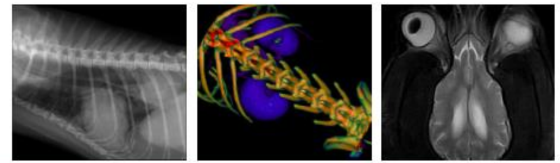

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1-800-838-4268 info@sonopath.com

PATIENT

Odie Mortensen

SPECIES

Canine

BREED

Dachshund Mix

SEX

MN

AGE

9 Years

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

Animal Health Care
Denver

REFERRING VET

Cathryn Sayer

INVOICE

51321

DATE

4-3-22

PRESENTING CLINICAL SIGNS

Odie presented for abdominal discomfort, ADR, inappetance. We performed an ultrasound and barium study, then the next day performed the CT due to abnormal appearing gallbladder on u/s. He did eat dinner the night before the CT. We are concerned because his ALP doubled in the last two months and his cholesterol is elevated. He is strictly fed Hill's c/d due to previous urolith. I have attached the ultrasound images.
Abnormal PE/Chem/CBC/UA Results: Odie has had elevated liver values starting 2 years ago. In April 2020 ALP was 274, April 2021 ALP was 780, August 2021 ALP was 923, and now 3/30/22 ALP is 1853. Cholesterol is chronically elevated, runs from 334 to 391. Also on recent BW the total WBC was at the high end of the range.

COMPUTED TOMOGRAPHY OF THE ABDOMEN

A high resolution pre- and post-contrast CT study of the abdomen is provided for review.

COMPUTED TOMOGRAPHIC FINDINGS

The serosal fat presents normal attenuation behavior. There is no evidence of peritoneal effusion or peritonitis.

Both kidneys present within normal limits for size, shape and organ architecture. After contrast administration multiple variable sized, well-defined, roundish parenchymal filling defects are seen throughout the renal cortex bilaterally.

The adrenal glands are within normal limits for size, shape and organ architecture.

The spleen presents with normal shape, even surface, uniformly attenuating parenchyma and homogeneous contrast enhancement, unremarkable.

The liver is normal in size and shape; post contrast administration, an ill-defined , roundish mild hypoattenuating parenchymal lesion is seen in the cranioventral aspect of the left medial liver lobe.

The gallbladder is significantly distended. Moderate dilation of the common bile duct is seen, measuring up to 3.3 mm in diameter.

Level with the corpus of the pancreas, an irregular, multiloculated mass with a heterogeneous contrast enhancement pattern, measuring 2.3 x 1.6 x 4.0 cm in size is visible. Post contrast administration a hypoattenuating zone, demarcated by moderate contrast enhancing capsule like structure is visible within the multiloculated pancreatic mass. The surrounding peritoneal fat presents mild to moderate fat-stranding. The pancreatic mass is encompassing the distal aspect of the common bile duct. The duodenal wall at the level with the pancreatic lesion presents with a maintained wall layering.

The position, delineation, wall and content of the gastrointestinal tract are considered within normal limits throughout.

The intervertebral discs T12/T13 to L1/L2 are mildly protruding into the vertebral canal.

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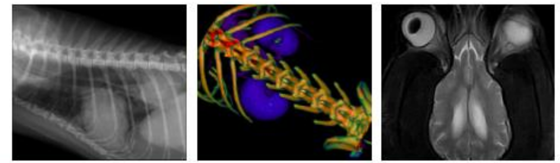

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COMPUTED TOMOGRAPHIC DIAGNOSIS

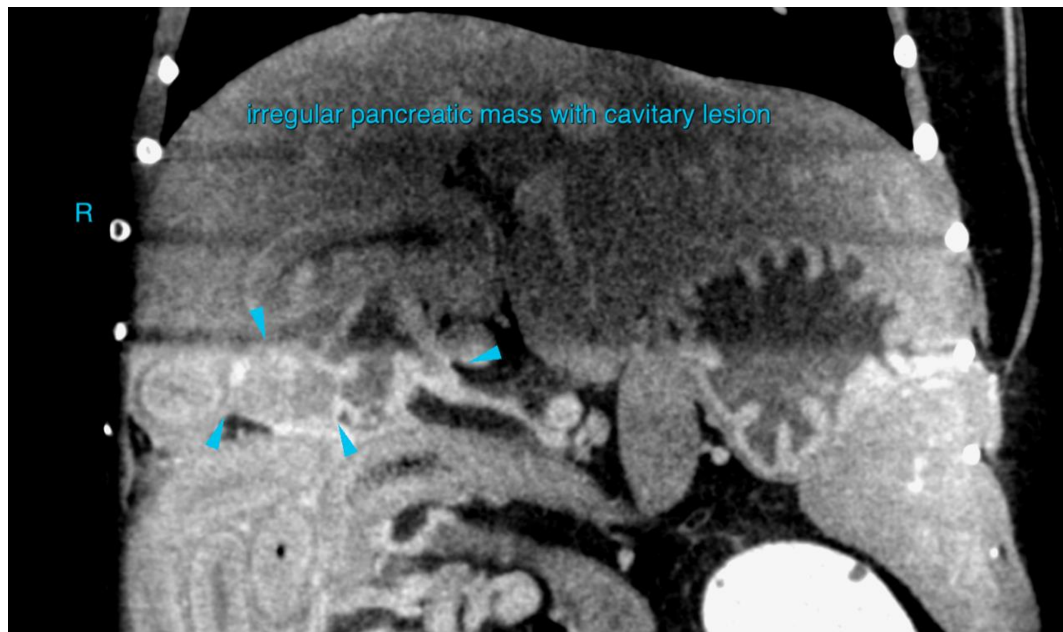
- Pancreatic multiloculated mass, level with the corpus of the pancreas, with a cavitary lesion
- Surrounding peritonitis
- Moderate dilation of the gallbladder and the common bile duct.
- Post contrast hypoattenuating parenchymal hepatic lesion
- Renal cortical cysts
- Mild intervertebral disc protrusion T12/T13 to L2/L3 without compressive myelopathy

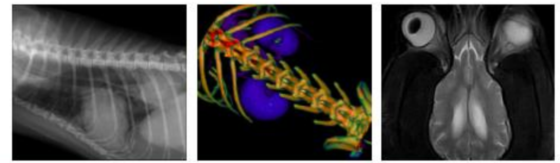
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The irregular focal pancreatic enlargement is concerning for neoplastic transformation of the pancreas and pancreatic adenocarcinoma with a zone of necrosis is the top differential; as the mass is encompassing the common bile duct, there is secondary extramural obstruction of the common bile duct. Pancreatitis with walled-of necrosis or pancreatic pseudocyst/retention cyst is a consideration but the focal enlargement is atypical. Ultrasound guided FNA sampling of the pancreatic mass is recommended as well as complementing workup by cpl to check for pancreatitis.

The supposed biliary obstruction is a plausible explanation for the progressive increasing ALP.

The hypoattenuating hepatic lesion is not specific and potentials include hepatic cyst, regeneration nodule, metabolic hepatopathy or metastasis.





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R
common bile duct entering pancreatic mass

R
hypoattenuating parenchymal hepatic lesion

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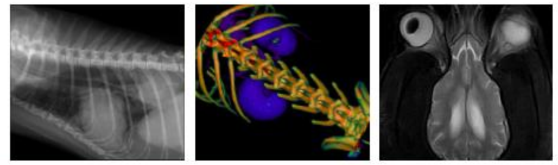

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Sebastian Schaub, Sebastian Schaub, DVM, Dr. med. vet. DipECVDI
sebast.schaub@gmail.com