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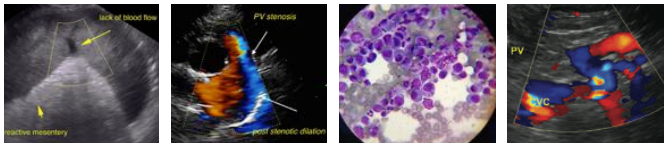

PATIENT

June Bug Anglin

SPECIES

Canine

BREED

Australian Labradoodle

SEX

Spayed Female

AGE

8 yrs

WEIGHT

7.4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Nigel Gumley

HOSPITAL NAME

Cedarview AH

REFERRING VET

Dr. Nigel Gumley

INVOICE

10201

DATE

5/5/2023

PRESENTING CLINICAL SIGNS

Vomiting frequently starting 5 days ago; abdominal discomfort, dehydrated. Improved with fluid therapy, low fat diet but periods of nausea/drooling/poor appetite. Initial amylase/lipase was normal, but cPli was elevated.

Abnormal PE/Chem/CBC/UA Results: Normothermic, no abdominal pain today. CBC - mild monocytosis; elevated amylase (1965) and marked elevation in lipase (5244); cPli and c-reactive protein pending. FNA taken from pyloric antral wall and cytology pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The urinary bladder wall appears slightly irregular and prominent measuring at 0.3 cm. The area of the trigone, ureteral papillae, and proximal urethra appear free of any mass, lesions, or calculi.

The left kidney has a normal shape and size (4.88 cm). Overall echogenicity is normal with adequate 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 (4.99 cm). Overall echogenicity is normal with adequate 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 0.48 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 0.49 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

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 gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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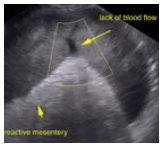

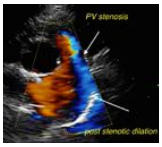

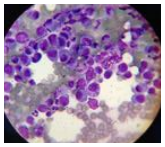
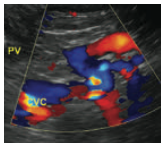

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Spayed Female

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WEIGHT

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Gastrointestinal

The stomach is moderately distended with fluid and mildly echogenic material. The stomach wall appears normal with intact wall layering in the region of the fundus measuring 0.49 cm. In the pyloric region, the wall appears more prominent with less defined layering measuring up to 0.81 cm with some mild surrounding inflammation. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum, and ileum have a relatively uniform diameter with mild to moderate fluid distension (particularly in the duodenum). 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 measured as normal (0.49 cm), and the jejunum measured as normal (0.37 cm.) 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 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 pancreatitis.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes. There is a small cluster of lymph nodes near the ileocecal junction which are enlarged measuring 0.76 cm and 0.55 cm in diameter and a splenic lymph node measuring 0.61 cm. The omentum is hyperechoic around the prominent lymph nodes.

PRIMARY FINDINGS

- Mildly irregular urinary bladder wall. Correlate these findings urinalysis and culture. This could be due to cystitis or secondary to a non-distended urinary bladder.
- Prominent mottled pancreas with surrounding hyperechoic mesentery. The pancreatic changes are most consistent with mild 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.
- Prominent thickened gastric and pyloric wall. The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.
- Mild mesenteric lymphadenopathy. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastric wall subjectively somewhat thickened and has reduced detailed wall layering. This could be secondary to gastritis or infiltrative disease. Consider a fine needle aspirate of the gastric wall (this was performed today). Additionally, a fine needle aspirate of a lymph node could be considered.

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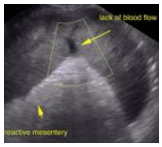
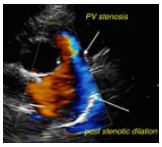
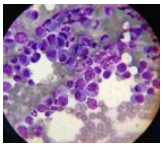
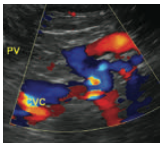

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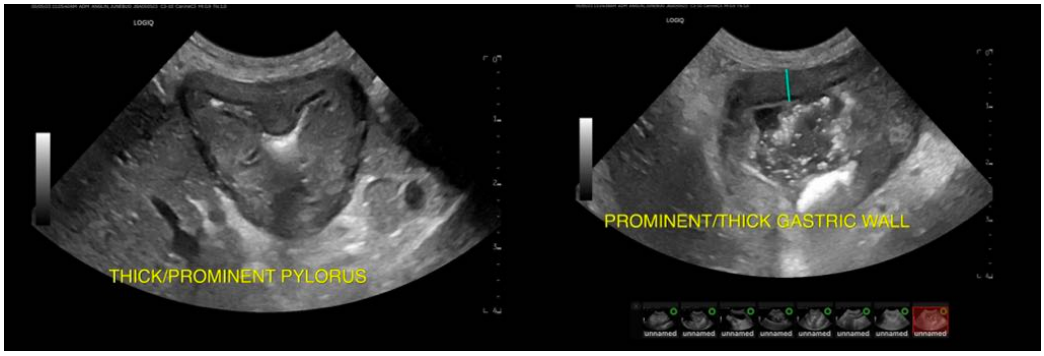
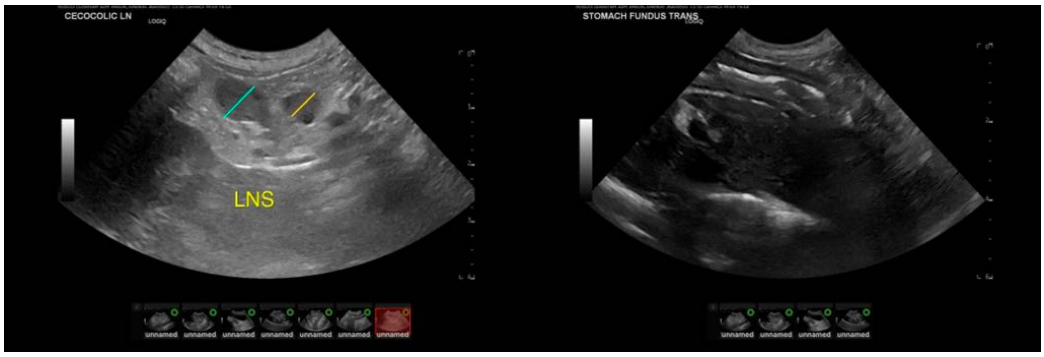
The pancreas appears somewhat prominent with inflammation in the region of the pancreas. Recommend empirical treatment for pancreatitis and gastroenteritis. If cytologic evaluation is not helpful and there is no response to symptomatic treatment then consider surgical evaluation with biopsies of the lymph nodes, stomach wall, and evaluation of the pancreas.

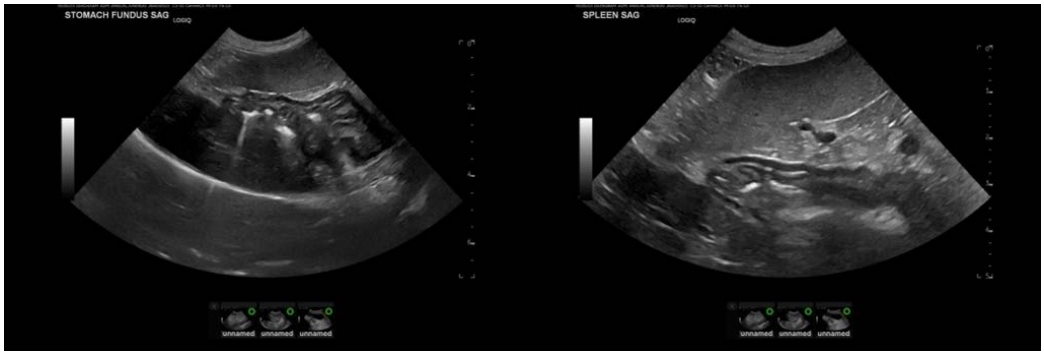
Although, no evidence of an obstruction or ingested foreign material is visualized this cannot be definitively ruled out. If symptoms are more chronic in nature you could consider a hydrolyzed/novel protein diet for possible dietary intolerance. Endoscopic evaluation if surgical biopsies are not desired.

Although, there is concern that deeper biopsies may be necessary, particularly to evaluate the pyloric region. If symptoms are improving, consider repeat evaluation with ultrasound to ensure that this appears to be improving.

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







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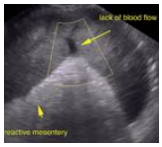

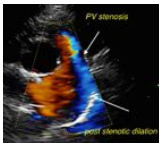

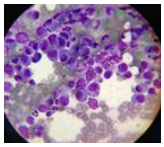
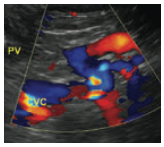

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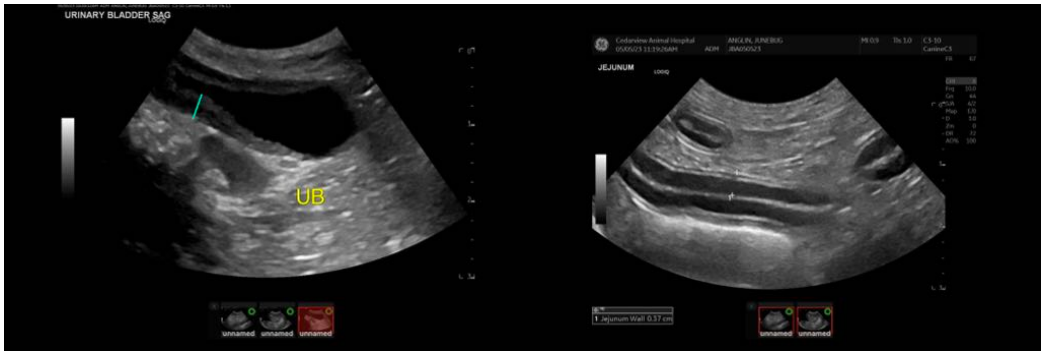

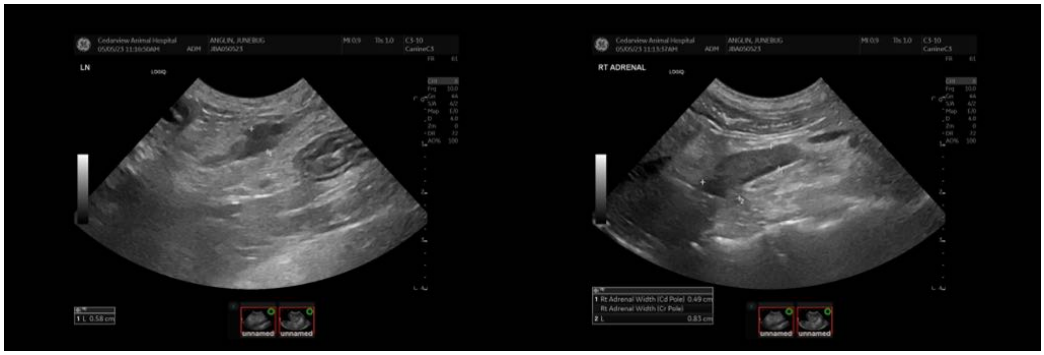

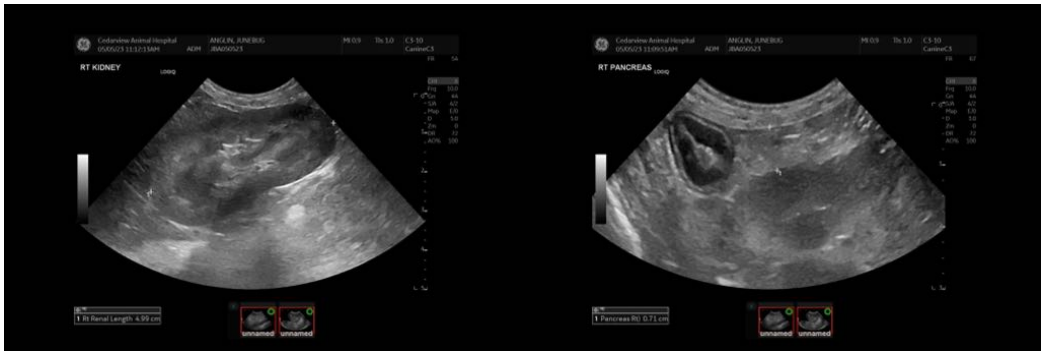

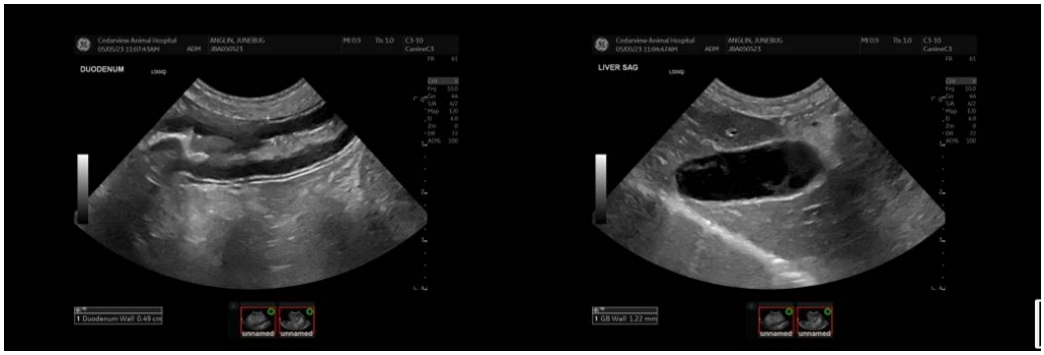

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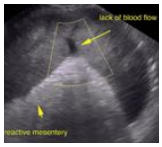

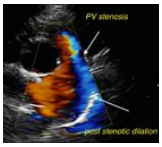

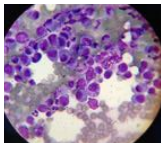
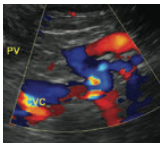

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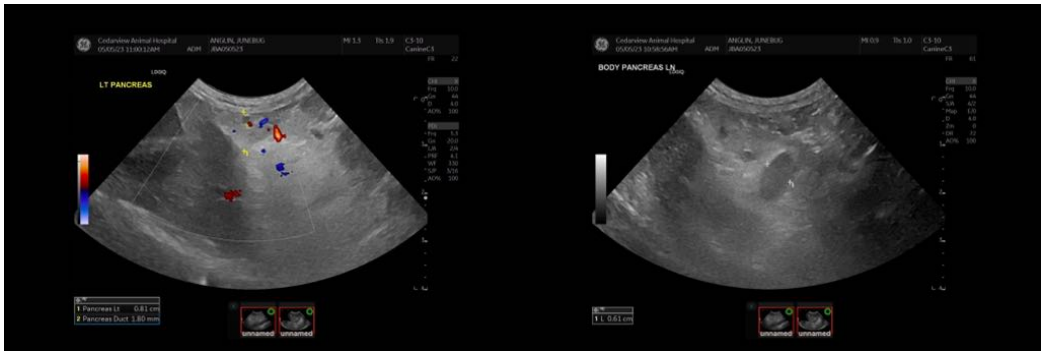

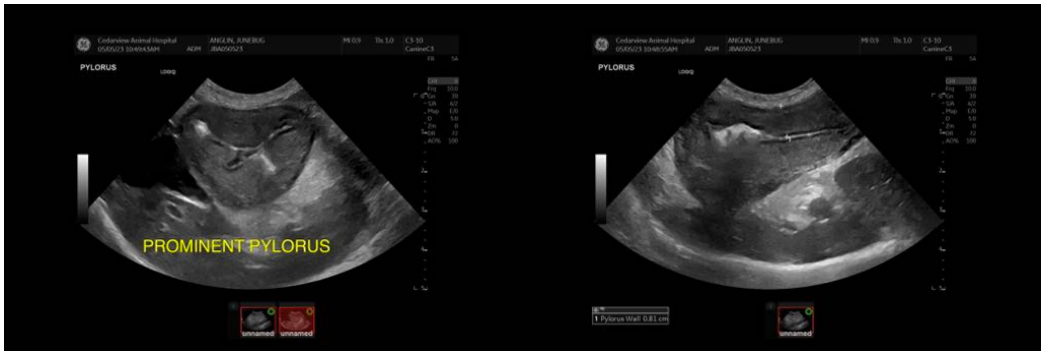

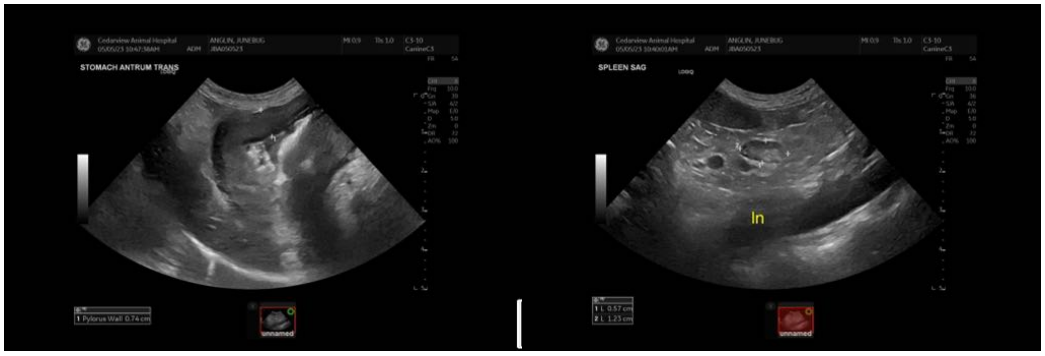

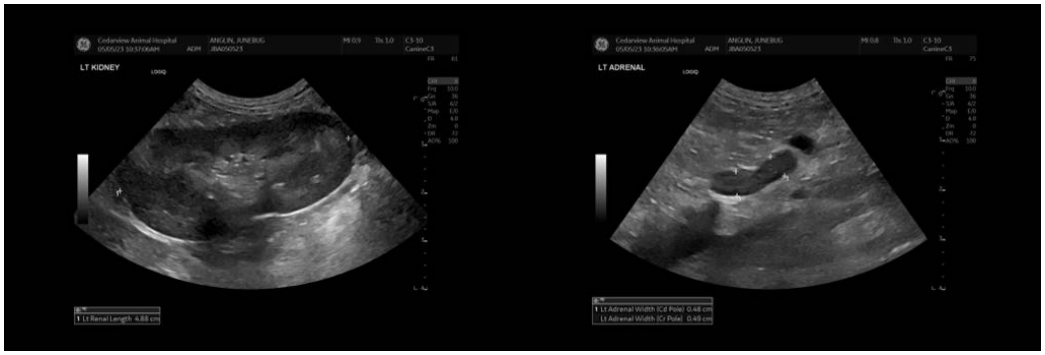

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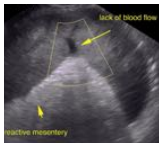

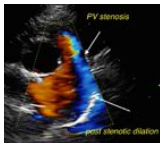

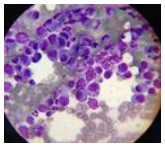
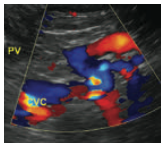

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