IMAGING PERFORMED BY

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

**PATIENT**

Lily Borszcz

**SPECIES**

Canine

**BREED**

Pomeranian

**SEX**

SF

**AGE**

7 Years

**WEIGHT**

10.2 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Sarah Pender, CVT

**HOSPITAL NAME**

SVS Imaging QC

**REFERRING VET**

Dr. Kayla Snyder

**INVOICE**

48309

**DATE**

11-12-21

## PRESENTING CLINICAL SIGNS

Spent weekend at emergency clinic for vomiting and anorexia for 3 days. They treated for GI upset, high liver values and pancreatitis. Now the vomiting has resolved and the patient is back to normal self. Abnormal PE/Chem/CBC/UA Results: Patient is diabetic on 2 units of insulin B.I.D. At emergency clinic patient had elevated total bilirubin. Repeat blood work on 11/8/21 showed elevated ALP, elevated ALT, elevated total bilirubin, elevated glucose (had not given insulin that morning due to concern of vomiting). Enlarged liver on palpation and Xray at emergency clinic. Pocketed area in liver on ultra sound on 11/8/21. Concern for hepatobiliary or hepatic disease/neoplasia/etc Previous scan 5/24/21: Pancreatitis with regional peritonitis - subjective moderate to severe, Reactive/vacuolar hepatopathy pattern, Mild distended gallbladder with minor luminal debris – non-mucocele, Gastroenterocolitis with subjective moderate to marked ileitis and proximal colitis

## 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.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. A moderately sized cyst occupied the majority of the cranial right kidney, medulla, and parenchyma measuring approximately 2.0 cm in diameter. The cyst was thinly walled containing anechoic fluid. The left kidney measured 4.1 cm in length. The right kidney measured 5.1 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 2.0 cm length x 0.40 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 1.7 cm length x 0.60 cm width at the caudal pole. No evidence of adrenal hyperplasia or tumors.

### *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 / Gallbladder*

The liver exhibited potential for mild generalized enlargement. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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The gallbladder was distended in overall size with sonographically unremarkable walls and moderate dependent to nondependent echogenic yet nonorganized subjectively mobile luminal debris. No evidence of peripheral gallbladder inflammation. The cystic and common bile ducts were normal.

### *Gastrointestinal*

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. The gastric body wall width measured 0.31 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 duodenum wall width measured 0.40 cm.

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

### *Pancreas*

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

### *Free Abdomen*

No overt lymphadenopathy or peritoneal effusion was present.

## ULTRASONOGRAPHIC FINDINGS

- Right kidney cyst.
- Hepatopathy - subjectively chronic, benign. Metabolic/reactive/vacuolar (diabetic) hepatopathy, hepatic parenchymal or hepatobiliary inflammation given the presence of gallbladder debris considered probable.
- Distended gallbladder with moderate nonorganized mobile luminal debris (nonmucocele)
- Persistent mild active to chronic active pancreatitis.
- Sonographically unremarkable gastrointestinal tract, likely resolved gastroenteritis.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urine culture and sensitivity on a sterile urine sample recommended if evidence of glucosuria.

Hepatosupportive medications including denamarin and ursodiol with monitoring for evidence of increasing cholestasis or hepatic enzyme elevations suggested.

Conservative therapy for mild active to chronic active pancreatitis given lack of clinical signs at this time and which may include dietary therapy and as needed gastroprotectants is recommended.

Sonographic reassessment suggested if recurrent signs of pancreatitis or cholestasis.

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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)**
**info@SonoPath.com**