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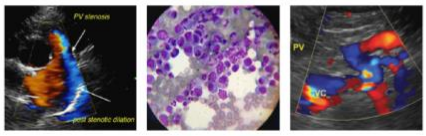

SonoPath
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PATIENT
Taj Tomasi

SPECIES
Canine

BREED
Yorkie X

SEX
Male

AGE
8 Years

WEIGHT
14 Pounds

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

IMAGING PERFORMED BY
Amy Mayhew, LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Family Pet Practice

INVOICE
37889

DATE
5/23/22

PRESENTING CLINICAL SIGNS

Current Medications: Cefpodoxime 100mg 1/2 tab SID Entyce 0.6mls by mouth SID Gaba 50mg tiny tabs- 1 tab TID (owner only giving SID) Famotidine 20mg 1/4 tab SID Cerenia tablet 16mg- 1 tab SID Patient History: 5-21-22 P started vomiting on Monday to tuesday, p stoped vomiting on wednesday but then vomtied again today. P bearly eating anything- a littlc cheese, spitting out treats. O declines AUS/ UCMIC. O approves IH BW, exam and IPS, P acting very lethargic. o took p to traverse city about 1 week ago. o does not think p got into anything. 5-23-22 Per owner still not eating since visit on 5/21/22. Very lethargic still. Per owner having gut sounds and hicups at home. Lots of lip licking. Owner offering RC GI LF canned food and patient showing no interest in food. Hasn't eaten since Saturday morning. Patient had a normal bowel movment yesterday. Per owner patient has not tried to deficate at all today, urinating fine though. No vomiting per owner. Per owner not much change/improvemnt overall.
Abnormal PE/Chem/CBC/UA Results: 1. QAR 5. Muddy MM, slow CRT ~ 3 seconds, moderate to severe tarter- worse upper left arcade, retained and mobile deciduous canine upper left.Prev rec dental 6.Grade III-IV heart murmur 7. Lungs clear 9/10. soft abdomen, no palpable fb or masses. flatulence on abdominal palpation. Hx of prostatomegaly rectal exam not performed today. standing with arched TL spine- per O arching of back is less since start of treatment 2 days ago. See attached labs

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – 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 prostate was enlarged in size (4.2 cm x 2.9 cm) with intact, symmetrical capsule contour. The margins of the gland were intact and able to be differentiated from the surrounding tissue. The prostatic parenchyma was mildly echogenic to heteroechoic without parenchymal mineralization.

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 minor loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.6 cm. The right kidney measured 4.85 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.45 cm at the cranial pole and 0.51 cm at the caudal pole. The right adrenal gland measured 0.50 cm at the cranial pole and 0.40 cm at the caudal pole.

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

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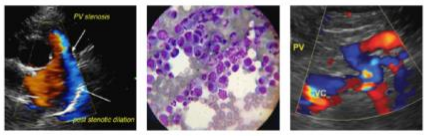

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The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. Very mild non-dependent to particulate luminal debris present in the area of the gallbladder neck. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact yet prominent wall layering. Ventral gastric body wall measured 0.30 cm. Moderate variably echogenic to shadowing gastric ingesta and chyme present.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Intermittent mild segmental duodenojejunal mucosal speckling present. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. Jejunum wall measured 0.26 cm. Duodenum wall measured 0.46 cm.

Normal visible colon wall layers were present with potential semiformed feces.

Pancreas

The left and right pancreatic limbs exhibited generalized enlargement with capsule asymmetry. Mixed echogenic to hypoechoic left and right pancreatic parenchyma echogenicity noted. Regional peripancreatic hyperechoic omentum present.

Free Abdomen

A solitary, mildly prominent medial iliac lymph node was present, measuring 1.0 cm x 0.37 cm. This lymph node was not consistent with inflammatory neoplastic criteria, and likely incidental. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

ULTRASONOGRAPHIC FINDINGS

- Active to chronic active pancreatitis with regional peripancreatic reactive to potentially mildly inflamed omentum.
- Gastritis pattern with non-specific variably echogenic to shadowing ingesta.
- Possible concurrent mild enteritis.
- Minor gallbladder debris (non-mucocele) – likely incidental.
- Benign prostatic hyperplasia, minor potential for prostatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary finding in this study is the pancreatic presentation, suggestive of mixed inflammatory pattern with secondary regional peripancreatic reactive to potentially inflamed omentum. Minor potential for neoplasia, which may present in similar sonographic manner, as pancreatic inflammation cannot be excluded, yet thought less likely. Given the patient's history of inappetence, the presence of focally shadowing gastric ingesta is non-specific. This could correlate with unknown recent meal ingestion, some degree of gastric hypomotility with retained ingesta, while technically the possibility of foreign material cannot be excluded. The shadowing ingesta may also correlate with medication administration.

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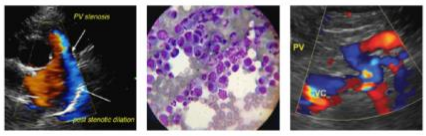

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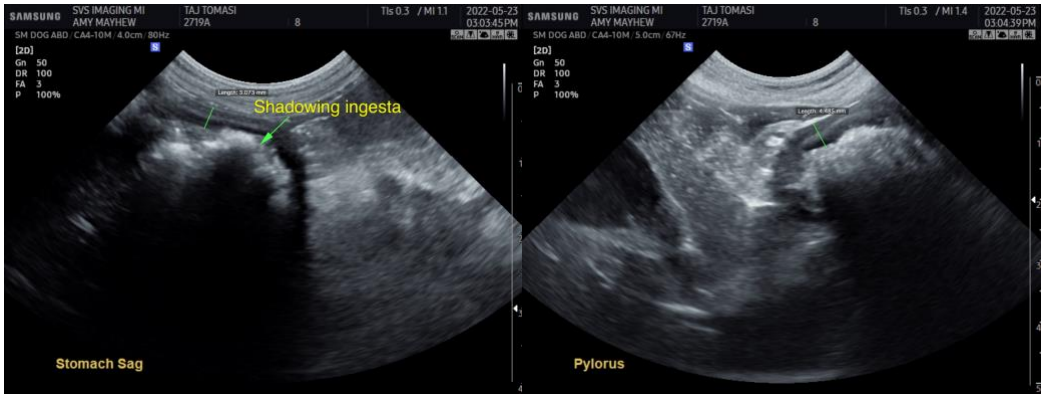
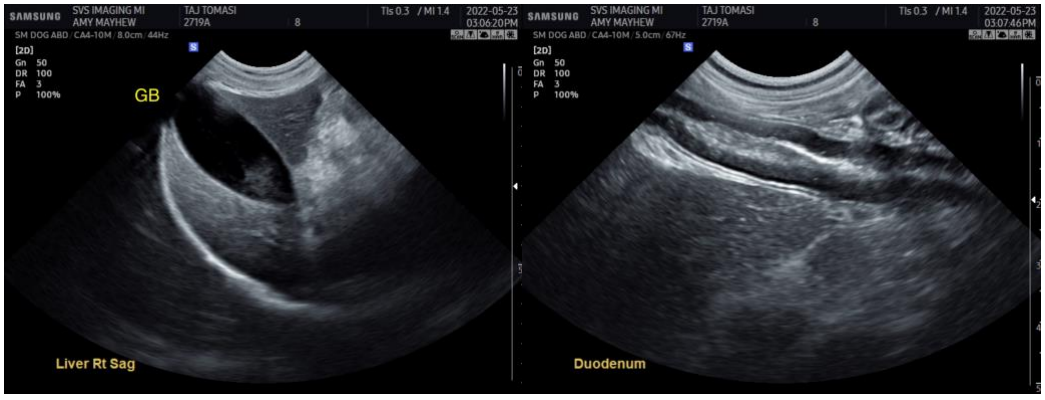
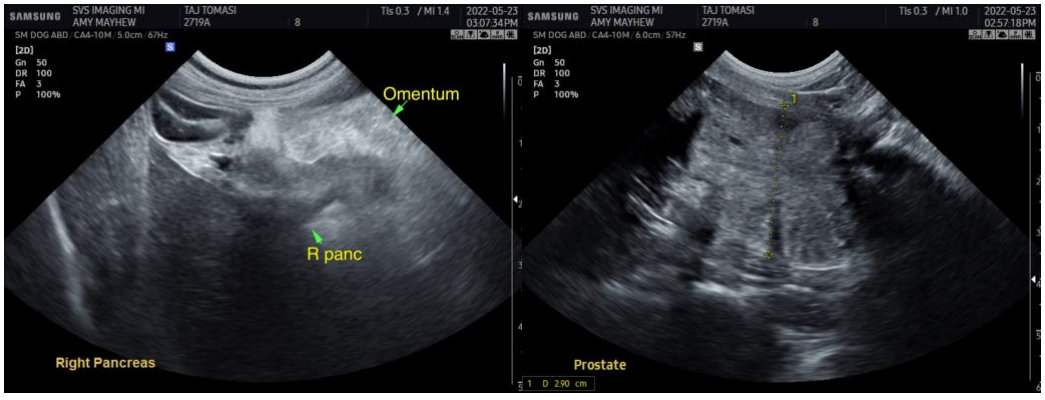
Hospitalization with 48-72 hour IV fluid support, medical therapy for gastroenteritis/pancreatitis and monitoring for normal gastric emptying recommended. Long-term therapy for chronic active pancreatitis, which may include continued bland to low-fat diet and as needed gastrointestinal support likely indicated.







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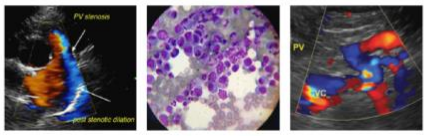

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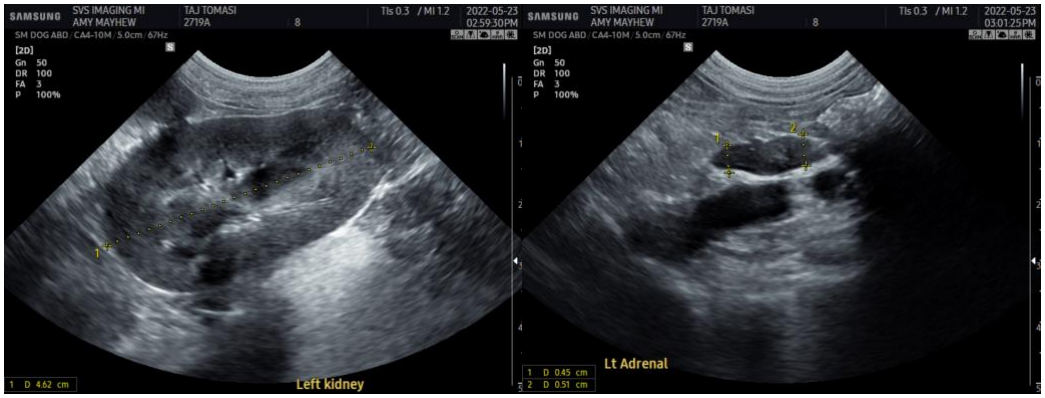

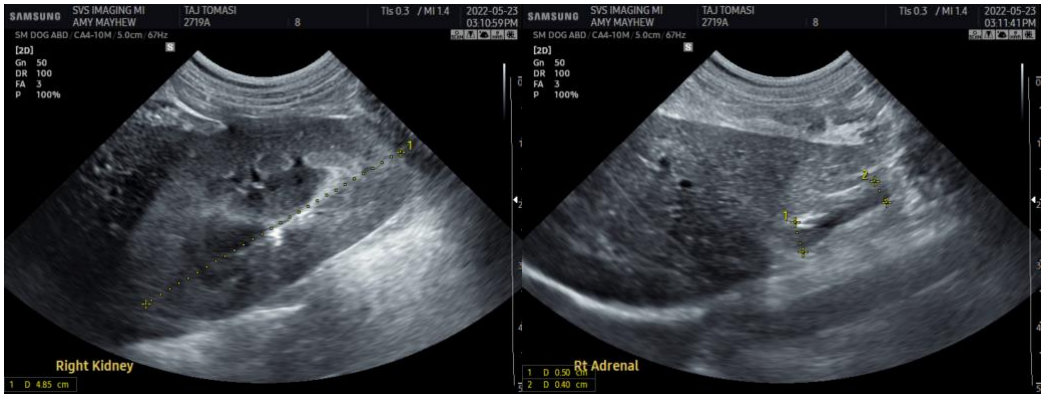

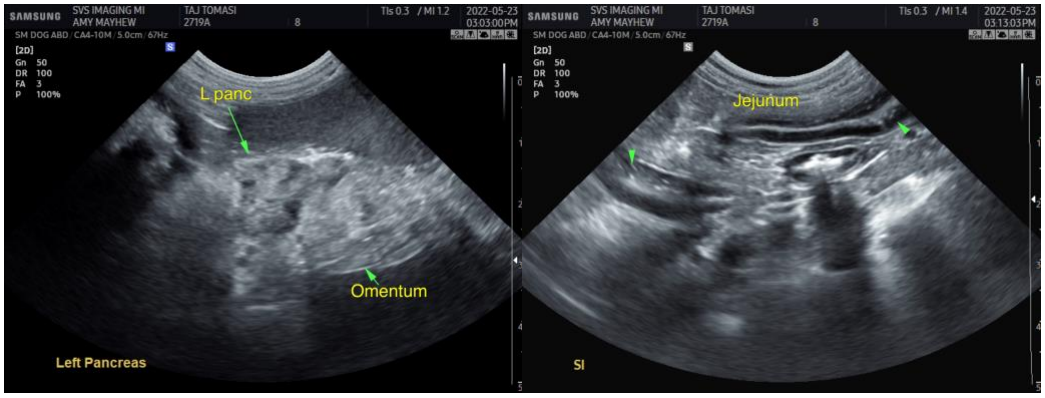

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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