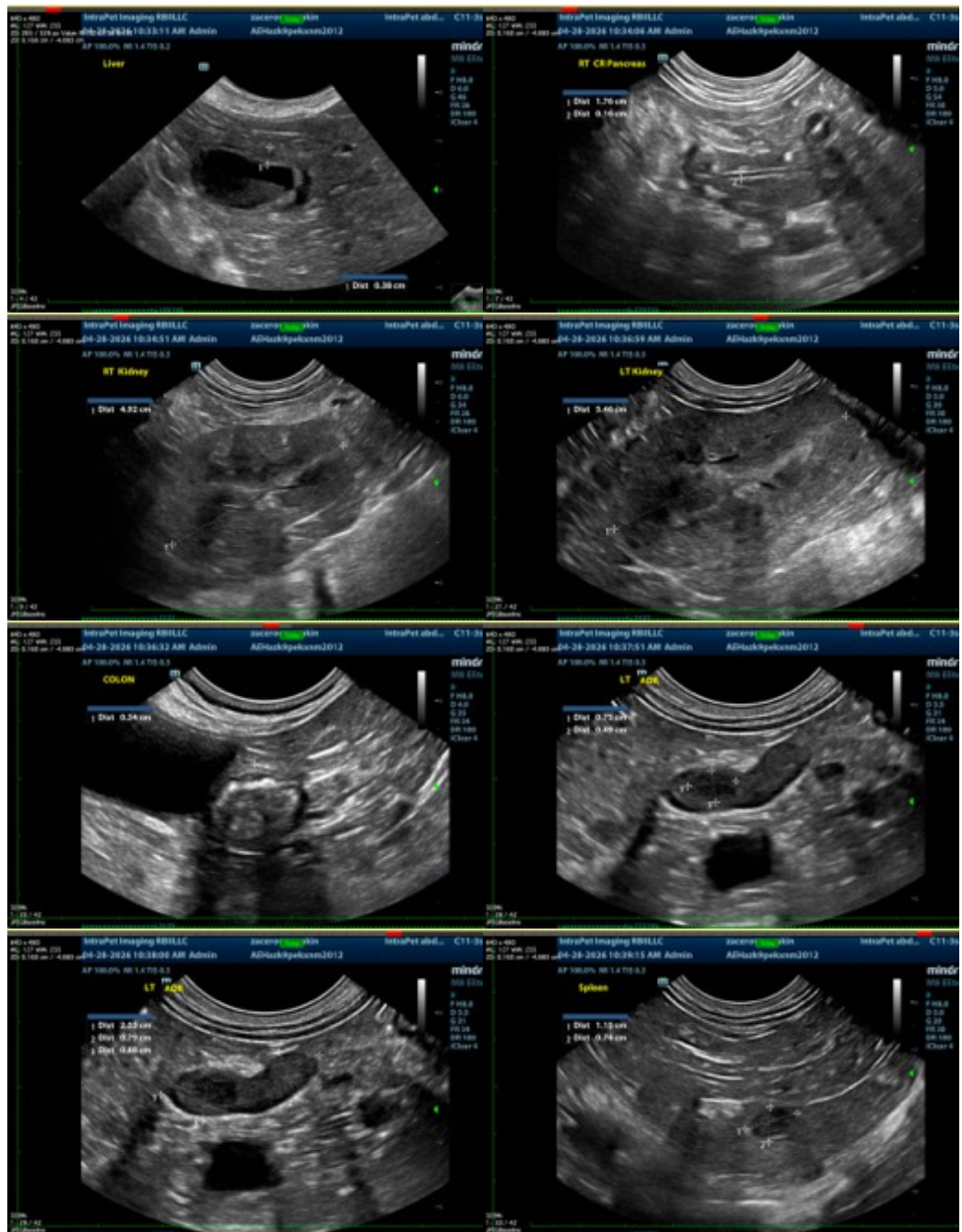
AS is reportedly already pending, a full general metabolic health screen is recommended to include CBC, chem panel, electrolytes, and urinalysis.

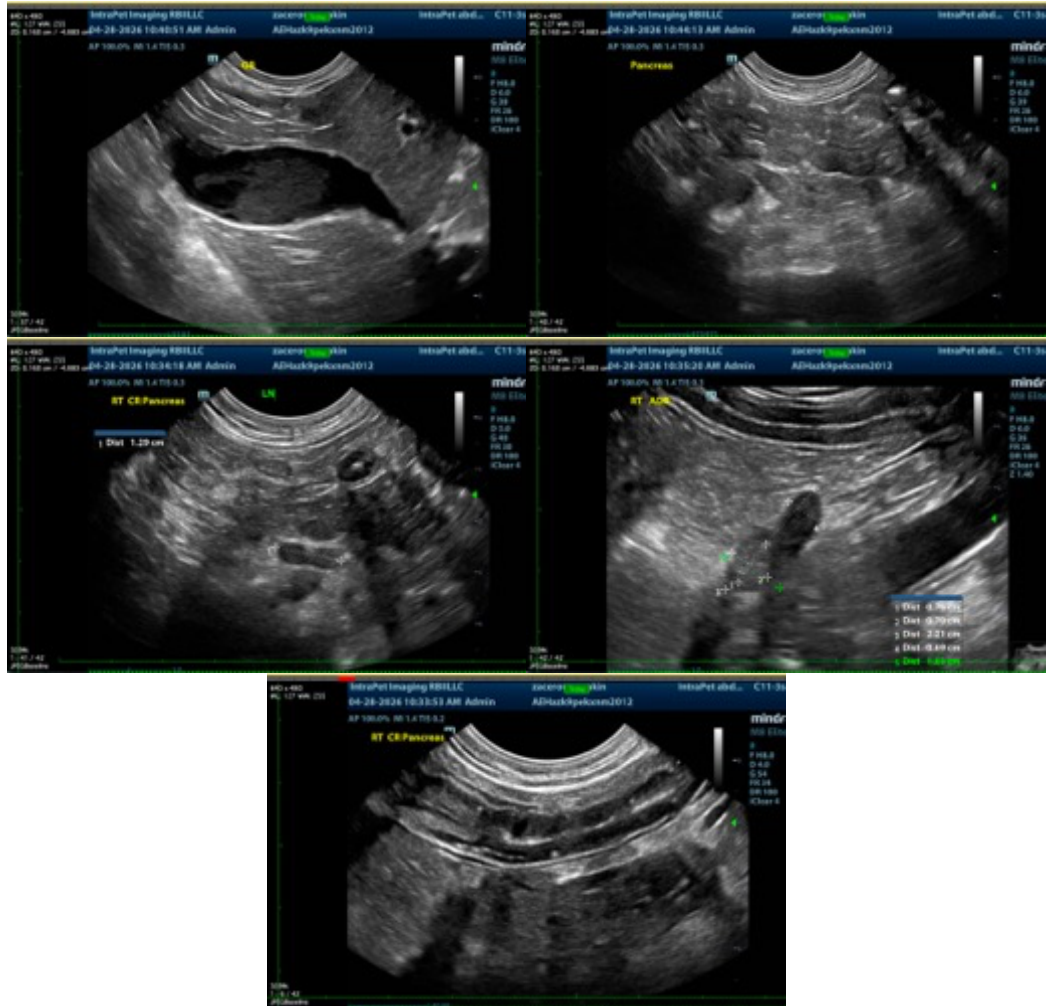
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Additionally, a routine fecal/giardia exam is recommended if not recently evaluated. As could a fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

While continuing workup, 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. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.

Further diagnostic and potentially treatment recommendations are largely dependent on results of above, as well as patient's response to management of suspected pancreatitis.





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.

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