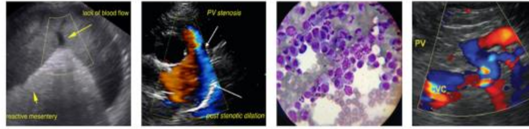


PATIENT

Skiddy Stamm

SPECIES

Canine

BREED

Rat Terrier

SEX

Neutered Male

AGE

9 years

WEIGHT

16.3 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME

Stanglein VC

REFERRING VET

Dr. Dinello

INVOICE

13839

DATE

2.7.2022

PRESENTING CLINICAL SIGNS

History: 4-day duration, PD, decreased appetite, painful, severe pancreatic elevations, history of seizures

Labs: WBC with band neutrophils, Amylase >2500, Lipase >6000, ALP 1734, ALT 163

Medication: Phenobarbital, Cerenia, Gabapentin, Metronidazole, Pepcid, Buprenex, Rimadyl

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. Mild non-dependent particulate sediment was present. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 0.69 cm in width.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was 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 4.5 cm in length. The right kidney measured 4.4 cm in length.

Adrenal Glands

The left and right adrenals glands were not visualized owing to regional omental artifact.

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.

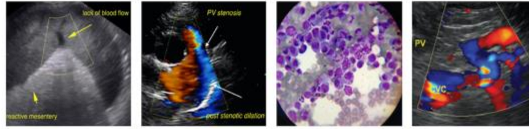
Liver

The liver presented 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, exhibiting mildly prominent to echogenic walls. Moderate, nondependent to mildly congealed nonmineralized luminal debris was present. The common bile duct was not definitively visualized owing to regional omental artifact yet without overt evidence of common bile duct stasis, dilation or post hepatic obstruction.

Gastrointestinal

The stomach presented moderate wall thickening secondary to echogenic mucosa hypertrophy. The stomach exhibited indistinct wall layering, primarily with subtle decreased gastric mural echogenicity.



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The stomach was primarily empty with mild luminal gas and without evidence of persistent retained fluid, ingesta or overt foreign material.

The small intestine presented intact wall layering and maintained 1:3 muscularis/mucosa ratio. Segmental areas of small bowel corrugation were present without overt evidence of mechanical ileus or obstruction to the level of the ieocolic junction.

Normal visible colon wall layers were present with segmental strongly shadowing feces present in the colon.

Pancreas

Diffuse enlargement of the pancreas 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. A fluid filled lesion, containing primarily anechoic fluid with mild cellular component was present in the area of the mid left pancreatic limb as well as in the area of the caudal aspect of the gastric body. This fluid filled lesion measured approximately 5.3 cm in diameter.

Free Abdomen

Generalized mildly non-uniform hyperechoic mesentery, primarily in the cranial abdomen around the stomach, pancreas and fuid filled lesion in the area of the left pancreatic limb and caudal stomach. Intermittent, associated mildly prominent to hypoechoic mesenteric lymph nodes, along with mild volume peritoneal free fluid. The peritoneal free fluid exhibited subjective mild cellular component.

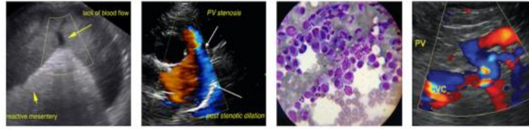
ULTRASONOGRAPHIC FINDINGS

- Active pancreatitis with concurrent generalized gastroenteritis pattern, exhibiting segmental small bowel corrugation.
- Fluid filled lesion in the area of the proximal to mid left pancreatic limb and caudal gastric body- strongly suspect left pancreatic limb or caudal gastric mural abscess with potential for necrosis, neoplastic criteria cannot be excluded.
- Associated, generalized primarily cranial abdominal peritonitis with mild volume peritoneal free fluid.
- Hepatopathy
- Cholecystitis with potential for atypical to emerging gallbladder mucocele

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, ultrasound guided FNA of the fluid filled lesion in the area of the left pancreatic limb and caudal stomach +/- screening hepatic FNA could be considered for screening cytology +/- culture and sensitivity, if clinically indicated. However, laparotomy with gross inspection of the fluid filled lesion with potential for debridement of suspected abscess or necrotic tissue likely indicated. Potential for partial pancreatectomy and/or gastrectomy may be indicated. Concurrent gross visualization of the gallbladder with potential for cholecystectomy and hepatic biopsies may also be indicated. Gastrointestinal biopsies may also be indicated based on gross inspection of the gastrointestinal tract.

Broad spectrum perioperative antibiotics and analgesia recommended with supportive care for pancreatitis/peritonitis.



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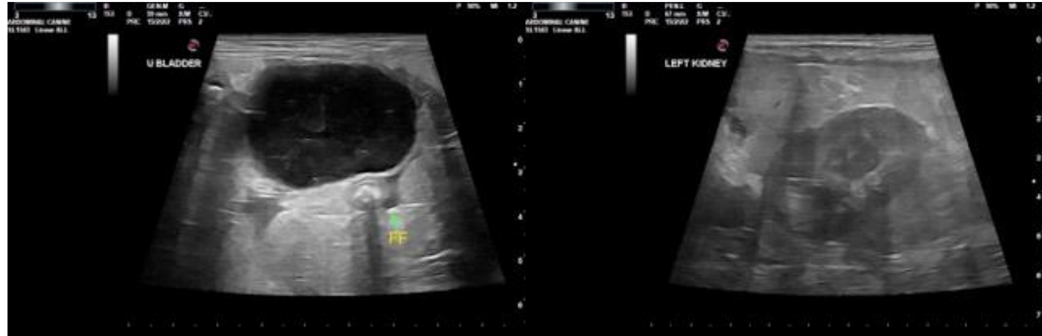

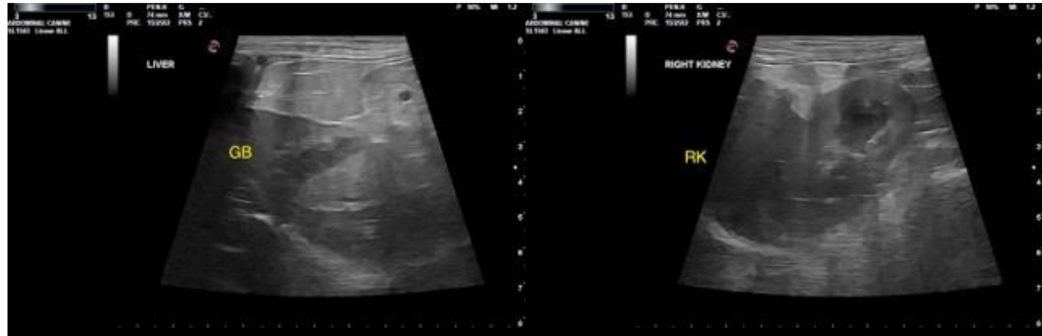

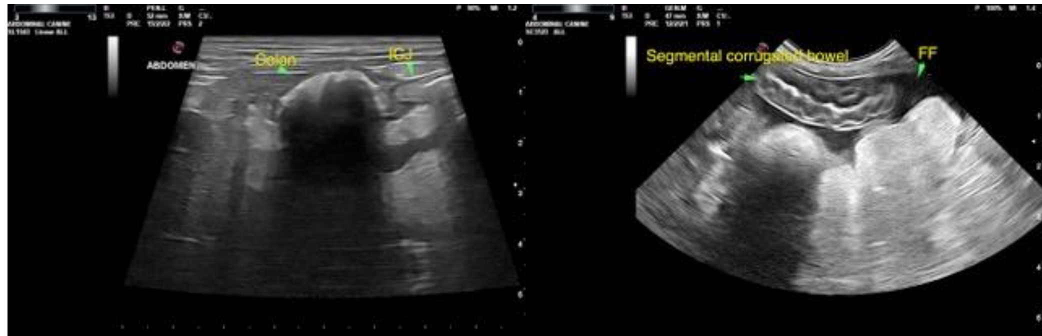

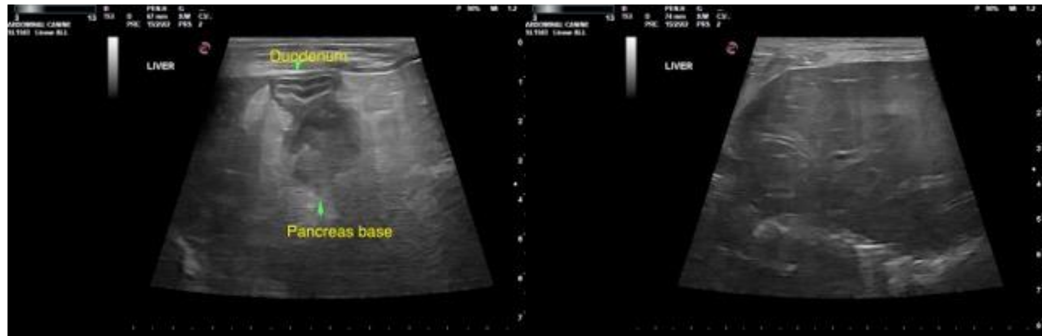

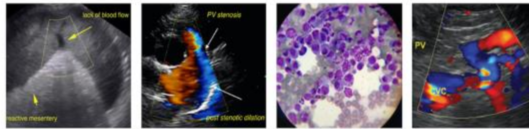

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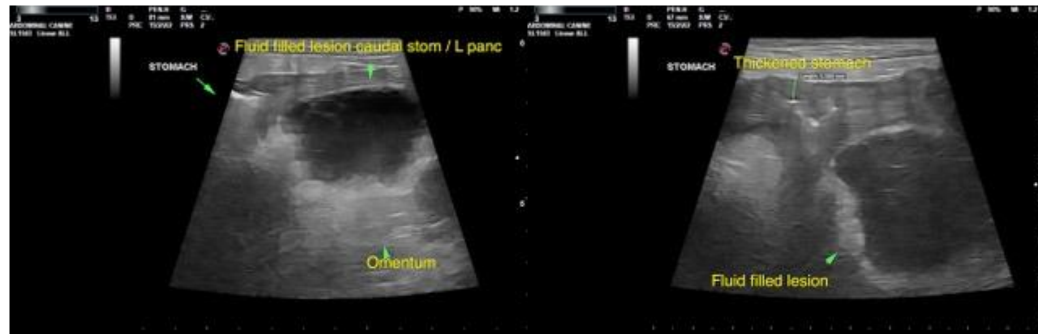

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com