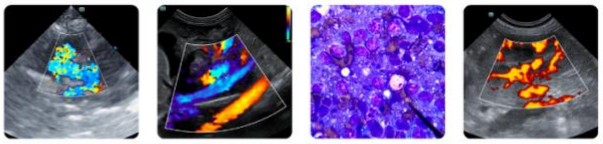


PATIENT

Anakin Villagrana

SPECIES

Canine

BREED

American Eskimo

SEX

Neutered Male

AGE

6 Years

WEIGHT

16.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Mallory Manes

HOSPITAL NAME

Wilvet South

REFERRING VET

Dr. Mallory Manes

INVOICE

16119

DATE

05/12/26

PRESENTING CLINICAL SIGNS

Patient presented on 5/10 for a 1-2 day history of vomiting and inappetence. P is known epileptic since 11 weeks of age and is managed on Phenobarbital, Levetiracetam, and Gabapentin. Since he was vomiting and inappetent, he was not receiving his seizure meds and he began having seizures. P hospitalized on 5/10 for seizure management and GI workup. BW and imaging performed on 5/10 were consistent with severe pancreatitis. P has been hospitalized since the 10th and has been completely inappetent in spite of hospitalization/supportive care and 2 appetite stimulants and has also been febrile. P had NG tube placed 5/11 and ~600 mls of fluid was removed from stomach. P sneezed out NG tube overnight. NG tube replaced 5/12 @ 12 PM and ~400 mls of fluid removed from stomach. Goal of AUS is to distinguish between extreme ileus or FB obstruction, and to evaluate pancreas. Labs: consistent with pancreatitis, hemoconcentration, hypokalemia, and hepatopathy suspect secondary to phenobarbital, hypoglycemia - artifact, normal BG confirmed with glucometer check

Abnormal PE/Chem/CBC/UA Results: Diagnostics performed on 5/10: A FAST- scant free fluid noted in abdomen, between SI loops and around bladder. No intestinal loop dilation, stomach non distended, Gall bladder dilated-anechoic fluid. No overt mass lesions noted. Mesentery hyperechoic and pancreas visible and hypoechoic compared to surrounding mesentery CBC- HCT 52.4, hemo 22.5, MCH 27.6, MCHC 42.9, Band neutrophils, Mono 1.29 suspect artifact from bands, Eos 1.75 suspect artifact from bands based on dot plot CHEM 17 - BG 59 manual BG taken and results 89 ALT 211, ALKP 1840, AMYL > 2500, Lipase 5121 lytes K 2.8 cPL > 2000 Radiographs: 3 view abdomen, no obstructive pattern, small bone fragments noted in stool in colon consistent with raw diet, mild decrease in serosal detail, mild hepatomegaly

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was mildly distended with normal tone. The trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild particulate urine sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

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

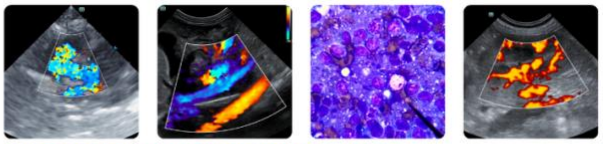
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 5.9 cm in length. The right kidney measured 6.2 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 0.57 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 0.58 cm width at the caudal pole.

Spleen



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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 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 mild nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation. No evidence of gallbladder inflammation or wall edema.

Gastrointestinal

The stomach presented mild thickened wall. Intact wall layering was maintained and distinct. The gastric lumen contained mild gas and mild retained nonshadowing chyme.

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.

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

Pancreas

Diffuse enlargement of the pancreas (primarily in the left pancreas extending into the area of the pancreas base) 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. Minor pockets of localized free fluid was present around the abnormal pancreas.

Free Abdomen

No visualized significant omental lymphadenopathy was present.

ULTRASONOGRAPHIC FINDINGS

- Pancreatitis with regional peripancreatic omental inflammation.
- Gastritis pattern with mild retained nonshadowing chyme, generalized empty small intestine.
- Hepatopathy- subjective benign, metabolic, reactive, vacuolar, cholestatic, inflammatory hepatopathy, secondary hepatopathy owing to medication or combination are all possible.
- Normal bilateral adrenal glands.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of gastrointestinal mechanical/metabolic ileus or foreign material. Minor potential for pancreatic neoplasia which may present in similar sonographic manner as active pancreatitis or occult hepatic neoplasia is thought less likely.

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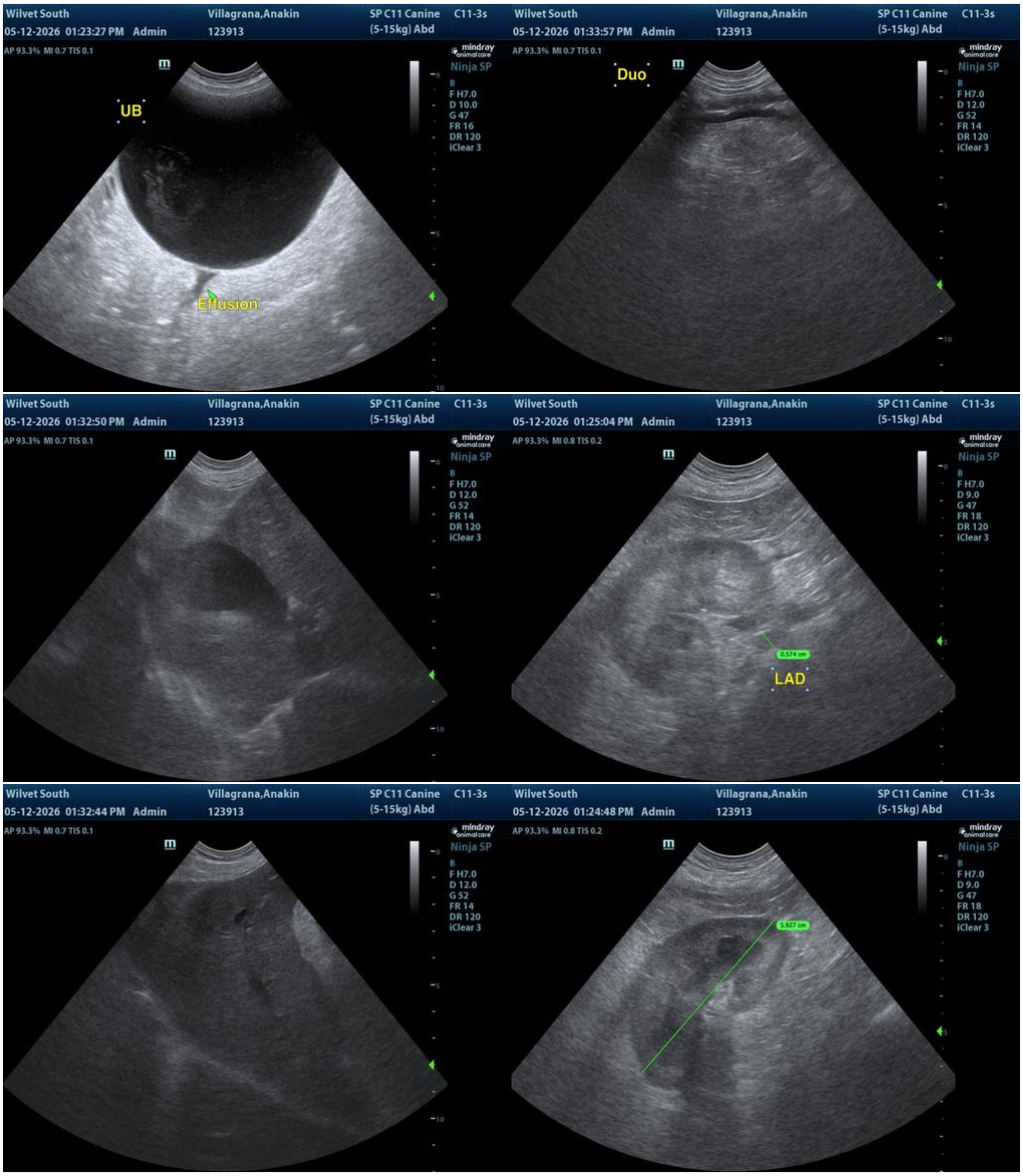
Continued aggressive supportive care for active pancreatitis and associated peripancreatic peritonitis including hepatogastrointestinal support with clinical monitoring is indicated. Recheck sonogram ideally in three to five days, sooner if progressive clinical signs.



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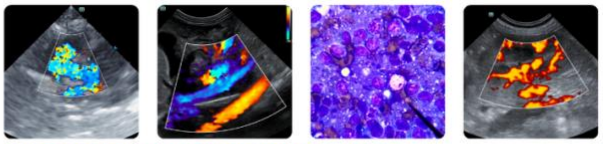

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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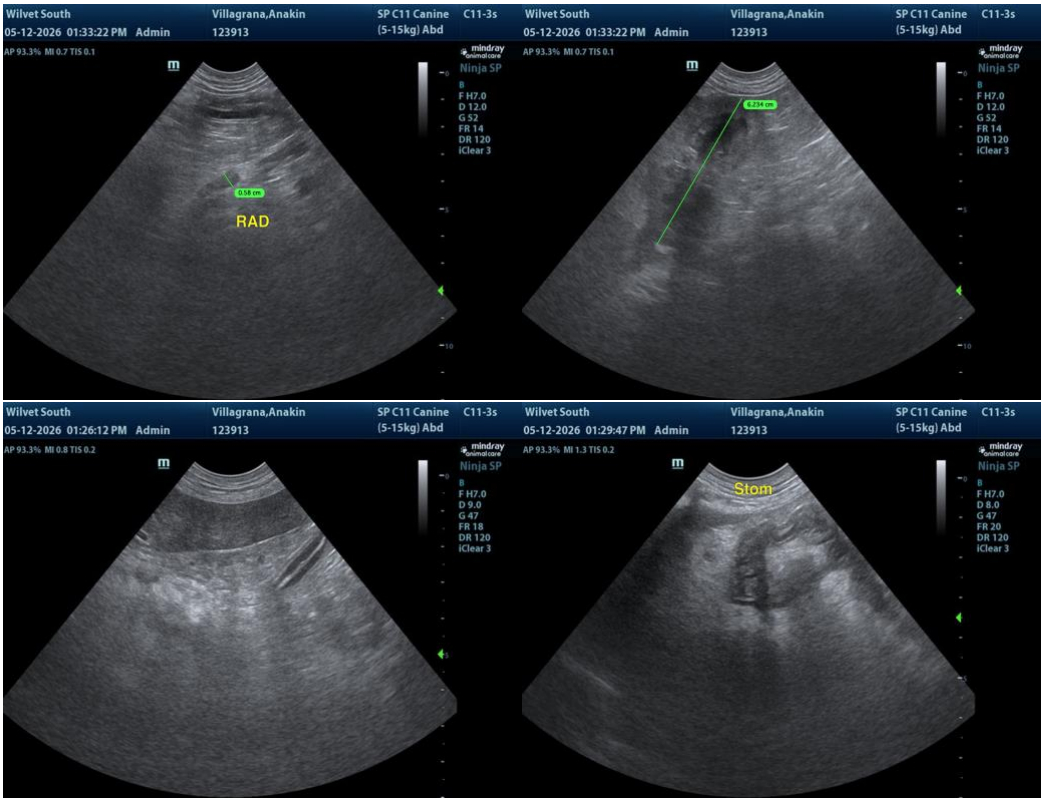

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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