

**PATIENT**

Sophia Hansen

SPECIES

Canine

BREED

Mix

SEX

Spayed Female

AGE

6 Years

WEIGHT

19.2 Pounds

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING PERFORMED BY**

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VETTown Center Vet
Associates**INVOICE**

41183

DATE

9/8/22

PRESENTING CLINICAL SIGNS

O states pt has been struggling with pancreatitis for a while now, previous vet had been doing pretty much the same treatment each visit when coming in for it. O notes this flare up has been occurring since yesterday, pt began not eating again and vomiting up mostly bile. O tried to feed boiled chicken and rice last pm, pt did eat some of this and then began having diarrhea. We are sending off fecal sample today, O did not find any blood in stool. Pt on diet of Royal Canin Intestinal I/D, gets dry and wet. O very careful of what pt gets, is very unlikely to get into anything she is not supposed to. Pt has never been a great drinker, does like wet food.

Abnormal PE/Chem/CBC/UA Results: Vomiting, diarrhea, dehydration, decreased appetite, mild lethargy- chronic pancreatitis vs other (IBD, Addison's). Stage 2 periodontal disease with #108 slab fx and gingival hyperplasia. Diagnostics: Lateral abdominal rad- no foreign material or obstructive pattern noted, mildly thickened small intestines diffusely with gas filled colon Senior screen to antech- pending Tx: LRS- ~250 mL SQ, Cerenia- 0.9 mL (9 mg) SQ Plan: Supportive care and pt to continue on current diet as it is low fat and a gastrointestinal diet, both of which are ideal for pancreatitis. Discussed further imaging (abdominal ultrasound) in the future, especially if increase in frequency of flare ups. I will be in touch with O tomorrow to see how pt is doing and discuss BW results. Discussed and recommended ProHeart 6 injection when pt is feeling better as O reports having a hard time getting Interceptor plus into pt. I also recommend a dental prophylaxis, with possible extraction of #108. Rx: Provable kit Metronidazole (100 mg/mL): 0.9 mL PO BID x 10 days #20 Credelio #1 Trazodone (50 mg tabs): 1/2 to 1 tab PO 2 hrs prior to stressful events, and then q8-12 hrs as needed #25 Question you want answered with an ultrasound: Discussed further imaging (abdominal ultrasound) in the future, especially if increase in frequency of flare ups. TTO-O reports pt seemed to be doing well for 2 days after visit and then she started vomiting again. Pt vomited a couple times daily over the weekend, and vomited once this morning and then ~4-5 times this afternoon. O notes that the vomit is a mix of white foam and bile- no undigested food or grass noted. O notes that pt does not have much of an appetite during the day, but seems to eat in the evening. Stools have returned to normal. Discussed the possibility for a food allergy and possibly trying a hydrolyzed diet vs another issue occurring- BW looked great, including normal pancreatic values. O is on board with doing an abdominal ultrasound to make sure we are not missing anything- O is leaving to go out of town for a week on Sunday. We will contact the mobile ultrasound that we use and see if we can get Sophia set up for an abdominal ultrasound this week- pt will need to be fasted 12 hrs prior to the ultrasound.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder is moderately 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.

The right kidney is normal in size (4.43 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 (4.55 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 (0.49 cm at the cranial pole and 0.52 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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The left adrenal gland is normal in size (0.43 cm at the cranial pole and 0.40 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

SPECIES

Canine

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.

BREED

Mix

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.

SEX

Spayed Female

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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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.

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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.

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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.

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Pancreas

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

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Free Abdomen

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

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Prominent, hypoechoic, rounded pancreaticoduodenal lymph nodes are visualized.

ULTRASONOGRAPHIC FINDINGS**INVOICE**

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- Chronic active pancreatitis
- **Enlarged pancreaticoduodenal lymph nodes** – likely reactive. Infiltrative neoplasia can't be ruled out but is considered less likely.
- **Gallbladder debris** - 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. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

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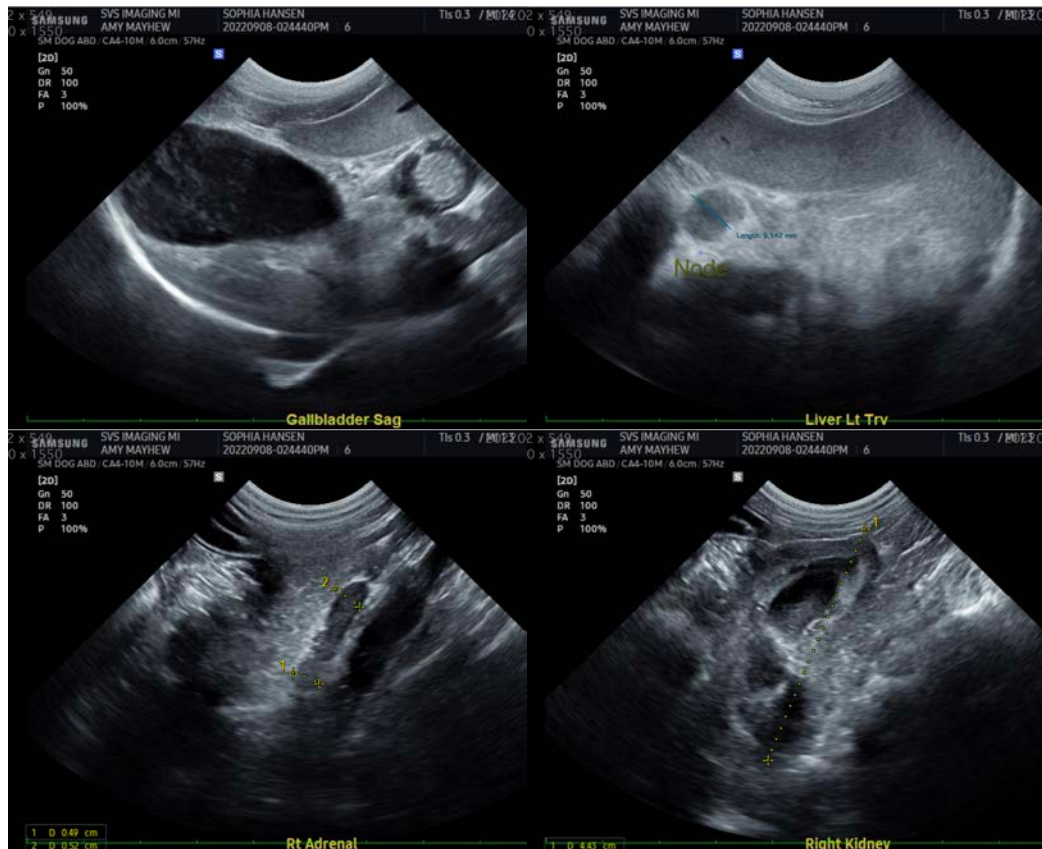
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Empirical deworming with a 5-day course of Panacur is recommended.

A fine needle aspirate of the enlarged lymph nodes could be considered if patient's coagulation status is appropriate and if the node can be reached safely. Alternatively, depending on gastrointestinal panel results, an empirical transition from a low-fat to a hydrolyzed diet could be tried on a trial-and-error basis, combined with cobalamin supplementation if indicated based on GI panel results, and the cranial abdominal changes/lymphadenopathy could be monitored.



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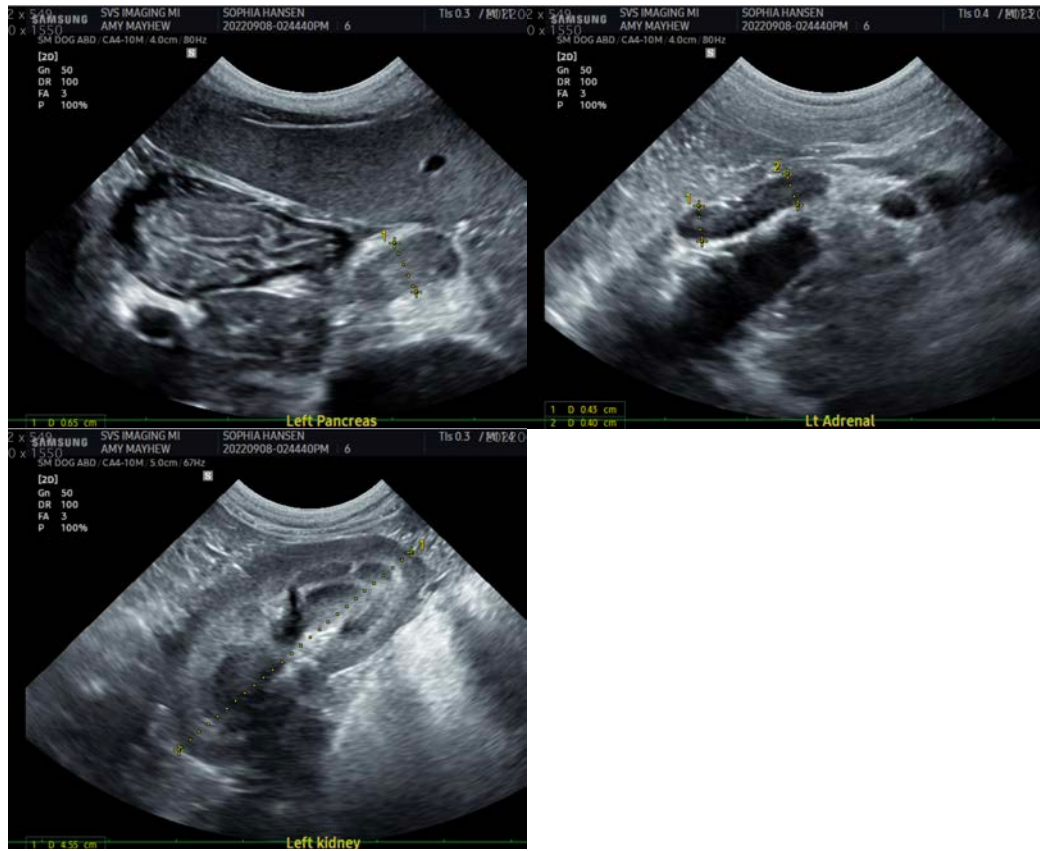
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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