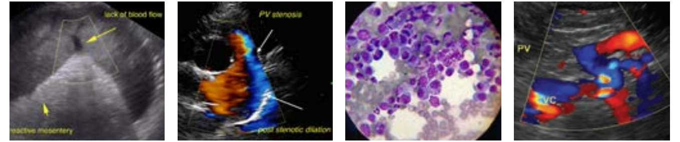
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Kimmie Maclachlan

SPECIES

Canine

BREED

Basset

SEX

Female

AGE

11 Years

WEIGHT

N/A

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Kurt Mychajlonka

HOSPITAL NAME

Craig Road AH

REFERRING VET

Dr. Kurt Mychajlonka

INVOICE

40881

DATE

8/30/22

PRESENTING CLINICAL SIGNS

P has been vomiting, panting, ataxic, owner was away for 2 weeks, came back and P was drinking a lot and not doing well, concerned diabetic, ascites, BW TBil high 0.9 (0.1-0.6) liver values elevated ALP 429 (20-150) ALT 306 (10-118) Phos 1.9 (2.9-6.6) NA+ 134 (138-160) unable to auscultate heart

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall is diffusely mildly thickened (0.88 cm), and the mucosa is mildly irregular. The trigone, ureteral papillae, and visible urethra (to a depth of 2cm) appear normal with no evidence of severe mucosal irregularities, masses or cystic calculi. Findings are most consistent with bacterial cystitis or lack of urine distension. Recommend urinalysis and culture.

The left kidney has a normal shape and size (6.6 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 (7.19 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 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 large measuring 1.25 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.

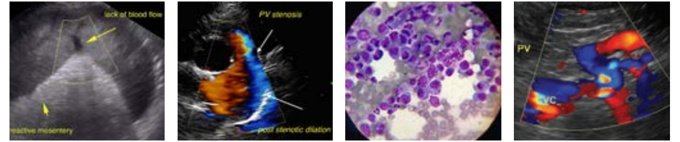
Spleen

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 large, heterogeneous, and hypoechoic. The visible portions of the vasculature and biliary tract appear normal. Some areas of the parenchyma appear somewhat motheaten and irregular, but no discrete mass lesion is visualized.

The gallbladder is large and distended.The wall is thickened and irregular, measuring 0.18 cm. There is a large amount of complex intraluminal debris. Soft tissue cannot be excluded. Additionally, there is intraluminal shadowing, likely due to the hyperechoic foci/mineralizations visualized within the gallbladder, but intraluminal gas cannot be ruled out. There is free fluid and severe inflammation surrounding the gallbladder. Findings are consistent with severe cholecystitis.



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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.

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. Duodenum wall measures 0.35 cm. Jejunum wall measures 0.32 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 moderate to severe pancreatitis.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

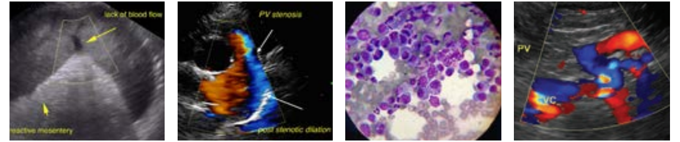
ULTRASONOGRAPHIC FINDINGS

- Large, distended, inflamed gallbladder – consistent with severe cholecystitis.
- Large, hypoechoic, irregular pancreas surrounded by hyperechoic mesentery – The pancreatic changes are most consistent with moderate to severe pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.
- Mild bladder wall thickening – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Borderline large right adrenal gland – No mass effect is visualized. Consider reevaluation once the gallbladder issue is addressed.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gallbladder is large, distended, and appears severely inflamed with surrounding fluid and inflammation. Gallbladder removal is recommended with aerobic and anaerobic cultures, biopsy of the tissue/debris at the neck of the gallbladder, and additionally biopsy and culture of the liver.

Unfortunately, the pancreas appears significantly prominent and inflamed. It is difficult to differentiate pancreatic inflammation from the inflammation surrounding the gallbladder. Recommend aggressive therapy for pancreatitis and consider a biopsy at the time of surgery.



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

SEVERE CHOLECYSTITIS

Gallbladder

Spleen

Pancreas

Urinary Bladder

Lt Kidney

Rt Kidney

INFLAMMATION/FLUID AROUND GB

Rt Liver

LIVER

MOTH EATEN APPEARANCE

Rt Liver

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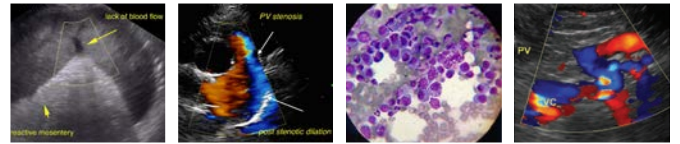

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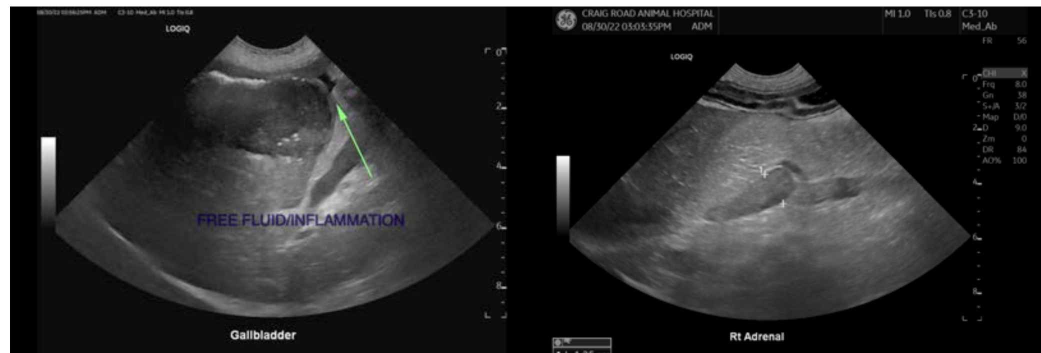

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com