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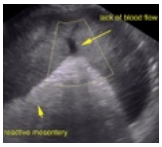
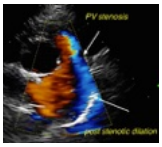
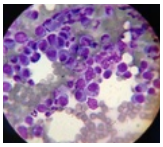
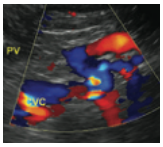

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1-800-838-4268 info@sonopath.com

PATIENT
Eli Dansky

SPECIES
Canine

BREED
Shi Tzuh

SEX
Canine

AGE
12 yr. 7 mo.

WEIGHT
20.6

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Anthony Krawitz, DVM

HOSPITAL NAME
Calusa Veterinary Center

REFERRING VET
Dr. Sid Ranade

INVOICE
10414

DATE
8/15/2023

PRESENTING CLINICAL SIGNS

Presented to our ER yesterday for vomiting 3 days in a row once a day, and then vomiting foamy fluid 6 times 2 nights ago. Also, lethargic and no appetite. In addition, had diarrhea with dark stools, that was black last night. History of 2 skin mast cell tumors removed April 2023, and cystotomy in 2021.

Abnormal PE/Chem/CBC/UA Results: Alb 1.8 with TP 4.4. CPL Bionote 1379 (<200) T bili 0.2., Cort >10. ALT 168, Alk phos 122. WBC 5.2, with 2+ toxic neutrophils. Ht 35%.

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.

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. Punctate non obstructive nephroliths noted bilaterally. There is no evidence of pyelectasia, or infarcts observed. The left kidney measures 5.02 cm. The right kidney measures 5.36 cm

Adrenal Glands

The right adrenal gland is normal in size (cranial 0.56 cm, caudal 0.51 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (cranial 0.5 cm, caudal 0.51 cm), 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

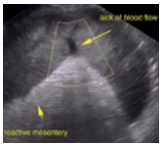
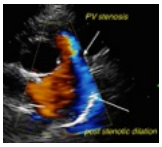
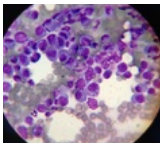
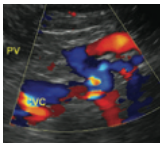
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is 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 otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is moderate luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

The visible small intestines are normal in wall thickness and layering. Bowel is diffusely mildly fluid distended without evidence of an obstructive pattern, plication and/or visible foreign material. Small intestinal hyperperistalsis is noted.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. There is no visible pancreatic duct dilation. There is subtly enhanced peripancreatic mesenteric fat as well as some amount of anechoic free fluid within the cranial abdomen.

Free Abdomen

There is some amount of anechoic free fluid within the cranial abdomen.

Reactive medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- **Emerging gallbladder 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.
- **Pancreatic nodular hyperplasia –** Infiltrative neoplasia cannot be ruled out but is considered less likely. Concurrent acute on low-grade smoldering chronic pancreatitis is also suspected given the enhanced mesenteric fat and free fluid.
- **Gastritis –** Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.
- **Gastroenteritis –** Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other.

SECONDARY FINDINGS

- Age related kidney changes with multiple punctate non obstructive nephroliths bilaterally.
- Urinary bladder debris
- **Reactive medial iliac lymph nodes-** infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient's gastritis/gastroenteritis/diffuse ileus are likely secondary at least in part to mild to moderate/emerging pancreatitis, +/- the concurrent emerging gallbladder mucocele. Micro ulceration with unknown relation if any to the previous history of mast cell tumor can't be definitively ruled out.

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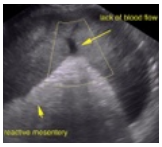
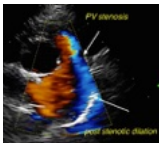
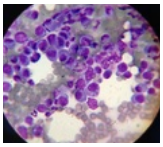
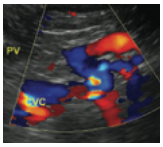

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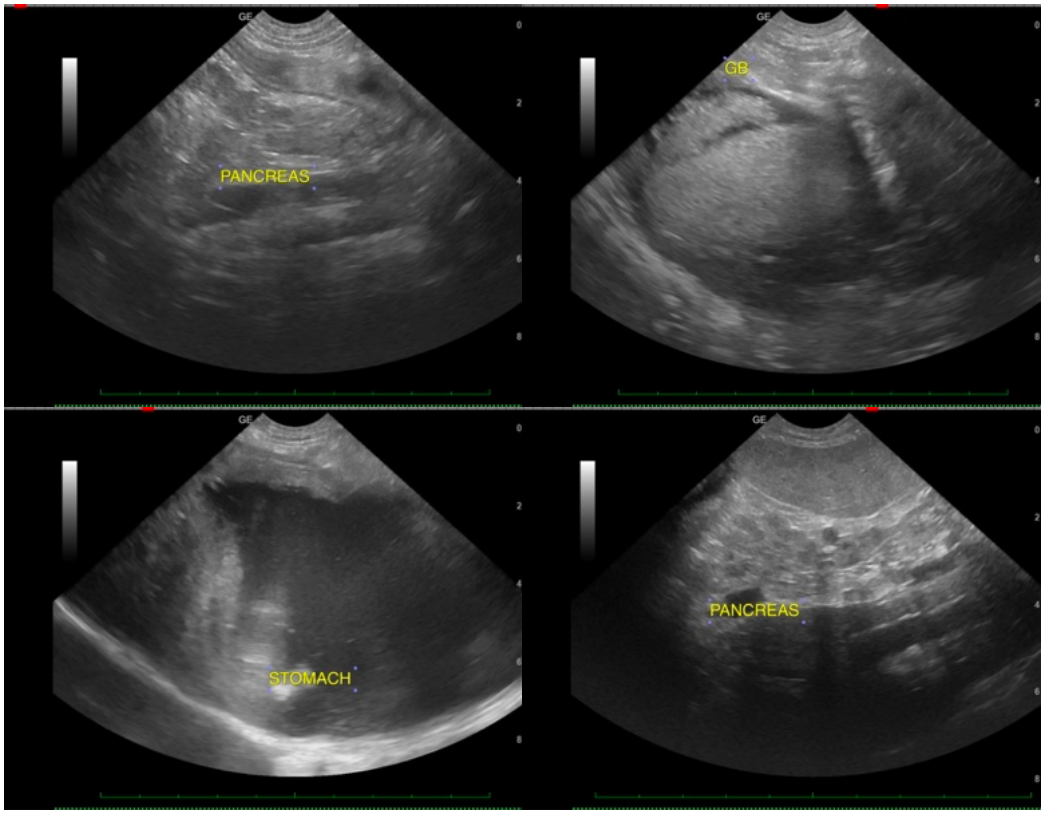
Further diagnostic recommendations include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

In the meantime, supportive/symptomatic medical management of acute gastritis/gastroenteritis/pancreatitis is recommended in the form of antiemetics, gastro protectants including Sucralfate, an appetite stimulant, if necessary, pain management if indicated, fluid therapy, etc. If clinical signs persist especially in the face of cranial abdominal pain, and/or liver enzyme changes to suggest that the gallbladder is playing a more active role further intervention of the emerging mucocele may ultimately be required in the form of a cholecystectomy.

However, if clinical signs persist and suspicion is underlying cause unrelated to the gallbladder upper GI, gastroscopy/endoscopy for further visualization of the GI tract and biopsies may be more appropriate instead. This would be recommended if hematemesis and/or continued melena are the primary presenting complainant.



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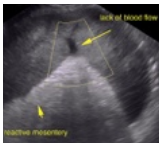
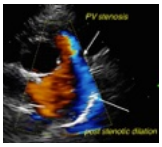
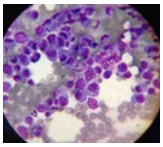
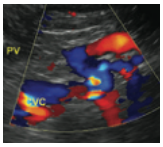

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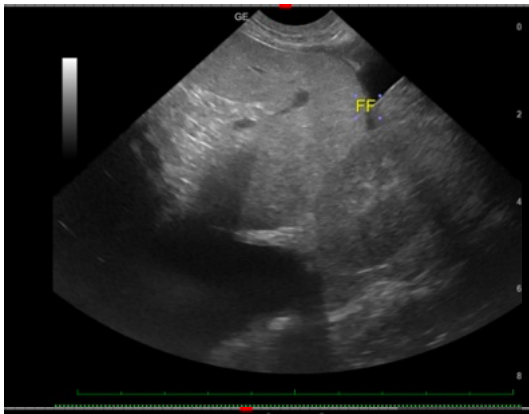

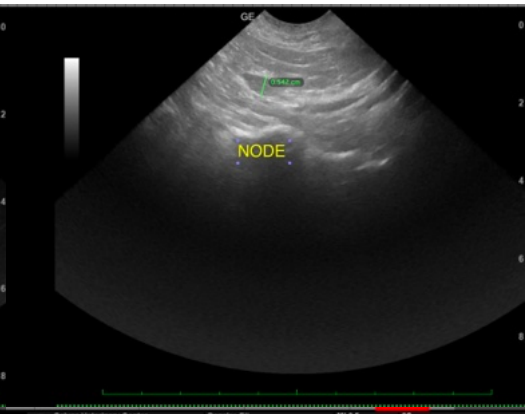

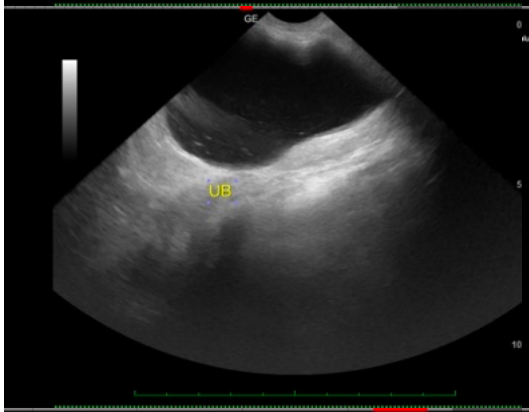

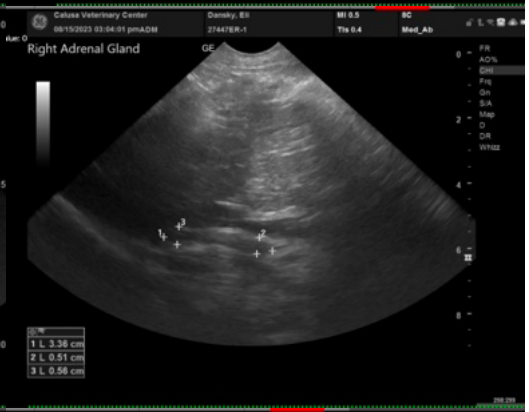

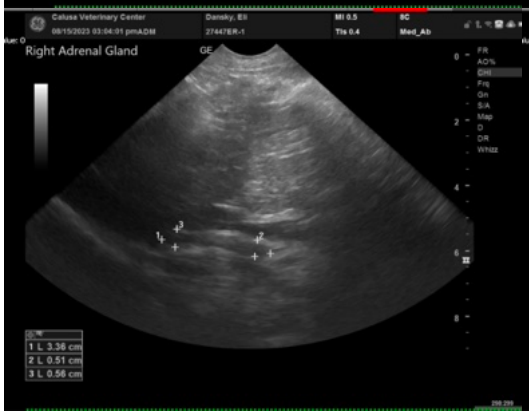

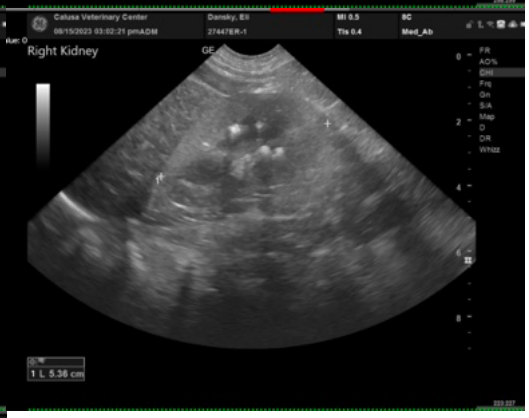

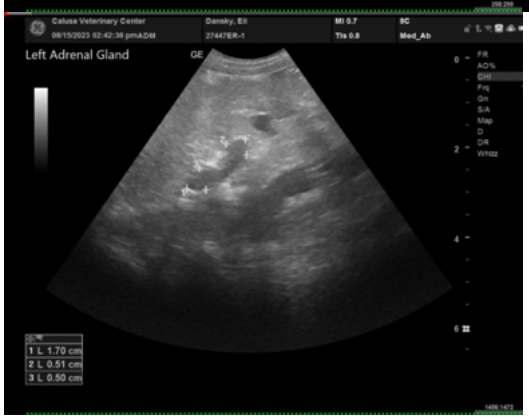

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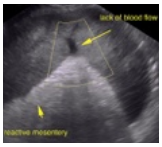
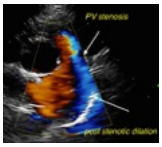
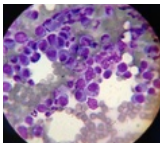
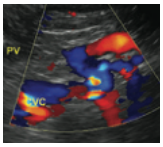

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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