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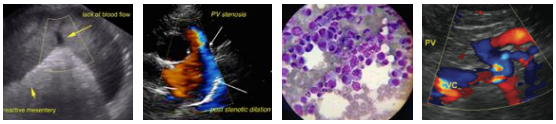


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Juno Jobes

SPECIES

Canine

BREED

Border Collie X

SEX

Spayed Female

AGE

13yr

WEIGHT

56.9lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

West Hills Animal Hospital

REFERRING VET

Dr. Remcho

INVOICE

10130

DATE

3/21/2023

PRESENTING CLINICAL SIGNS

Chronic vomiting and intermittent anorexia. Recent radiographs and lab work may be suggestive of pancreatitis. Current Medications 50 mg Carprofen q 12-24 hours and 300 mg Gabapentin q 24 hours Radiograph Assessment: Mild sternal lymphadenopathy. This may be inflammatory or metastatic in nature. FNA might be considered. Mild decreased peritoneal detail. Some low degree of peritoneal effusion +/- peritonitis is not excluded. An abdominal ultrasound might be considered. Minimal bilateral degenerative coxofemoral joints disease.

Abnormal PE/Chem/CBC/UA Results: Amylase 1696, Lipase 1380, proBNP 1018 (remainder of cbc and chem and T4 - wnl)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is minimally 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. A full evaluation of the urinary bladder is difficult with lack of urine distention.

The left kidney has a normal shape and size (5.73 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.08 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

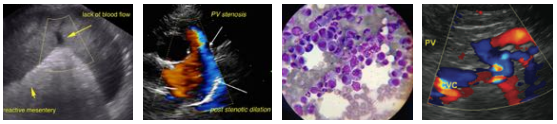
The left adrenal gland is normal in size measuring 0.61 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.44 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.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and 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.

Liver



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

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. 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 layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of 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. The duodenum is significantly thickened and measures at 0.77 cm and the jejunum measured as normal (0.43 cm.) Visualized peristalsis appears appropriate. There is a focal section of small intestine in the right cranial abdomen most consistent with duodenum, which appears to have focal thickening and surrounding edema/hypoechoic tissue and surrounding hyperechoic mesentery. This could be in reaction to local pancreatic inflammation or could be a source of inflammation causing secondary pancreatic inflammation. Findings are consistent with severe focal enteritis.

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 mild to moderate pancreatitis particularly in the right limb.

Free Abdomen

Evaluation of the peritoneal cavity did reveal scant free abdominal fluid. There is an occasional prominent lymph node noted. There is a large hypoechoic rounded lymph node in the cranial abdomen measuring 1.4 cm in diameter. The omentum is severely hyperechoic in the right cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Large irregular poorly defined pancreas with surrounding severe inflammation. Inflammation is worse in the right cranial abdomen, but there is some patchy inflammation in the left as well. The pancreatic changes are most consistent with moderate to severe pancreatitis/pancreatic infiltration. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

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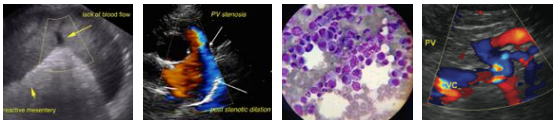

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- Severe focal thickening and inflammation surrounding the duodenum in the right cranial abdomen. Findings are consistent with severe focal enteritis; neoplastic change cannot be ruled out.
- Cranial abdominal lymphadenopathy. Most likely differentials include reactive lymph node or neoplastic change.

SECONDARY FINDINGS

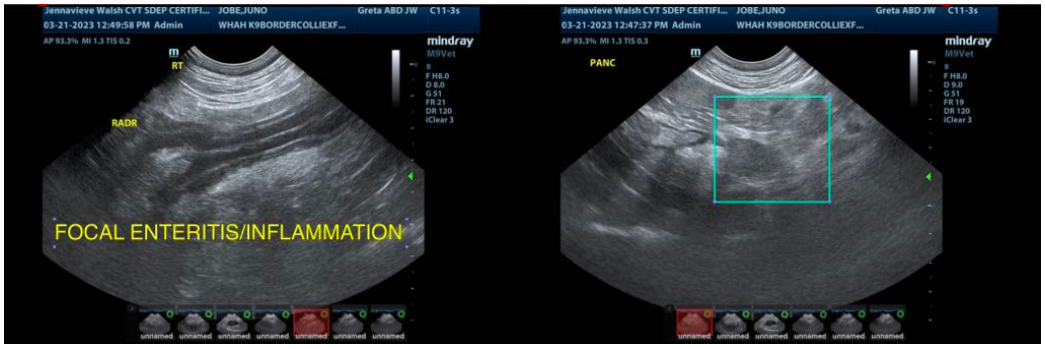
- Loss of corticomedullary distinction in both kidneys. The bilateral renal findings are consistent with age-related change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large amount of inflammation in the cranial abdomen. The region of the pancreas on the left appears somewhat patchy with hypoechoic regions of prominent pancreas. The right cranial abdomen is severely inflamed with the duodenum appearing severely thickened focally and adjacent severely hypoechoic and inflamed pancreas. It is unclear if the inflammation of the right limb of the pancreas is causing the enteritis or if there is focal enteritis causing subsequent pancreatic inflammation.

Additionally, there is a significant lymphadenopathy in the area. Recommend a fine needle aspirate of an enlarged lymph node and possibly some of the inflammatory tissue around the duodenum/area of the pancreas. Recommend treatment for severe pancreatitis but with the chronicity of this issue a more complicated process could be considered. Consider serial imaging in a few days to see if there has been a response to treatment. If the patient is not improving then you could consider surgical evaluation of the region, for debridement/flushing and obtaining biopsies. Additionally, a contrast CT scan could be considered of this area, looking for more of a focal mass effect.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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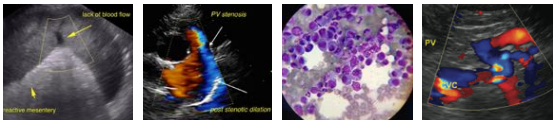

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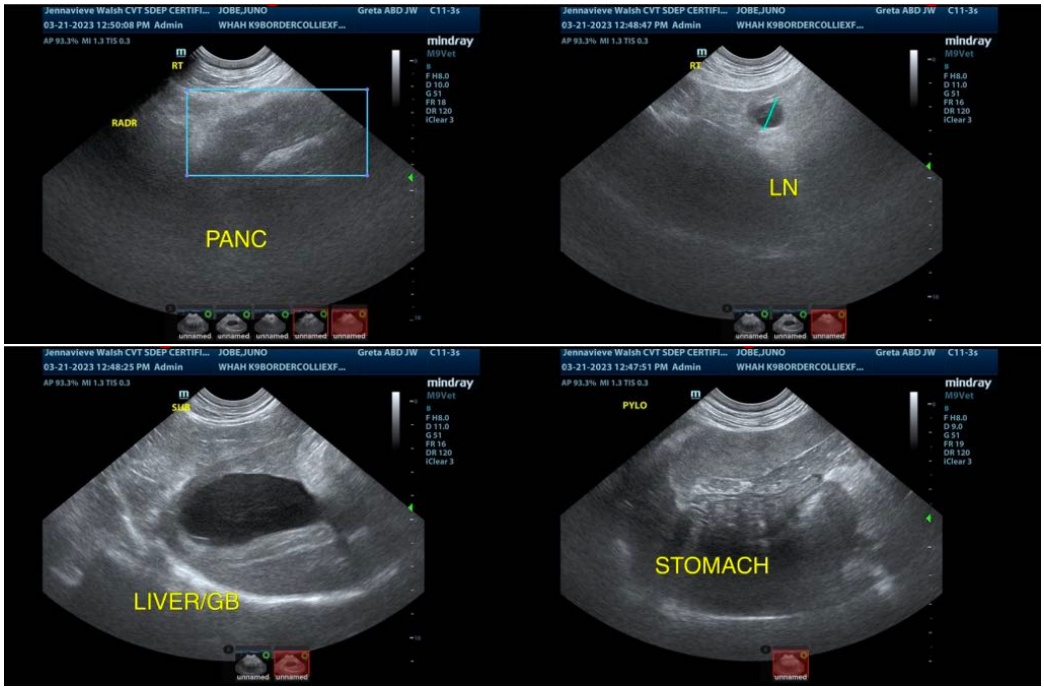

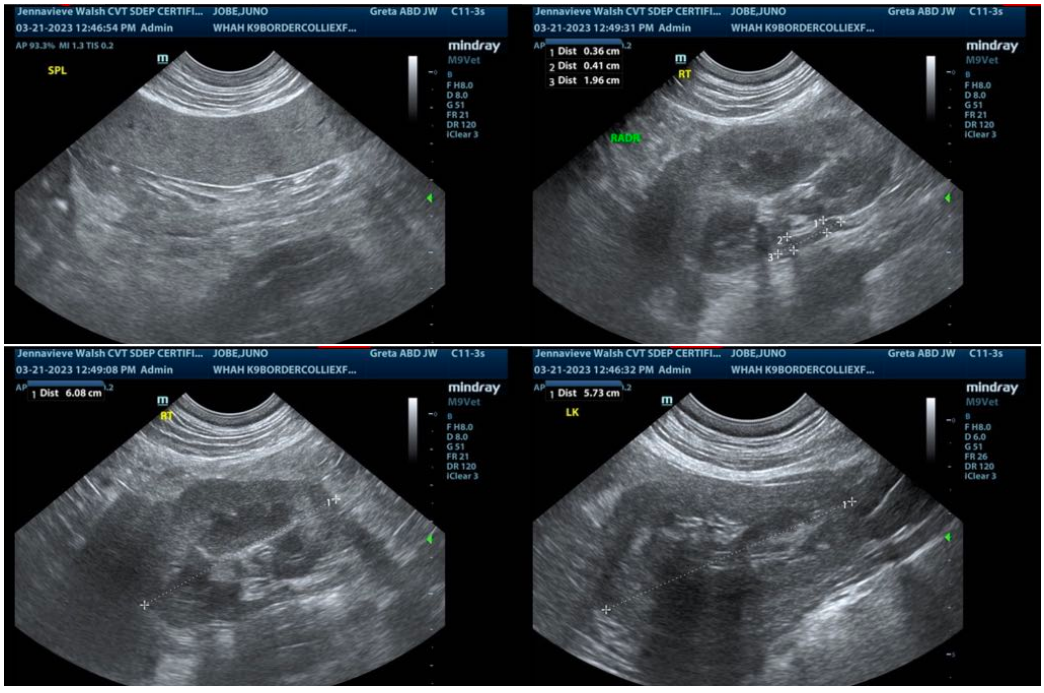

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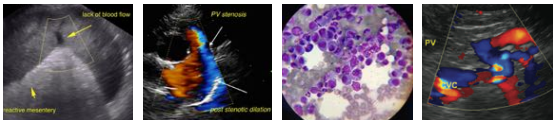

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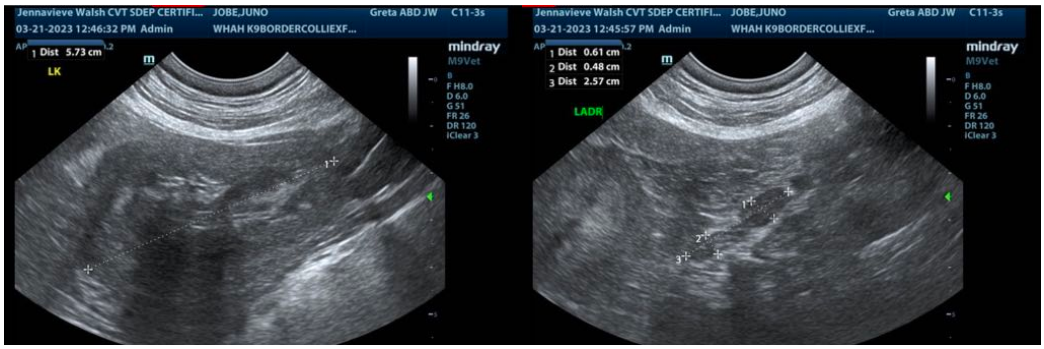

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small animal Internal Medicine)

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