

**DATE**

1/13/22

PRESENTING CLINICAL SIGNS

History: Loss of appetite beginning Sunday, came in Tuesday, started treatment. Has pancreatitis. Not responding to treatment.

PATIENT

Duncan Kenney

Current Medications: Giving 1000 LRS & 500 NaCl BID, Keflin 1 gram BID IV, Baytril 5 cc IV BID, Cerenia 4.5 cc SID SQ, Torbugesic 0.5 cc SID SQ.

Lab Results: Pancreatitis, also see other blood work results (attached separately).

Radiographs: Attached separately.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Andi Parkinson,

SPECIES

Canine

BREED

Labrador Retriever

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

Neutered male

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

AGE

12/28/10

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

WEIGHT

101.4 lbs

The left kidney has a normal shape and size (8.9 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

INTERPRETED BY

Kathleen Sennello
DVM, MS, Diplomate
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The right kidney has a normal shape and size (7.29 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

HOSPITAL NAME

Animal Medical Clinic
of Dulaney Valley

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.72 cm at the caudal pole It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

REFERRING VET

Dr. Chrest

Spleen

The spleen is subjectively normal in size. The spleen echotexture is heterogenous and mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

INVOICE

95212

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed. The gallbladder lumen is severely

distended. The wall of the gallbladder is mildly thickened at 0.43 cm with a relatively smooth luminal surface. There is a large amount of non-organized, echogenic debris in the gallbladder. The cystic and common bile ducts are normal/not visible. I suspect these findings are consistent with a biliary obstruction secondary to pancreatitis.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

Much of the cranial abdomen is obscured by the hyperechoic inflamed mesentery. The proximal jejunum appears thickened with a hypoechoic wall measuring 0.6 cm. This is likely an inflammatory change due to its location next to the inflamed pancreas. More distally the jejunum appears normal and measured 0.31 cm with normal layering. No focal lesions consistent an obstruction or mass effect is 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 pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with severe pancreatitis.

Free Abdomen

There is scant free fluid present. No lymphadenopathy is visualized. There is severely hyperechoic omentum in the cranial abdomen adjacent to the pancreas and surrounding the liver. The findings are most consistent with a sterile peritonitis secondary to pancreatitis.

Heart

A brief view of the heart was submitted. No pericardial effusion was seen.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Large, hypoechoic, amorphous pancreas with surrounding hyperechoic mesentery. The pancreatic changes are most consistent with (mild/moderate/severe) pancreatitis/pancreatic infiltration. I recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider FNA if not improving.

Irregular mottled spleen. The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Heterogenous, hypoechoic liver. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

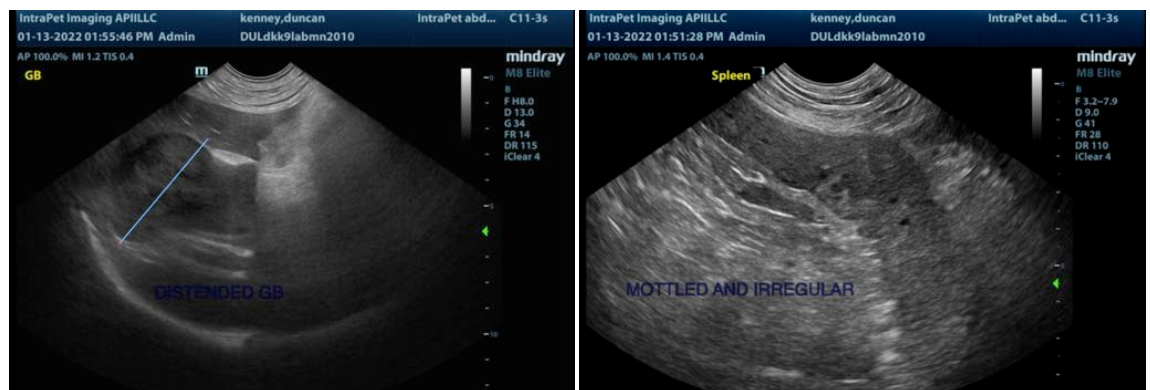
- Distended gallbladder with thickened wall. Suspect biliary obstruction secondary to pancreatitis. Primary gallbladder disease is also a consideration.
- Severe gastric distension with fluid. The findings are most consistent with severe ileus and possibly a partial pyloric gastric outflow obstruction due to inflammation created by the inflamed pancreas.
- Thickened, proximal duodenum. This is likely regional enteritis associated with proximal to the pancreas.
- Cranial abdominal peritonitis. The findings are most consistent with sterile peritonitis secondary to pancreatitis.

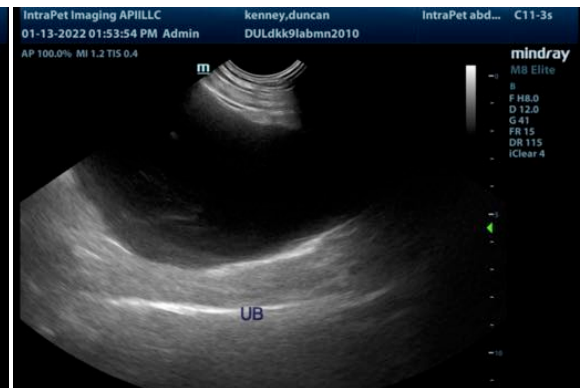
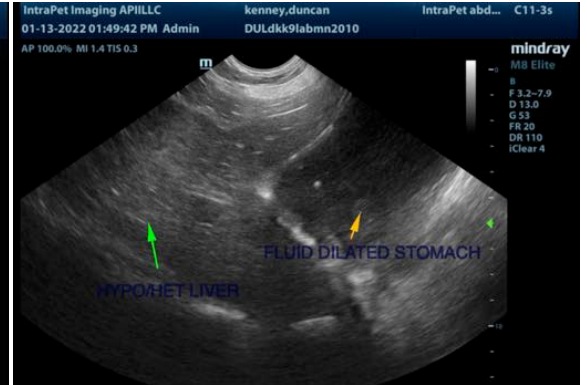
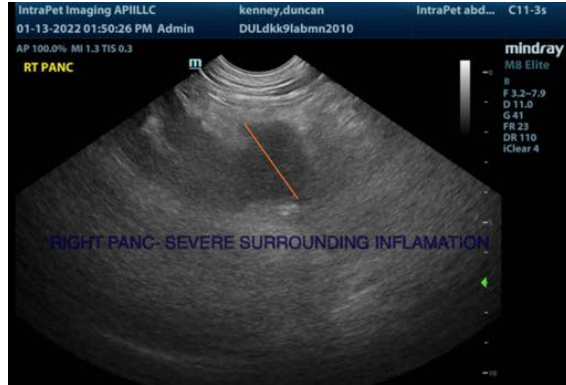
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

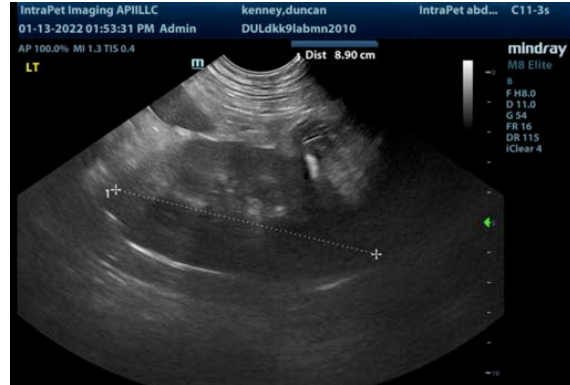
Severe pancreatic inflammation is present. Associated with that we are seeing some distension of the gallbladder indicating a likely partial secondary biliary obstruction. Additionally the adjacent structures are all inflamed.

The spleen appears very mottled and irregular. The tail of the spleen is rounded in a mass like fashion. Consider a FNA of the spleen once the pancreatitis is improving.

This patient has been in the hospital for several days with no significant improvement. More aggressive therapy can be considered such as placing a feeding tube, draining the gastric lumen with a nasogastric tube for comfort and help treat the ileus. Metoclopramide +/- plasma transfusions +/- hyperbaric therapy, etc.







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.

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