The Focal Zone
FUELED BY SONOPATH VETERINARY ULTRASOUND

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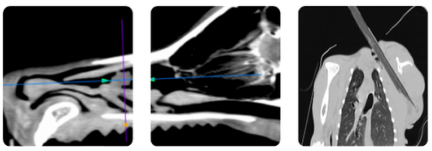


Teleradiology
Educational Teleconsultation Services™

PATIENT

Spencer Therrien

SPECIES

Canine

BREED

Dachshund

SEX

Neutered Male

AGE

8 Years

WEIGHT

13.5 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Beatties Stoney Creek

REFERRING VET

Dr. Song

INVOICE

35618

DATE

11/24/25

PRESENTING CLINICAL SIGNS

History: Findings: - Seen 11/21 for 2 day history of hyporexia/anorexia - Chronic allergies and skin issues - new lump found in mouth - Possibly DX with renal disease by rDVM (no records available) - Severe concerns with lab work done 11/22 and 11/23 Current Medications Methadone, Maropitant, Ampicillin, Zentonil. chronic use of fortiflora and Apoquel.

Abnormal PE/Chem/CBC/UA Results: Nov 22 - ALT too high to read after 1:2 dilution, ALKP 1294, PLT low 110. UA - 3+ RBCs, and cocci bacteria Nov 23 - ALT >4000, ALKP 1833, PLT 93 - Witness Lepto test negative Primary Question to Be Answered in This Exam - cause for thrombocytopenia and severely elevated liver enzymes.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The right kidney measured 5.86 cm in length. The left kidney measured 5.88 cm in length.

Adrenal Glands

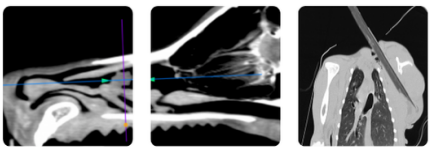
Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 1.91 cm in length and 0.62 cm at the cranial pole and 0.74 cm at the caudal pole. The right adrenal gland measured 2.32 cm in length and 0.94 cm at the cranial pole and 0.6 cm at the caudal pole.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.



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The gallbladder is mildly distended anechoic bile. Gallbladder wall is diffusely significantly thickened and hypoechoic with a hyperechoic luminal mucosal surface, measuring up to 0.88 cm in thickness. Common bile duct is not overtly distended.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The entire pancreas is enlarged and hypoechoic with surrounding hyperechoic mesentery. No fluid accumulations visualized. No mass effect consistent with pancreatic neoplasia visualized.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

There is a small volume of effusion visible in every quadrant.

Mesentery/omentum is diffusely hyperechoic consistent with peritonitis.

ULTRASONOGRAPHIC FINDINGS

- Pancreatitis with peritonitis
- Abdominal effusion- secondary to peritonitis versus other
- Severely thickened gallbladder wall- cholangiohepatitis versus acute anaphylactic reaction versus other cause of passive congestion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Gallbladder wall thickening together with severe pancreatic changes and evidence of significant abdominal inflammation is concerning for acute cholangiohepatitis with pancreatitis and secondary peritonitis. An acute anaphylactic reaction can also cause the gallbladder wall appearance or any other cause of acute congestion/right sided heart dysfunction. This does not typically result in secondary peritonitis and pancreatitis, however.

Treatment for pancreatitis is supportive and involves fluid support, GI support (anti-nausea, appetite stimulant), analgesia and enteral nutrition. Panoquell should be considered if available. Antibiotics are generally not warranted for acute pancreatitis as it is generally sterile, however, in the presence of

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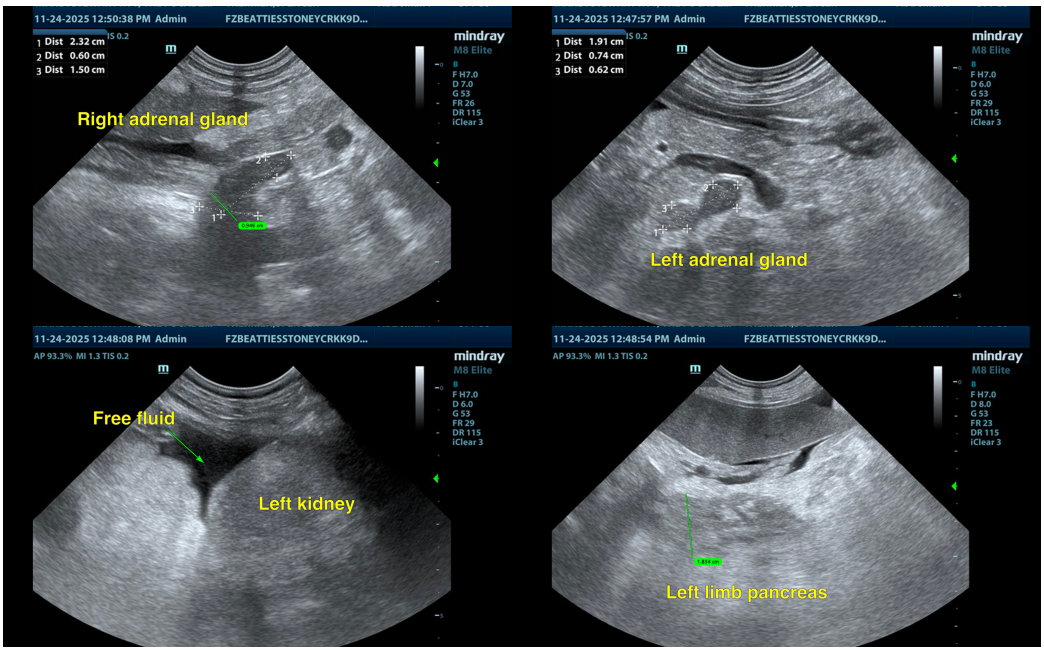
evidence of concurrent cholangiohepatitis antibiotics should be considered. Antibiotics that are effective against gram-negative, aerobic, enteric bacteria and excreted into the bile are recommended. Amoxicillin, amoxicillin-clavulanic acid, cephalosporins, and fluoroquinolones are suggested first choices. Metronidazole (7.5 mg/kg PO, IV q 12 hrs) may be added for extra anaerobe coverage. Serial imaging is indicated if clinical signs are not resolving to assess for possible progression to pancreatic abscessation or post hepatic bile duct obstruction.

Abdominocentesis with plan for fluid analysis and cytology is recommended to further evaluate the cause of abdominal effusion. Measurement of contemporaneous serum bilirubin and fluid bilirubin should be considered if deemed clinically indicated.



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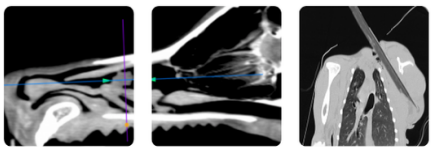

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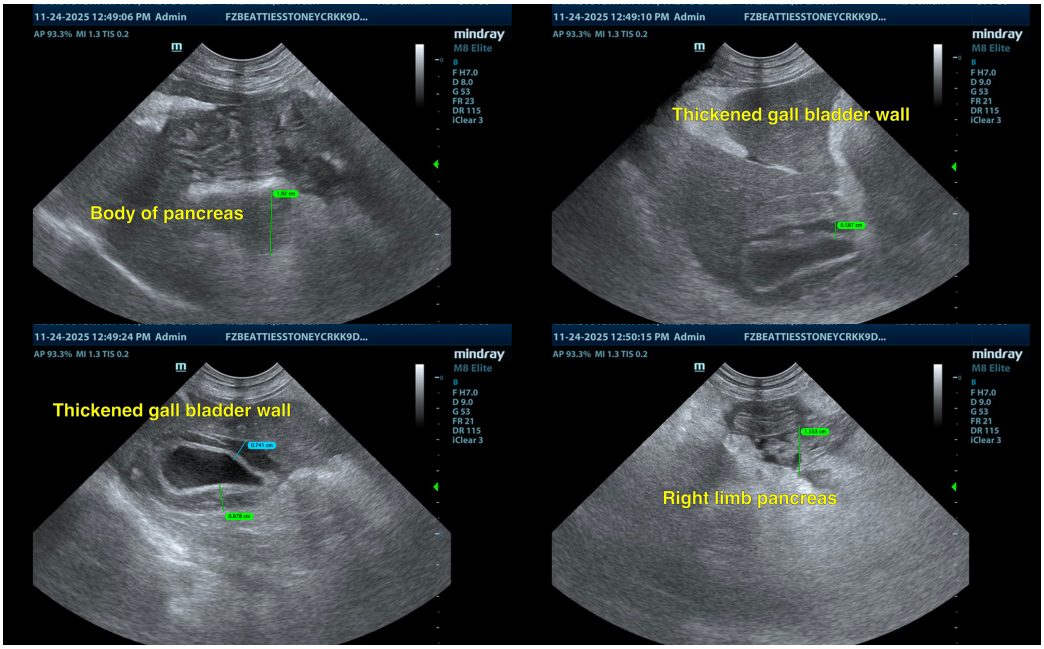

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

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