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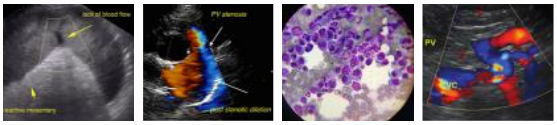

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Mollie Stefansen

SPECIES

Canine

BREED

Golden Retriever

SEX

Spayed Female

AGE

8 Years

WEIGHT

77.2 Lbs.

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

VCA Westmoreland AH

REFERRING VET

Dr. Bugarovich

INVOICE

13532

DATE

1/21/22

PRESENTING CLINICAL SIGNS

History: seen 1/12/22 for vomiting and inappetence for x3days on PE found tacky mucous membranes seen 1/20/22 for decreased appetite and vomiting for ~10 days, -physical exam -tacky mucous membrane -ABD palpation WNL, no pain - lethargy -icterus Current Medications cerenia, gabapentin

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted. Aortic trifurcation was normal.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 6.9 cm in length. The right kidney measured 7.2 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 2.8 cm in length x 0.49 cm width at the caudal pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 2.0 cm in length x 0.56 cm width at the caudal pole.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver exhibited mild subjective enlargement. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder exhibited moderate to significant distended size containing primarily anechoic content with mild nondependent yet nonorganized particulate luminal debris. The gallbladder walls were sonographically unremarkable without evidence of thickening or inflammatory criteria. Concurrent moderate cystic biliary duct dilation was present, measuring 2.0 cm in diameter. Although indistinctly visualized owing to regional increased omental artifact, subjective concurrent moderate common bile duct dilation, extending from the cystic duct caudally, approaching the duodenum, measuring 1.1 cm - 1.2 cm in diameter was present.

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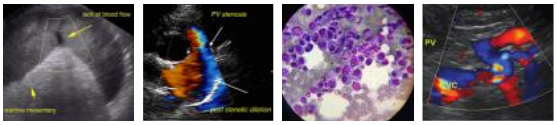

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Gastrointestinal

The stomach presented mild wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The gastric body wall measured 0.48 cm width. Minor retained anechoic fluid and subjective chyme were present without evidence of foreign material or mechanical pyloric outflow obstruction. The pylorus wall measured 0.57 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The jejunum wall measured 0.36 cm. The duodenum wall measured 0.40 cm.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was indistinctly visualized owing to concurrent increased regional peripancreatic omental artifact. Potential for mildly prominent to hypoechoic right pancreatic limb possible.

Free Abdomen

Regional, primarily right cranial abdominal hyperechoic mesentery was present without overt evidence of concurrent free fluid or lymphadenopathy.

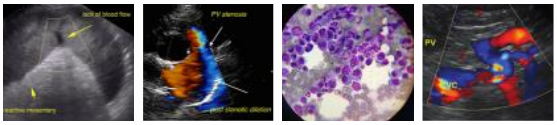
ULTRASONOGRAPHIC FINDINGS

- Acute to chronic hepatopathy
- Significantly distended gallbladder containing mild nondependent to particulate luminal debris
- Subjective moderate cystic biliary and common bile duct dilation extending caudally, approaching the level of the duodenum
- Gastritis pattern with mild gastric hypomotility
- Possible concurrent mild to possibly resolving pancreatitis
- Regional, primarily right cranial abdominal reactive to potential inflamed mesentery

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the degree of hepatic enzyme elevation and cholestasis along with sonographic abnormalities, high concern for common bile duct obstruction is warranted in this case, although a definitive cause of obstruction (i.e., calculus stricture, mucoduct, duodenal papilla pathology, mass, etc.) was not definitively evident. Some degree of low-grade to potential resolving pancreatitis is suspected, although the sonographic appearance of potential low-grade pancreatitis was not overtly consistent with that which would typically be associated with posthepatic obstruction. No overt evidence of pancreatic neoplastic criteria which is considered less likely.

Given this presentation, exploratory laparotomy with gross inspection of the common bile duct, gallbladder and area of the duodenal papilla recommended with potential for common bile duct flush, redirection technique +/- cholecystectomy and hepatic biopsies. Coagulation panel



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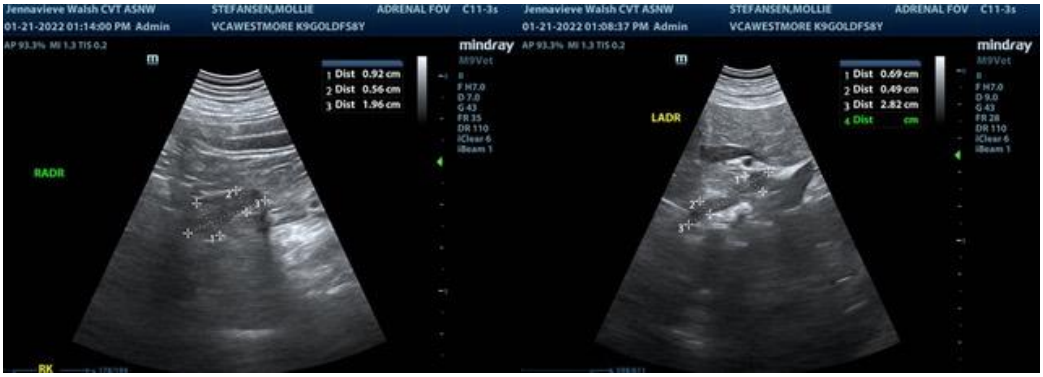
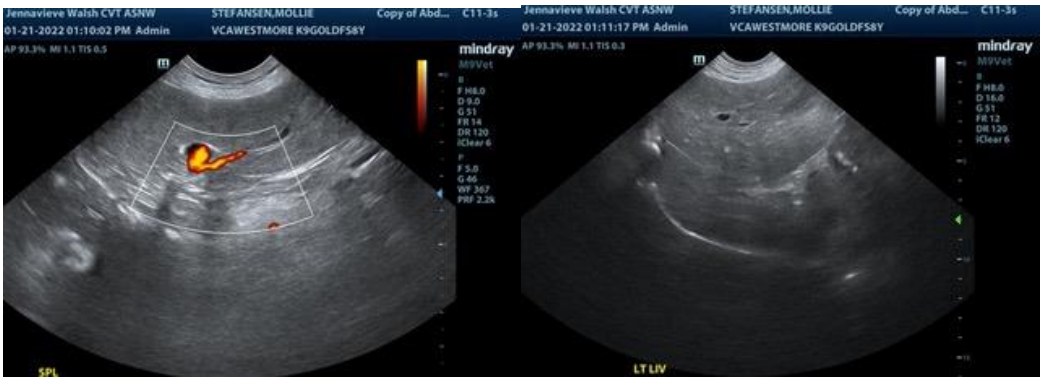
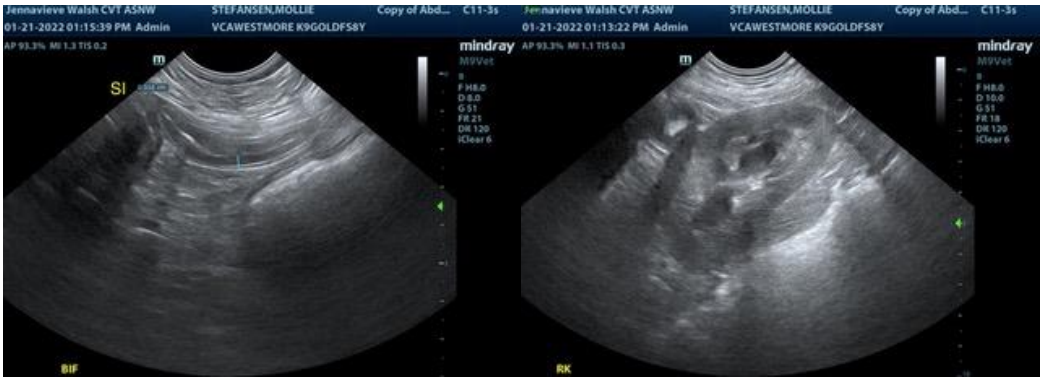
recommended prior to any potential surgical considerations. Potential guarded to very guarded prognosis indicated.







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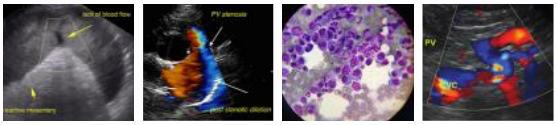

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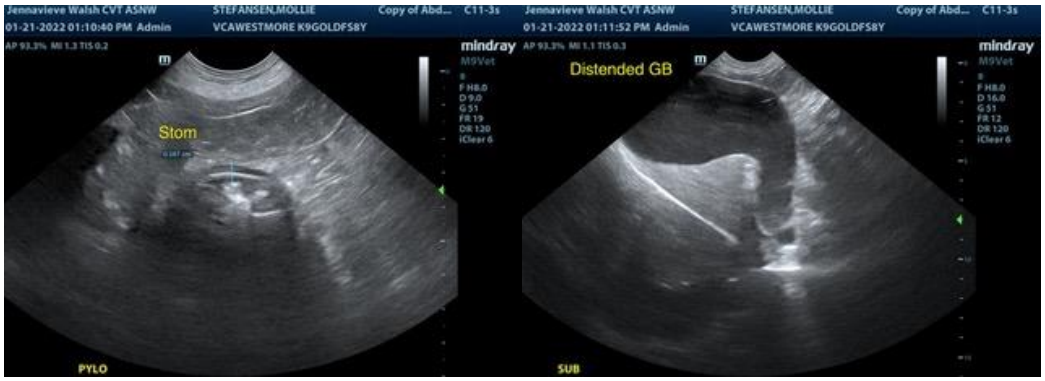

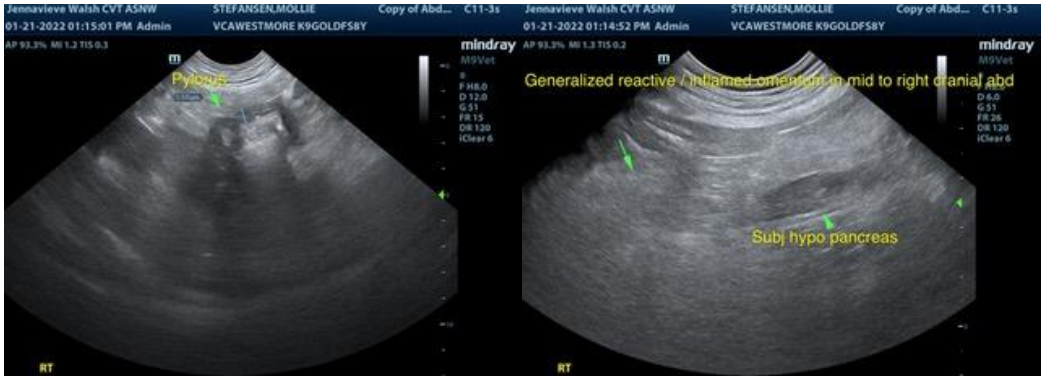

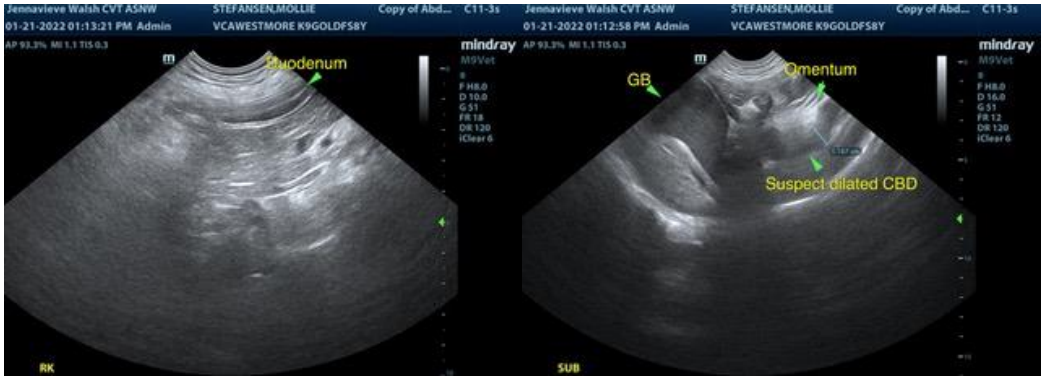

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
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