

**DATE**

1/5/22

**PRESENTING CLINICAL SIGNS**

History: Hx necrotizing pancreatitis with sterile cysts. Hx seizures. Recent vomiting, lethargy, increase in seizure frequency.

**PATIENT**

Current Medications: Phenobarbital, Lyrica, Budesonide, Cerenia, Entyce, Midazolam PRN for seizures.

Date of Previous IntraPet Ultrasound: 4-2-2021; 3-8-2021; 2-28-2021.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Banksy Simon

Imaging Performed By: Andi Parkinson, RDMS.

**SPECIES**

Canine

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

**BREED**

Pomsky

**SEX**

Neutered male

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 6.6 cm. The right kidney measured 6.6 cm.

**AGE**

5/16/19

**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 3.07 x 0.72 cm at the cranial pole and 0.72 cm at the caudal pole. The right adrenal gland measured 2.63 x 0.8 cm at the caudal pole and 0.79 cm at the cranial pole.

**WEIGHT**

37.1 lbs

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**Spleen**

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

**HOSPITAL NAME**

Timonium AH

**REFERRING VET**

Dr. McIntyre

**Liver**

The **liver** was uniform and mildly enlarged with slightly increased portal markings. Abscess in the left liver measured approximately 2.0 cm. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal.

**INVOICE**

95028

**Gastrointestinal**

**Gastric** stasis was present as the pancreatic pathology enveloped the upper duodenum causing delayed outflow. The pyloric wall was moderately thickened. The duodenum itself was mildly thickened. Regional adhesions and free fluid were present.

### **Pancreas**

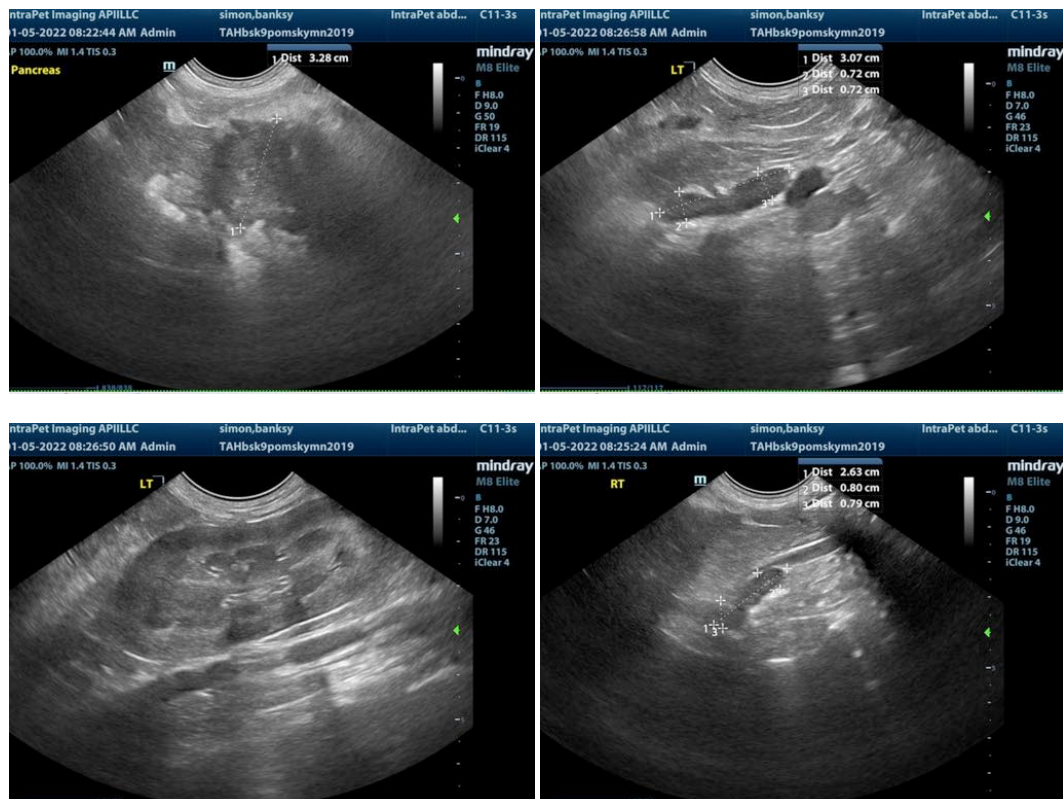
The **pancreas** presented persistent extensive mixed hypoechoic parenchymal changes that measured up to 3.3 cm with surrounding hyperechoic mesentery. This represents granulation bed. Multiple areas of the hypoechoic areas of the pancreas were void of blood flow. This is consistent with necrosis. Areas of abscessation were also noted.

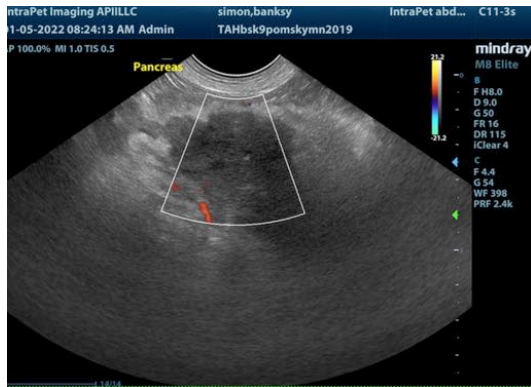
### **ULTRASONOGRAPHIC FINDINGS**

Persistent, extensive pancreatic pathology. Necrosis, peritonitis and adhesions with tethered upper gastrointestinal tract.  
Chronic duodenitis/gastritis.

### **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

At this point I think it is essential to perform surgical intervention with expectations of significant pancreatic debridement. Liberation of the upper gastrointestinal tract, appropriate biopsies of the pancreas, lymph nodes, gastrointestinal tract and liver are recommended. I cannot rule out an underlying small penetrating foreign body that may be present within the extensive necrosis and adhesions. J tube placement post surgery would likely be in this patient's best interest. The prognosis is guarded. There was minor shadowing material noted in the pyloric outflow. This is likely medications. Plasma transfusion, plasma expanders, broad spectrum antibiotics and pain management are all warranted for stabilization. However, surgery with debridement is essential in this case. Gastric tube evacuation would also likely be fruitful from a palliative standpoint until surgery can be performed given the amount of gastric over distension.







The information and recommendations provided are based on the images presented by the referring veterinarian. 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.

**Eric Lindquist**, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com  
Eric.Lindquist@SonoPath.com