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Clinical Sonography & Telecytology
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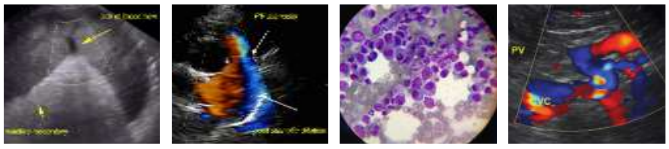


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Harlow Nixon

SPECIES
Canine

BREED
Boxer

SEX
FS

AGE
8

WEIGHT
20.4 kg

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

IMAGING PERFORMED BY
Dr. Alastair Westcott

HOSPITAL NAME
Dr. Alastair Wescottm, DVM

REFERRING VET
Dr. Alastair Westcott

INVOICE
12619

DATE
11/15/21

PRESENTING CLINICAL SIGNS

Acute presentation of facial angioedema especially periorbitally and urticaria. She does have access to the outdoors and was outside for a prior to development of these symptoms. Additionally has had a reduced/lack-of appetite for the past 48 hours with grass eating and subsequent vomiting. She has been on meloxicam for degenerative joint disease and a once a month chondroprotective supplementation injection. She did not receive meloxicam today but did receive the medication while demonstrating GI signs. There has been no diarrhea no coughing. No apparent PU/PD. Diet: RAW food
Abnormal PE/Chem/CBC/UA Results: A little anxious, periorbital swelling or puffiness, slight facial angioedema, urticaria over the flanks, markedly thickened stifles bilaterally, mucous membranes somewhat injected. Hemoconcentrated - dehydration vs splenic contraction. Stress lymphopenia Elevated AMYLASE Marked elevation in LIPASE with an abnormal cPL Urinalysis: Well concentrated Alkaline Mild bilirubinuria Thoracic radiographs: Cardiac dimensions are a little on the small-side. No overt pulmonary vessel distension. There is a mild, diffuse bronchial pattern.

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 was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were 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 to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.8 cm in length. The right kidney measured 6.9 cm in length.

Adrenal Glands

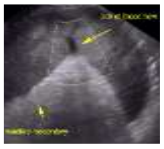
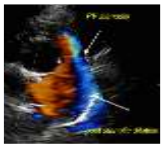
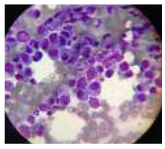
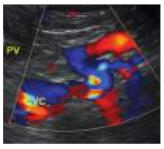
The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 2.0 cm length x 0.48 cm width in the caudal pole. The right adrenal gland measured 2.8 cm length x 0.48 cm width in the caudal pole.

Spleen

The spleen exhibited subjective mild generalized enlargement yet maintained symmetrical to curvilinear capsule contour. Subtle generalized parenchyma heterogeneity was noted. No distinct splenic masses or nodules were present. Normal splenic vascularity was noted without evidence of hilar thrombosis.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to

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benign parenchymal remodeling. Subjective increased prominence of the portal vascular borders was present in the liver. No evidence of hepatic masses or nodules was noted. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with mild congealed yet nonorganized gallbladder debris. The gallbladder was otherwise normal in size without evidence of gallbladder or peripheral inflammation. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mild wall thickening secondary to mild echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild gastric distension with minor retained anechoic fluid was present. The gastric body wall width measured 0.31 cm.

The small intestine presented intact wall layering and primarily maintained a 1:3 muscularis/mucosa ratio with subjective propensity for generalized mildly prominent to echogenic submucosa. The duodenum wall width measured 0.54 cm. The jejunum wall width measured 0.42 cm. The ileum wall width measured 0.39 cm.

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

Pancreas

The pancreas was normal in size and contour. The pancreas presented heterogeneous to mildly hypoechoic parenchyma with generalized increased pancreatic size. No signs of active inflammation or neoplasia.

Free Abdomen

Small pockets of scant free fluid were noted primarily around the liver within the cranial abdomen. Subjective minor colic lymphadenopathy, not indicative of overt neoplastic criteria and suggestive of minor colic lymphoid hyperplasia or minor reactive lymphadenitis, was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Subjective increased prominence of hepatic portal vasculature borders - nonspecific
- Mild gallbladder debris (non-mucocele), no signs of gallbladder inflammation or wall edema
- Active to chronic active pancreatitis
- Gastroenteritis pattern - potential to chronic, possible inflammatory bowel
- Possible mild splenomegaly - subjectively benign
- Scant, primarily perihepatic free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt evidence of pancreatic neoplastic criteria. Although not definitive, given the lack of chronic gastrointestinal signs, the potential for underlying low-grade chronic inflammatory enteropathy as a potential concurrent etiology to the chronic pancreatitis may be possible.

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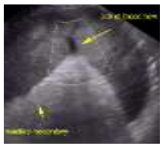
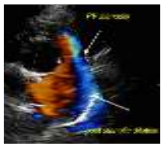
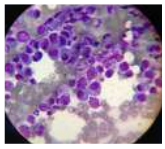
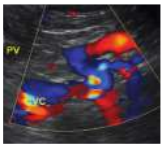

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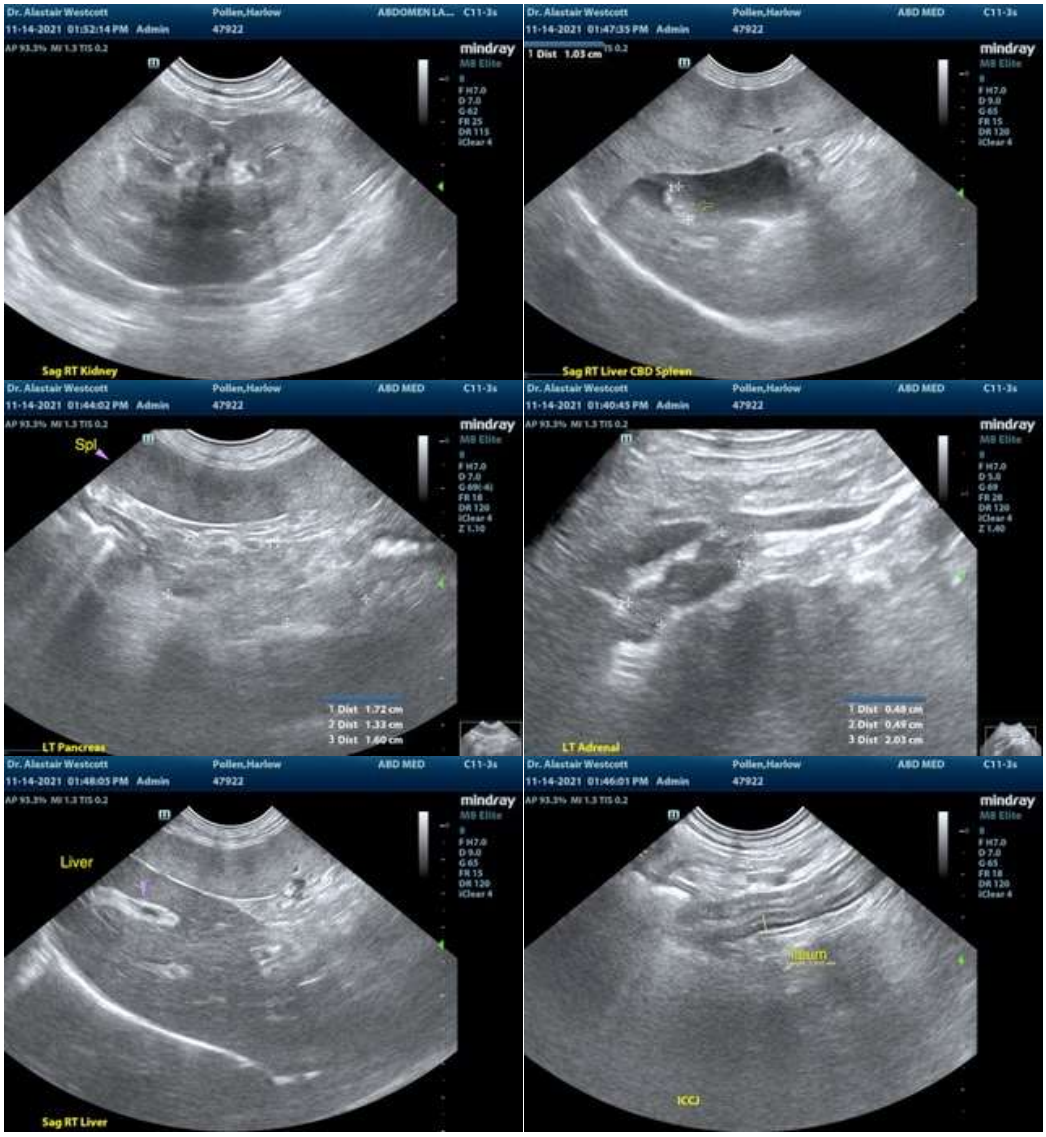
Pending hepatosplenic screening cytology, a GI panel to assess serum Cobalamin/Folate levels could be considered for further assessment. Mild reactive hepatopathy is suspected.

The minor free fluid in this case, assuming normal albumin levels, is likely secondary to active to chronic active pancreatitis.

Empirically, medical therapy for pancreatitis with as-needed gastrointestinal support would be appropriate.



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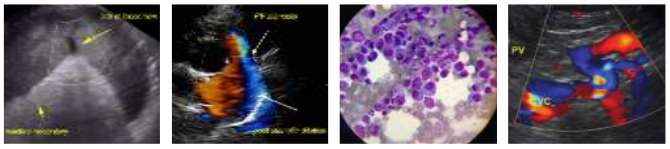

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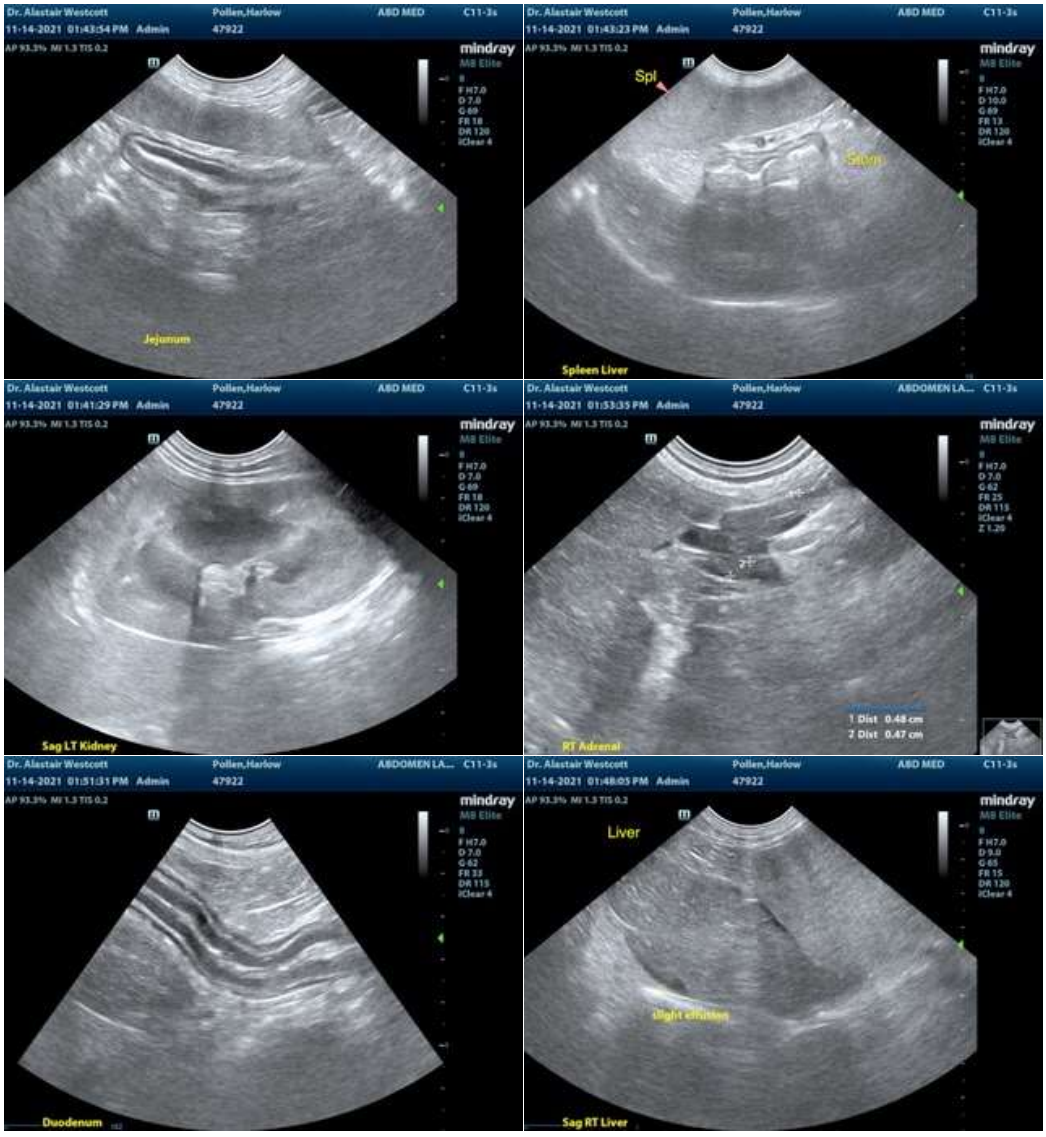

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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