

**PATIENT PRESENTING CLINICAL SIGNS**

Sadie Bussey

History:

Linear FB surgery requiring 2 enterotomies Feb 27. Dehiscd w/ septic peritonitis and was repaired surgically March 1. JP drain present - fluid production lessening and cytology shows improvement in cellularity and intracellular bacteria. NG tube in place.

**SPECIES**

Canine

P now has persistent regurgitation when attempting trickle feeding and requiring frequent gastric aspiration (4 hourly) to prevent regurgitation. Small amt of diarrhea passing.

**BREED**

Peekapoo

Current medications:

Methadone 0.1mg/kg q6h

Cerenia 1mg/kg q24h

**SEX**

Pantoprazole 1mg/kg q12h

Cisapride 0.9mg/kg q8h

Female Intact

Metoclopramide 2mg/kg/d

Cefazolin 22mg/kg q8h

**AGE**

2 years

Baytril 10mg/kg q24h

Metronidazole 10mg/kg q12h

KCl/Dextrose supplementation as needed.

**WEIGHT**

2.69 kg

Abnormal PE/Chem/CBC/UA Results:

BCS 2/9

Mild jaundice today.

Rest of PE unremarkable at present. Normotensive, normothermic.

**INTERPRETED BY**

Tam Mengine, DVM,  
DABVP (canine/feline  
practice)

Stable nonregenerative anemia (hct 30)

Persistent neutrophilia w/ left shift (23.06)

Mod monocytosis (2.35)

Mild thrombocytopenia (125)

Gradually worsening ALP (now 553).

ALT normal.

Gradually worsening TBil (now 63).

Hypoalbuminemic but gradually improving (now 19g/L)

Mild hypocalcemia (total, ionized not tested).

Hypoglycemic but maintaining on 5% Dextrose

Recurrent hypokalemia without supplementation.

Red-coloured urine following ultrasound - no cysto performed and first time seen. New UA pending.

**IMAGING PERFORMED BY**

Dr. Guenther

**HOSPITAL NAME**

Central Island  
Emergency VH

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**REFERRING VET**

Dr. Daniel

**Urinary System**

The urinary bladder is moderately distended with anechoic urine. A small amount of echogenic luminal sediment is present, which is freely movable. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 3.0 cm.

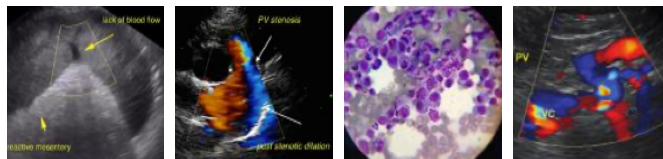
**INVOICE**

12337

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a 1:3 cortex to medulla ratio. There is trace pyelectasia present in the left kidney. There is no evidence of nephrolithiasis, mineralization, cystic change or hydronephrosis. The proximal ureters are not visible (normal). The left kidney is 3.6 cm in length. The right kidney is 3.8 cm in length.

**DATE**

3.5.23



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**Adrenal Glands**

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland height is 4.1mm at the cranial pole and 4.9 mm at the caudal pole. The right adrenal gland height is 6.8 mm at the cranial pole and 4.1 mm at the caudal pole.

**Spleen**

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

**Liver**

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is markedly distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

**Gastrointestinal**

The stomach is moderately distended with hypoechoic fluid. The gastric wall is 3.8 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness, up to 1.3 mm, with intact wall layering. The ileocecal junction is not visualized.

**Pancreas**

Both limbs of the pancreas are swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic duct appears normal.

**Free Abdomen**

There is focal free fluid present within the abdomen. The omentum and intra-abdominal fat are hyperechoic. The medial iliac lymph nodes are enlarged, measuring up to 2.5 cm in length. There is a mesenteric lymph node that is diffusely anechoic, consistent with abscessation. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

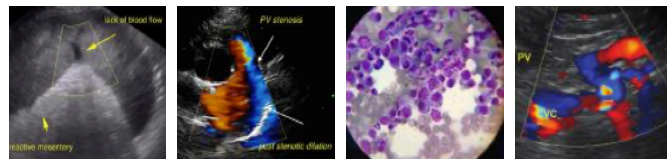
**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Abscessed mesenteric lymph node
- Swollen, hypoechoic pancreas with necrosis

**Secondary Findings**

- Diffuse peritonitis, consistent with history
- Trace pyelectasia in the left kidney, consistent with IV fluid history



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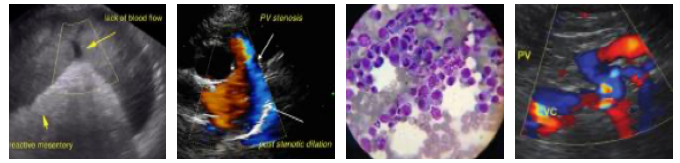
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The significant inflammation in both limbs of the pancreas, suggests that extrahepatic biliary obstruction, secondary to pancreatitis, is the likely reason for the icterus. It is my understanding that the abscessed lymph node has been surgically drained previously, but appears to have recurred. If the patient fails to improve clinically, then another exploratory surgery could be considered, to remove this lymph node. Surgical dividement of the pancreas may also be considered, especially if areas of abscessation are identified. If the patient is still having trouble with regurgitation, then a jejunotomy tube could also be placed. However, if the patient continues to improve clinically, then ongoing medical management would be reasonable. Eating small meals of a low-fat diet may help encourage intestinal motility. The addition of Carafate is recommended, to address the possibility of underlying esophagitis, which may be contributing to the regurgitation. Finally, additional pain medication, such as lidocaine CRI, could be considered in case pain is contributing to ileus.





**PATIENT**

Sadie Bussey

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.

**SPECIES**

Canine

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.

**Tam Mengine, DVM, DABVP (canine/feline practice)** info@SonoPath.com

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