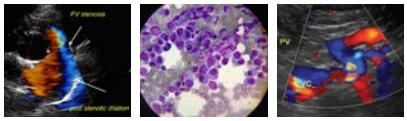
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

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DATE

6/15/23

PATIENT

Bo Seipp

SPECIES

Canine

BREED

Bichon Frise

SEX

Neutered Male

AGE

3/6/09

WEIGHT

18.7 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Martinoli

INVOICE

43211

PRESENTING CLINICAL SIGNS

Vomited last night. This morning ate breakfast and seemed fine most of the day until 5:30 pm, he vomited up some of his breakfast. He was still hungry though, and ate some chicken and rice, but then vomited that. Was whining and seemed uncomfortable. Was at rDVM 3 weeks ago for diarrhea (owner though also constipated but sounds like he was straining); was put on Metronidazole and Probiotic; last dose of both was 3 days ago. Other recent symptom has been intermittent blood in urine. Had UA done, was normal, and abdominal radiographs done 3 weeks ago showed no stones.

Current Medications: Buprenorphine, Protonix, Ondansetron.
Lab Results: ALT 664.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

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

The right kidney is normal in size (5.62 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.

The left kidney is normal in 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.

Adrenal Glands

The right adrenal gland is normal in size (1.72 cm long x 0.60 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.

The left adrenal gland is normal in size (1.78 cm long x 0.42 cm at the cranial pole and 0.53 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.

Gallbladder is moderately overdistended with organized, aggregated and centralized non-gravity dependent sludge. Striations of sludge separated by anechoic areas are noted extending from the lumen to the luminal wall. The wall is mildly thick, irregular and hyperechoic. There is no evidence of CBD dilation.

Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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 (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, except for mildly hyperperistaltic proximal duodenum adjacent to the pancreas.

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. **The change is most prominent in the right limb.

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

The entire cranial abdomen primarily adjacent to the gallbladder and surrounding the stomach, proximal duodenum and right limb of the pancreas is diffusely enhanced/hyperechoic.

PRIMARY FINDINGS

- Acute pancreatitis
- Gallbladder mucocele

SECONDARY FINDINGS

- Urinary bladder debris

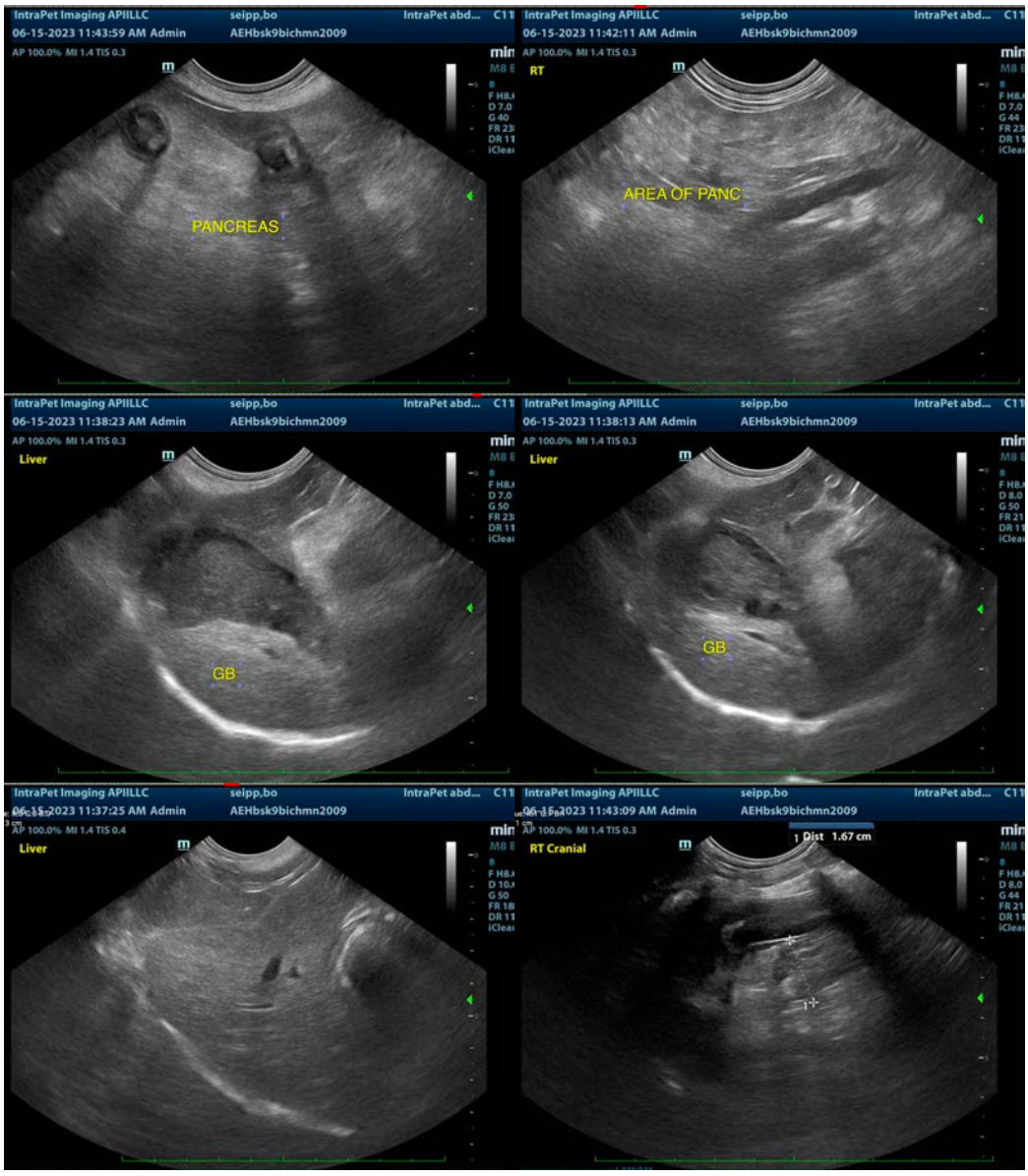
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

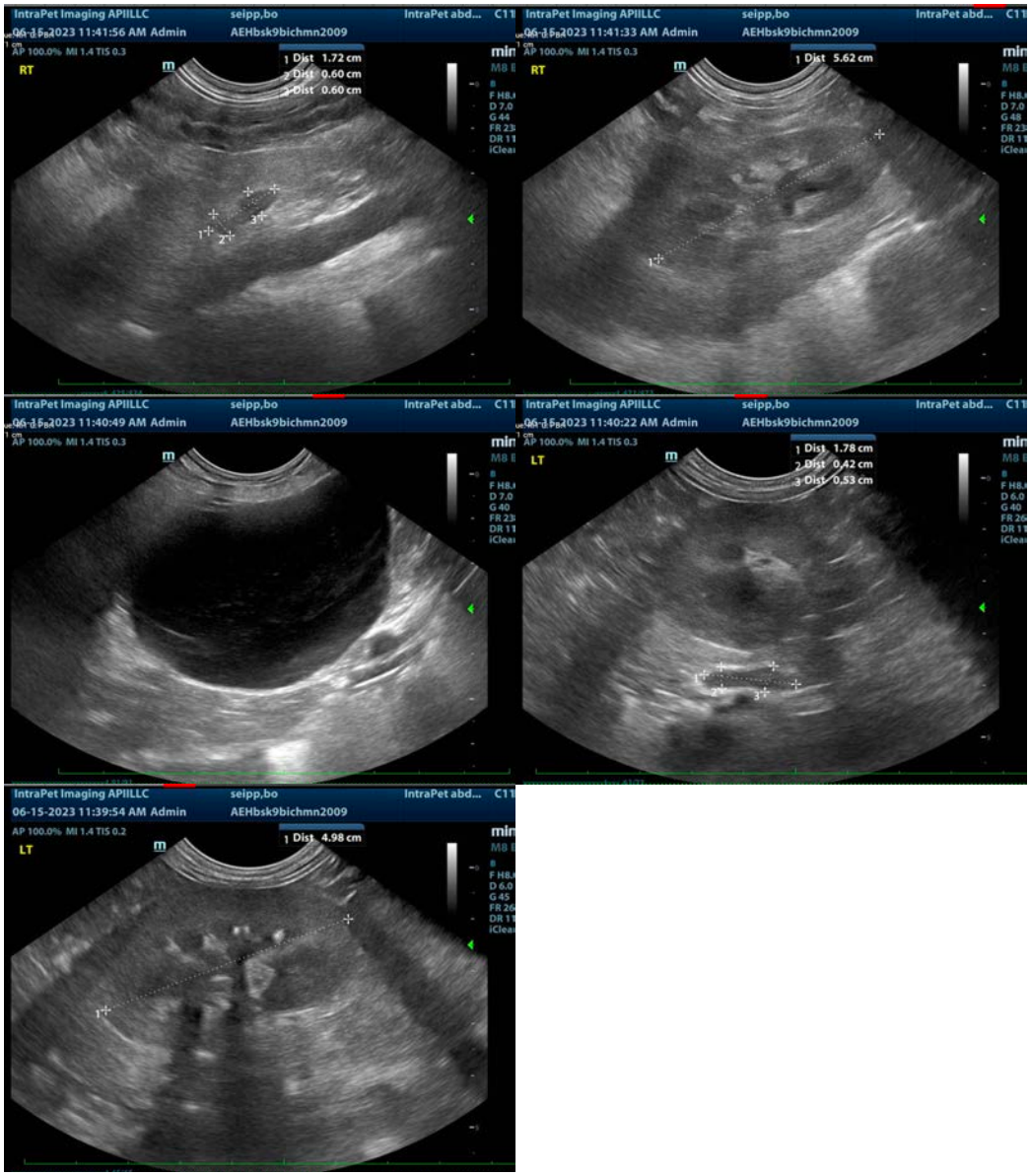
The cranial abdominal changes consistent with inflammation in this patient are likely a combination of inflammation from the acute pancreatitis as well as an unknown amount of contribution from the emerging mucocele/mucocele. Both scenarios can cause similar clinical signs, cranial abdominal pain, and even laboratory changes.

Therefore, recommendations include supportive/symptomatic medical management of acute pancreatitis in the form of antiemetics, gastroprotectants, appetite stimulants, or nutritional support as needed, pain management, broad-spectrum antibiotics, and fluid therapy, as well as hepatic nutraceuticals including Ursodiol, with close monitoring for improvement versus progression. If improvement isn't noted and/or

patient's clinical signs worsen, further intervention up to and including possible cholecystectomy may be ultimately necessary.

If a more invasive approach is elected sooner, and patient is stable to undergo surgery at this time, it would not be unreasonable to proceed with a cholecystectomy, liver biopsy, etc. versus trying medical management first.





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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