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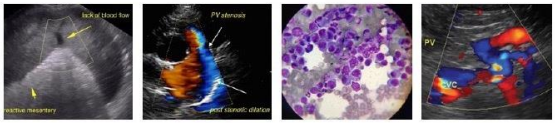


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Pai Clark

SPECIES

Canine

BREED

Jingo Mix

SEX

MI

AGE

4yr

WEIGHT

7.98kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Hamilton Region Veterinary Emergency

REFERRING VET

Dr. Vercaigne

INVOICE

12464ag

DATE

12/19/2022

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Moderate abdominal distension, discomfort.

Current Medications methadone, cerenia

Abnormal PE/Chem/CBC/UA Results: ABNORMAL Labwork Values - hemoconcentration, HCT 64% - mild neutrophilia with left shift - moderate lymphopenia - moderate hyperglobulinemia and TP (normal albumin) - mild elevated ALP - low normal Cl - high normal tT4 Radiographic Findings CONCLUSIONS: 1. Moderate to severe gastric fluid and gas dilation could be due to a functional ileus or pyloric outflow obstruction could also be considered but should be correlated to the severity of vomiting. Small intestinal frothy gas could indicate an enteritis or passing material but could be food or foreign material without overt obstruction. 2. Similar severe left and mild right chronic nephropathy with left nephrolith, which could indicate chronic obstructive uropathy. RECOMMENDATIONS: Repeat radiographs after 8 to 12 hours of confirmed fasting could be considered to reevaluate the small intestinal tract. This would also allow evaluation of the stomach for changes in distention. An abdominal ultrasound can be considered to evaluate for causes of a functional ileus, and to attempt to evaluate the pyloric outflow tract, and would also allow evaluation of the kidneys if clinically indicated.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 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.

The left kidney was subnormal in size compared to the right with mild to moderate loss of corticomedullary border demarcation. A focal area of non-obstructive medullary mineral to small renoliths was present. No evidence of pyelectasia.

The right kidney exhibited mild loss of corticomedullary border demarcation was normal in size and contour. No evidence of pyelectasia.

The left kidney measured 2.8 cm in length. The right kidney measured 3.9 cm in length.

The area of the aortic trifurcation was free of pathology.

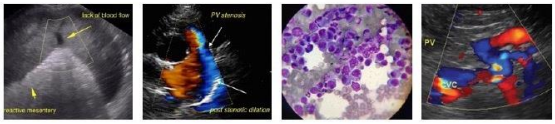
The area of the prostate appeared normal and free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.47 cm width at the caudal pole and 1.4 cm length. The right adrenal gland was indistinctly visualized owing to regional increased peri adrenal omental artifact without overt pathology. The right adrenal gland measured 0.40 cm width at the caudal pole and 1.4 cm length.

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.



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Liver

The liver presented mildly enlarged in size. 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. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mild to moderate wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The pylorus body wall measured 0.60 cm width. Mild gastric distension with moderate retained primarily anechoic fluid was present. No evidence of mechanical pyloric outflow obstruction, foreign material or obstructive mural pathology.

The small intestine presented intact mildly prominent duodenal wall layering with generalized non-obstructive ileus. The jejunum and ileum to the level of the colon exhibited minor segmental ileus pattern without evidence of mechanical obstruction or foreign material.

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

Pancreas

Diffuse enlargement of the proximal left limb, pancreas base and proximal right pancreatic limb with ill-defined, hypoechoic to heterogeneous parenchyma and asymmetrical contour was present. The surrounding omental fat around the enlarged to hypoechoic pancreas was echogenic indicative of reactive change, adhesions, focal peritonitis, or saponification. Mild localized free fluid was present around the abnormal pancreas. Regional peripancreatic hyperechoic mesentery was present extending into the mid abdomen and around the caudal gastric margins.

Free Abdomen

Intermittent pocket of scant peritoneal free flid was present in the mid to cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Active pancreatitis with regional peritonitis
- Secondary hypomotile gastroduodenitis
- Benign metabolic/reactive hepatopathy
- Nonspecific subnormal left kidney size with non-obstructive medullary mineral/small renolith

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The study is consistent with active pancreatitis with secondary upper GI inflammation and non-obstructive stasis as a primary cause of the patients clinical signs. Minor potential for pancreatic neoplasia considered less likely. No evidence of mechanical GI obstruction or foreign material was present. Hospitalization with aggressive therapy for pancreatitis, as needed GI support, plasma expanders and/or antibiotics if clinically indicated and clinical reassessment over the 48-72 hours is suggested. Potential recheck sonogram recommended if progressive clinical signs or evidence of increasing peritoneal effusion.

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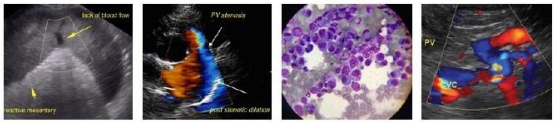

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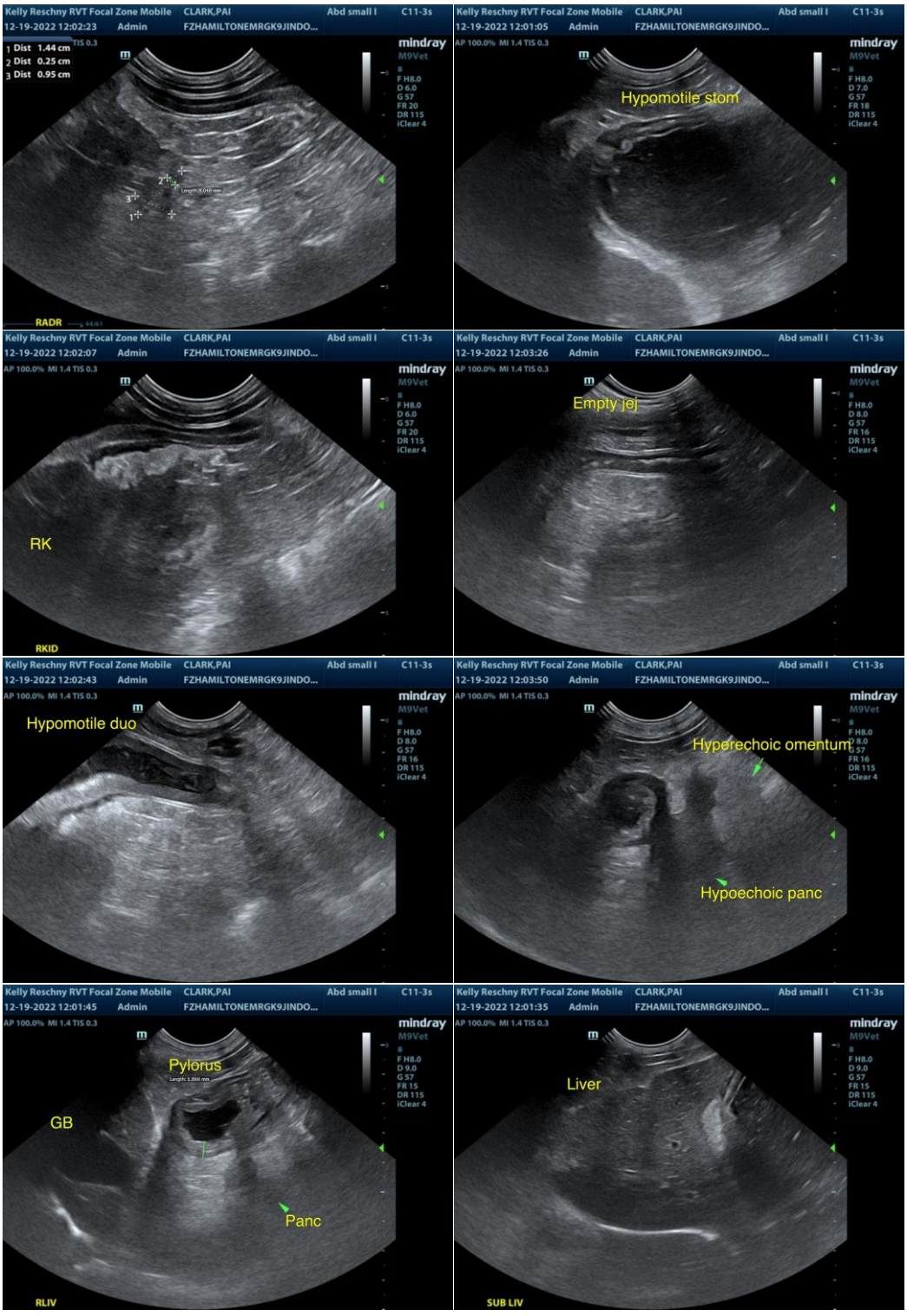

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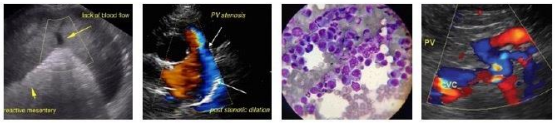

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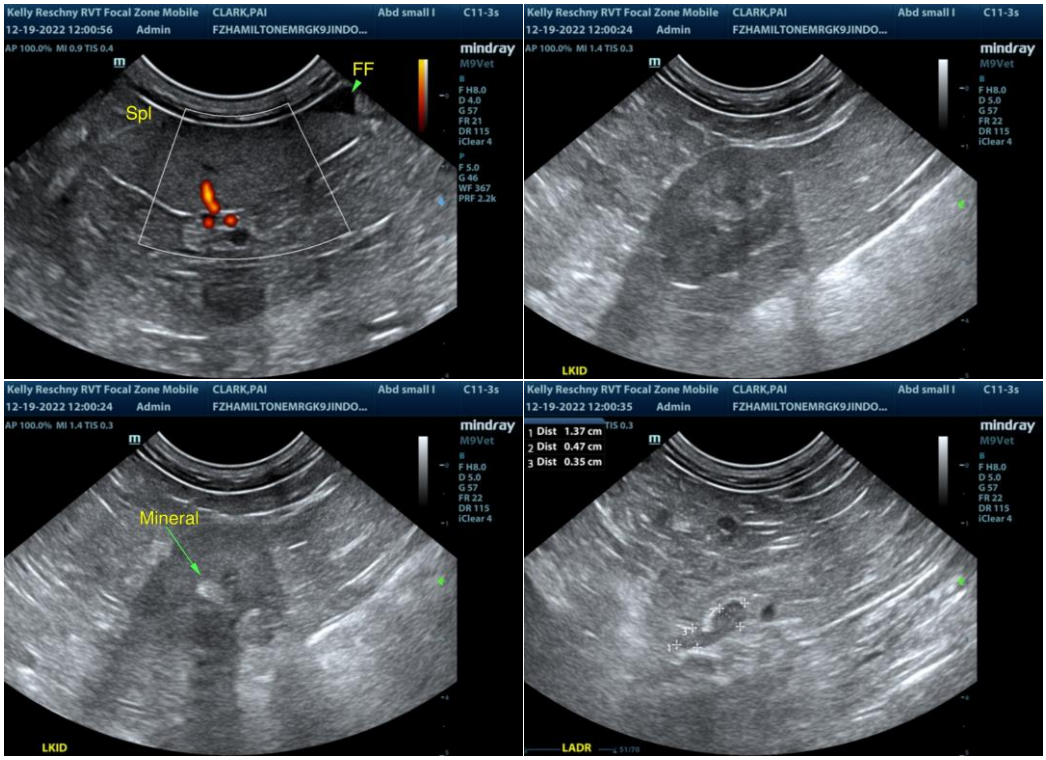

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com