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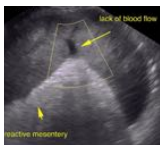
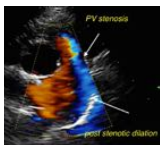
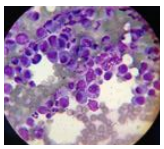
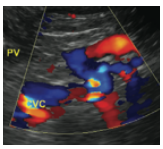

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1-800-838-4268 info@sonopath.com

**PATIENT**

Napoleon BC
Chihuahua Rescue

**SPECIES**

Canine

**BREED**

Chihuahua

**SEX**

Neutered male

**AGE**

11 years

**WEIGHT**

2.9 kg

**INTERPRETED BY**

Beth Johnson, DVM
DACVIM

**IMAGING PERFORMED BY**

Alejandro Vargas Lumbreras, RVT

**HOSPITAL NAME**

Central Island Veterinary Emergency Hospital

**REFERRING VET**

Dr. Daniel

**INVOICE**

32089

**DATE**

7/30/22

## PRESENTING CLINICAL SIGNS

History: Hyporexia, painful - hx pancreatitis: seemed to get over the pancreatitis - was doing well, pain free, "happy go lucky". Owner gave dewormer (had worms in feces). On Tuesday this week, appetite declined, Wednesday was bowing and seemed uncomfortable, started vomiting and having diarrhea again - owner restarted Cerenia and codeine. Couldn't get into rDVM but they refilled meds. Codeine doesn't seem to be lasting long enough - wakes up in pain. Syringing water. Gave codeine at 6am. Owner is giving codeine every 8 hours. Vomit some last night in spite of having Cerenia. Ondansetron seemed to help better w/ vomiting. No full abdominal rads performed - just chest to assess heart (nothing abnormal seen on cranial aspect). Hx from rDVM: V/D intermittently, decreased appetite, heart murmur, coughing. Did have some blood in the stool. Sent home w/ sulcrate, metronidazole, cerenia, probiotics (not eating), codeine.
Abnormal PE/Chem/CBC/UA Results: Unable to perform oral exam - muzzled. OU lenticular sclerosis. gr 4/6 heart murmur PMI left base. lungs clear. Abdomen mildly painful on cranial palpation. BW from rDVM: highly suggestive for pancreatitis w/ markedly elevated amylase and lipase, leukocytosis. UA: proteinuria w/ low USG (no azotemia).

## 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 (2.5 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 (2.8 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 (0.64 cm at cranial pole and 0.38 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. A hyperechoic nodule was noted in the cranial pole of the left adrenal gland that does not disrupt normal shape and/or architecture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.32 cm at cranial pole and 0.5 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.

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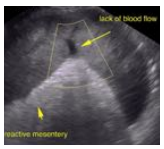
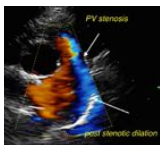
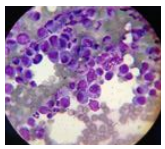
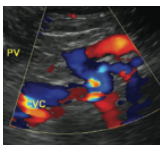

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### *Liver*

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 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 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. 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 evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

Mild acute or potentially acute on chronic smoldering pancreatitis.

Hyperechoic right adrenal nodule.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the chronicity of the gastrointestinal signs combined with the pancreatitis recommendations include:

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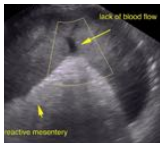
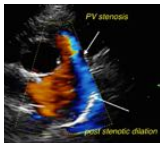
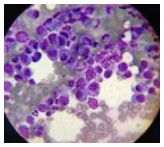
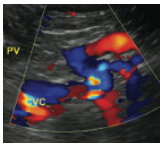

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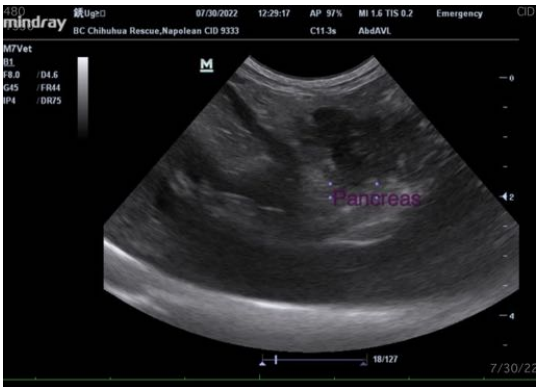
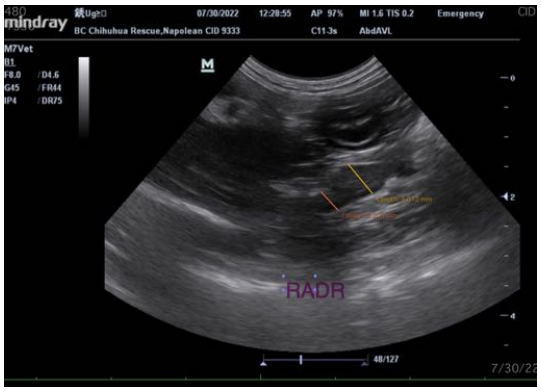
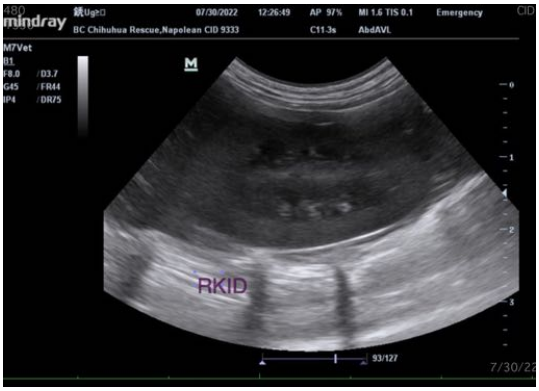
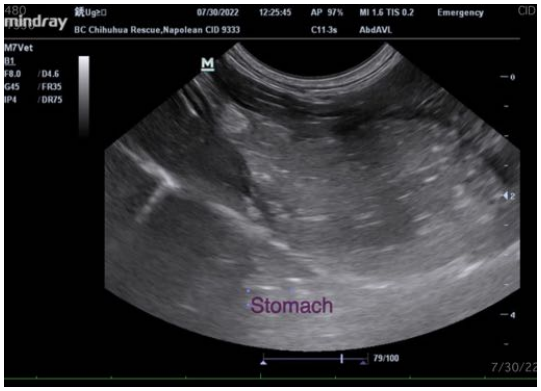
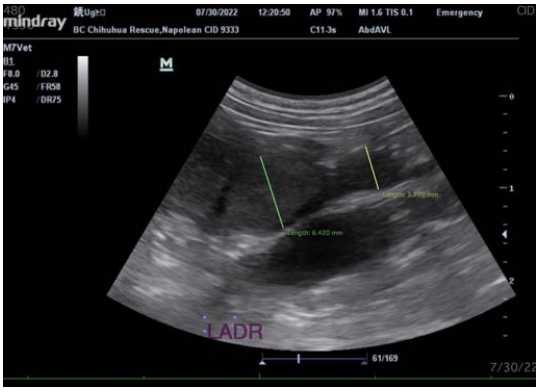
1. A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
2. Continue medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics and fluid therapy. If improvement is not noted a fresh frozen plasma transfusion and/or hyperbaric oxygen therapy if available would be beneficial. A low-fat diet is recommended long term for this patient given the recurrence of clinical signs.

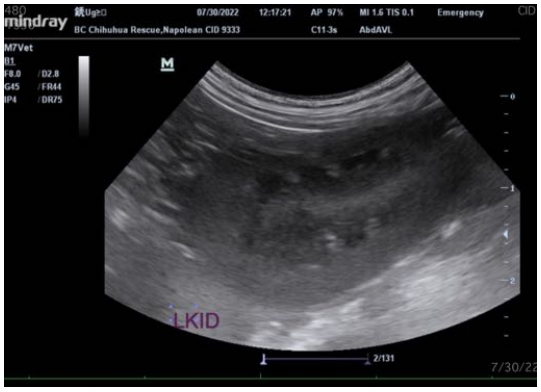












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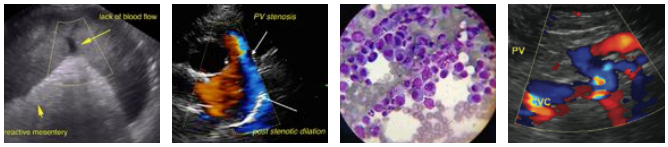


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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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