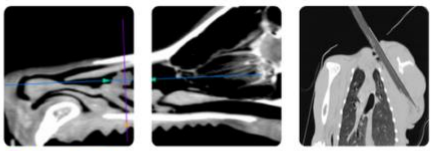

PATIENT

Oliver McArthur

SPECIES

Canine

BREED

Terrier Mix

SEX

Neutered Male

AGE

7 Years

WEIGHT

7.14 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hamilton Region Emergency Veterinary Clinic

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INVOICE

16355

DATE

05/19/26

PRESENTING CLINICAL SIGNS

Presented with Hyporexia that progressed to anorexia and developed diarrhea over the past 10 days. May 9 RDVM noted elevated pancreatic lipase, rest of BW was WNL and was sent with Metronidazole and Tramadol. No improvement since then. Recheck RDVM May 18 revealed severe cholangiohepatopathy with improved catalyst pancreatic lipase. U/A voided sample USG 1.020, +++Bilirubinuria, quiet sediment. P UTD on Lepto vaccine. May 18 PE - quiet, dull, pale icteric MMs, painful abdomen. AFAST free fluid score 0/4, stomach distended with fluid despite anorexia, NG tube placed, Indwelling catheter placed, Lepto Witness negative, Lepto culture pending. Start IVF, Maropitant, Methadone, Ampicillin, Metoclopramide, Acepromazine, Trazodone, Gabapentin.

Abnormal PE/Chem/CBC/UA Results: May 18 RDVM diluted sample ALT 337, ALP still too high to read, GGT 89, total Bili 130, pancreatic Lipase 533. U/A dark in color, USG 1.020, mild hematuria, moderate bilirubinuria.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended. Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended. There appears to be a urinary catheter in place.

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

Left kidney is normal in size (4.19 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, or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

Right kidney is normal in size (5.14 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, or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

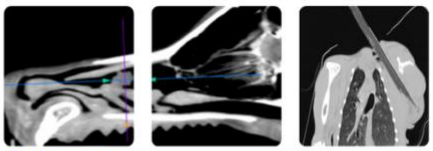
Adrenal Glands

Left adrenal gland is normal in size (0.44 cm at cranial pole and 0.49 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.68 cm at cranial pole and 0.52 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). Splenic vasculature appears normal. Near the cranial aspect of the spleen, there is a very subtle non-capsule disrupting approximately 2.0 cm in diameter homogenous, focally rounded, iso- to slightly hyperechoic density.



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Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. 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 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. 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 no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Suspect moderate acute pancreatitis.
- A concurrent hepatopathy cannot be ruled out, but an obvious cause for the subtle liver changes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia (considered unlikely), etc. cannot be definitively ruled out.
- The subtle splenic changes described above are non-specific and can represent a benign or infiltrative neoplastic process which cannot be differentiated without tissue sampling.
- Punctate non-obstructive mineral densities in the kidneys bilaterally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Fine needle aspirates of the spleen +/- liver could be considered if patient's coagulation status is appropriate.

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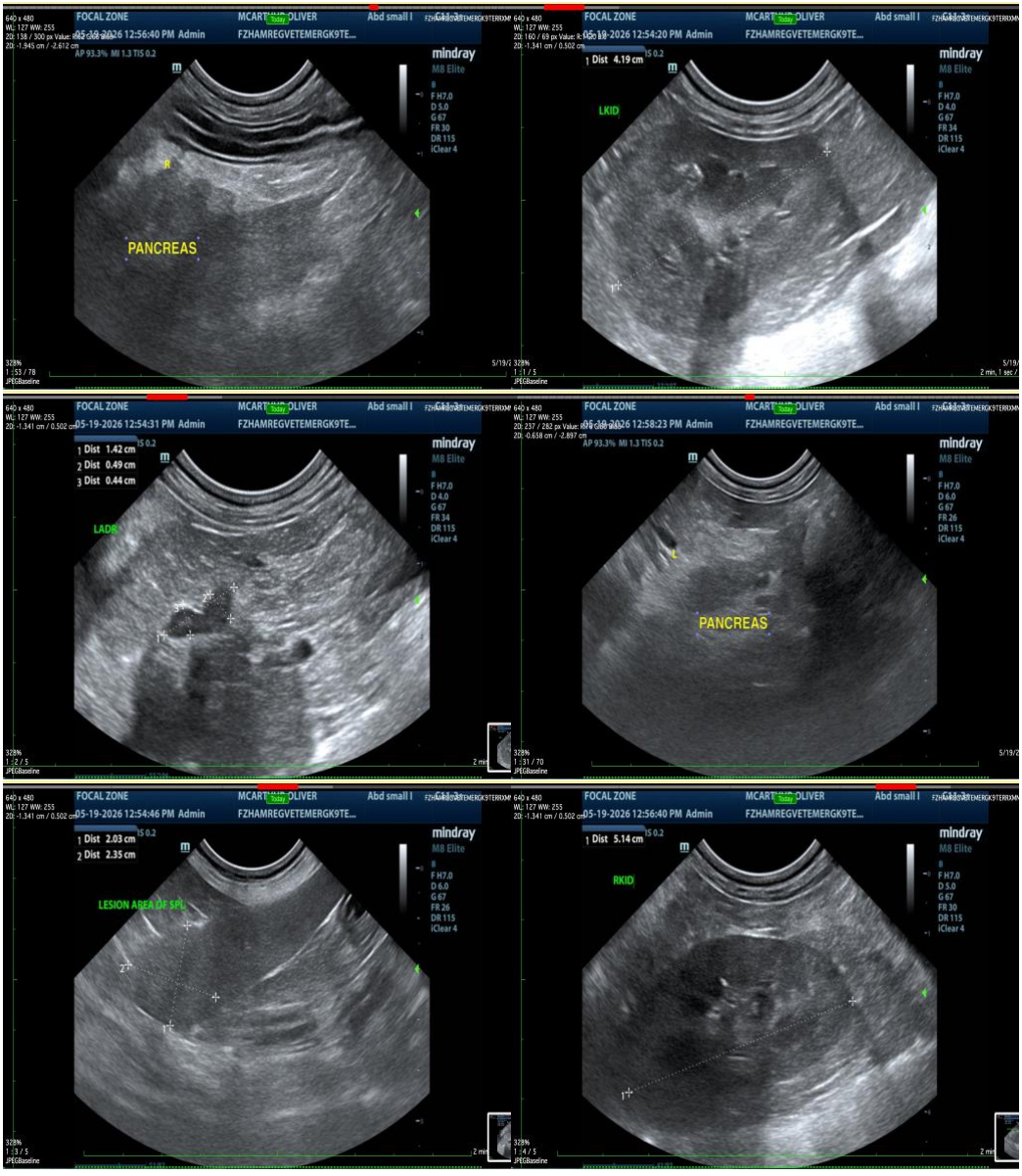
In the meantime, however, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. If possible, a fresh frozen plasma transfusion and hyperbaric oxygen 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.



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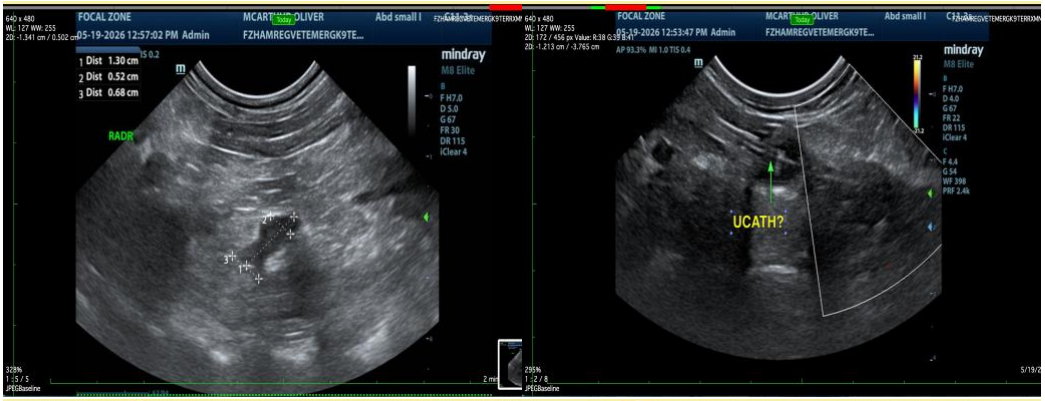

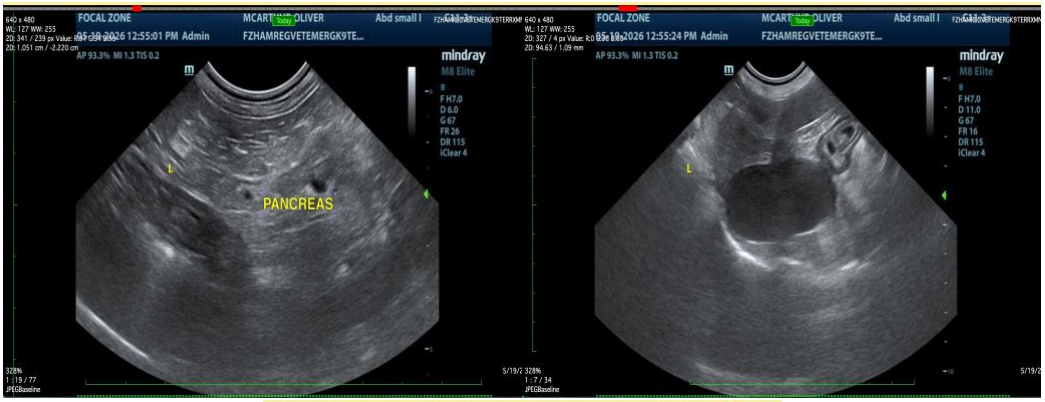

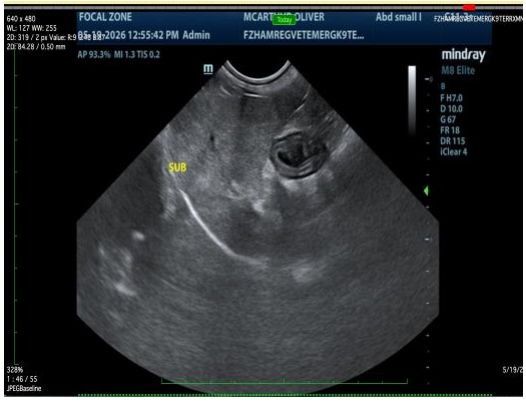

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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