

**PATIENT**

Hank Kreinbring

SPECIES

Canine

BREED

Poodle X

SEX

Neutered male

AGE

10 years

WEIGHT

12 pounds

INTERPRETED BYR. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)**IMAGING PERFORMED BY**

Sara Pender CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Doerscher

INVOICE

10246ag

DATE

03/29/2022

PRESENTING CLINICAL SIGNS

History: 3rd opinion - ~7-10 day duration of inappetence. From other DVM records: 3/21 Presented for ann wellness but O reported NFW. V overnight. Maybe PU/PD. Soft stool, lethargic. Eating Purina lamb/rice, takes Apoquel regularly. Declined DX, DVM RX Purina EN, Cerenia (inj & tabs), AmoxiClav @ 20.8 mg/kg 3/24 Recheck, O reported not eating, no stools, no more V. BW done. Inflamm LG & mild inc ALP (565), abnormal cPL snap. DVM refilled Cerenia, rec chicken/rice food. 3/26 Went to AEC, declined DX, they did SQF, Cerenia, Baytril injection, Buprenorphine 3/29/22 owner says has not eaten anything since at least Sunday

Abnormal PE/Chem/CBC/UA Results: 3/29: Presented to our clinic, hasn't eaten since Sunday. Exam generally unremarkable except abdomen is tense and distended. Vitals WNL, exam otherwise WNL. P is overweight/obese. Grade 2 dental disease, mm were pink & moist. P did make a little hacking sound after my PE was completed. We did rads (noted distended stomach and small bowel, suspect fluid-filled),

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. Mild pyelectasia present in the left kidney. The left kidney measured 4.4 cm in length. The right kidney measured 4.7 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the residual prostate appeared normal measuring 1.0 cm in width.

Adrenal Glands

The left adrenal gland was mildly prominent in with normal contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 1.9 cm width at the caudal pole and 0.53 cm width at the cranial pole. The right adrenal gland was not definitively visualized owing to regional right perirenal pathology.

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 generalized enlargement with areas of capsule asymmetry. Mild generalized hyperechoic to nonuniform hepatic parenchyma exhibiting multifocal variably sized to mildly expansive hypoechoic nodules to macronodules were present. The largest nodule measured approximately 3.0 cm.

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The gallbladder was non-distended in size with thin walls and mild congealed yet nonorganized hyperechoic gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal**SPECIES**

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The stomach presented mild to moderate wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild gastric distension with a moderate amount of retained anechoic to echogenic fluid and chyme extending into the area of the pyloric outflow was noted. No evidence of mechanical pyloric outflow obstruction was noted.

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The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A mild to variable yet nonobstructive jejunal ileus pattern consisting of mild fluid accumulation in the intestinal lumen was present without obstruction or foreign material.

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The colon walls presented intact yet mildly prominent wall layering with mild thickened to echogenic submucosa. Nonformed to liquid fecal matter consistent with diarrhea was present in the colon lumen with lumen dilation.

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Pancreas

Diffuse enlargement of the pancreas base and right pancreatic limb with ill-defined, hypoechoic to heterogeneous parenchyma and asymmetrical contour was present. Potential for left pancreatic limb inflammation caudal to the stomach vs hypoechoic to swollen focal mesenteric lymph node measuring 1.8 cm x 1.5 cm was observed. 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.

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Free Abdomen**INTERPRETED BY**

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Generalized hyperechoic mesentery primarily in the mid to cranial abdomen around the pancreas, liver and stomach with small pockets of scant free fluid was noted.

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ULTRASONOGRAPHIC FINDINGS

- Hepatomegaly exhibiting multifocal variably sized hypoechoic to nonhomogeneous nodules/macronodules. Possible vacuolar hepatopathy, inflammatory hepatopathy with areas of hyperplasia, hematopoiesis, hepatic neoplasia is possible.
- Acute gastroenterocolitis with mild to moderate hypomotile gastritis.
- Moderate to severe active pancreatitis, potential for pancreatic neoplasia.
- Associated primarily mid to cranial abdominal peritonitis exhibited by hyperechoic mesentery and scant free fluid.
- Potential concurrent hypoechoic to swollen cranial mesenteric lymphadenopathy.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**INVOICE**

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Assuming normal clotting tatus and using a 25g needle, an ultrasound guided FNA of the hepatic parenchyma and macronodule as well as the right pancreatic limb would be warranted for screening cytology. Additionally, if possible, collection of abdominal fluid for analysis and cytology +/- C/S to assess for evidence of peritonitis is recommended. Empirically, aggressive therapy for active pancreatitis with as needed gastrointestinal support which may include broad spectrum antibiotics, analgesia, IVF and gastric protectants with assessment of clinical response would be warranted. Sonographic reassessment pending clinical response in 3-5 days would be appropriate. This patient

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has a very guarded prognosis pending additional diagnostics and therapy.

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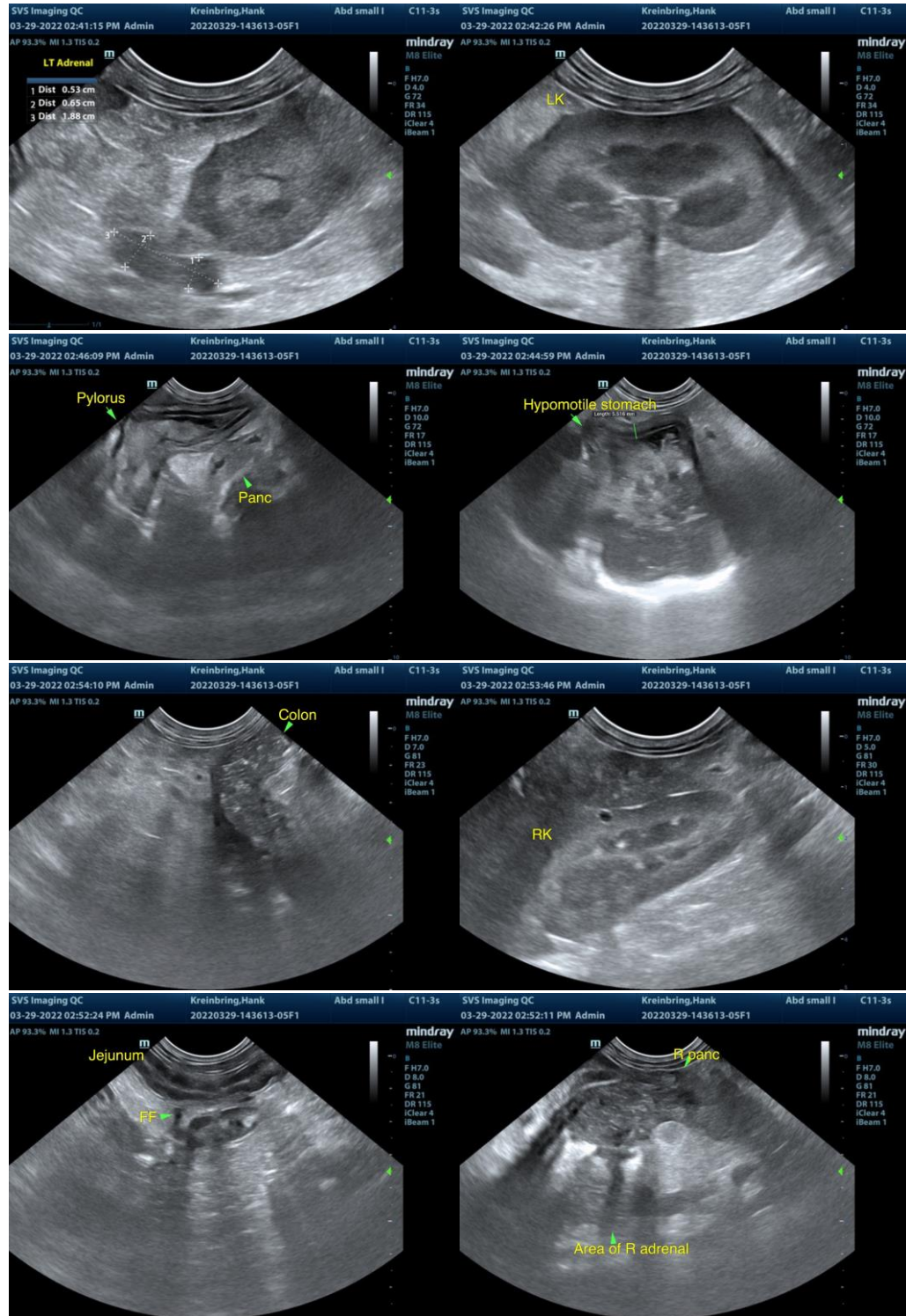
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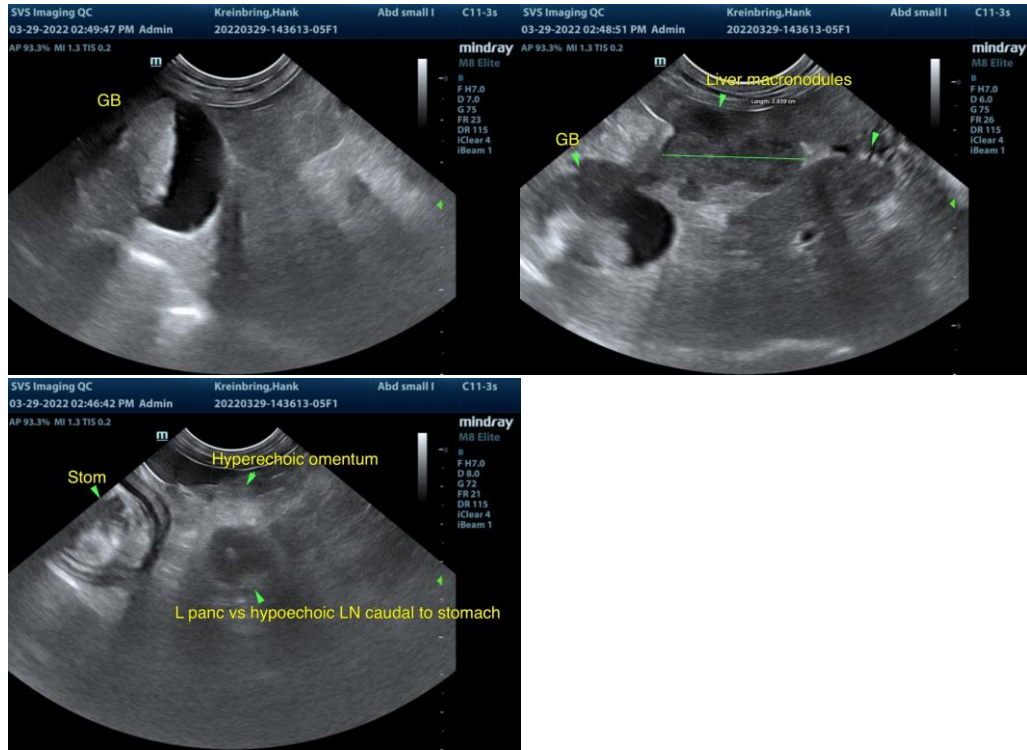
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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