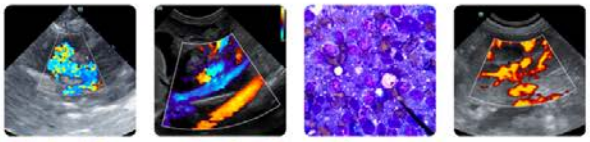


PATIENT

Ellie Grant

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

13 Years

WEIGHT

6.45

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Melissa Helstein

HOSPITAL NAME

Veterinary Emergency Group – Burlington, VT

REFERRING VET

Dr. Melissa Helstein

INVOICE

75192

DATE

5/16/26

PRESENTING CLINICAL SIGNS

Ellie is a 13 yr old FS Mixed Breed dog that presents for lethargy. Ellie was boarded a few weeks ago for the day with a family dog. Both Ellie and the family dog got kennel cough. Ellie was treated with doxycycline for 5 days with the last dose being Wednesday, there was improvement but once she was off the antibiotic the lethargy started and today she began vomiting. Ellie was seen with the primary care provider this week and started on Benadryl. Ellie is on benadryl, and a probiotic currently. Ellie does have a history of elevated liver enzymes that have been monitored in the past. History of heartworm disease that was treated at the time of adoption when she was ~4-5yrs of age. Has since recovered and hs continued to test negative.

Abnormal PE/Chem/CBC/UA Results: Please see attachments

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae and trigone are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. The urethra is not clearly visualized, presumably due to an intrapelvic location.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There are small cortical cysts present within the cortex of the right kidney. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureter is not visible (normal). Left kidney measures 4.6 cm. Right kidney measures 5.0 cm.

Adrenal Glands

The left adrenal gland is identified in its normal location. It is of normal size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland height is 3.1 mm at the cranial pole and 3.8 mm at the caudal pole. The right adrenal gland is not distinctly visualized, but the region appears unremarkable.

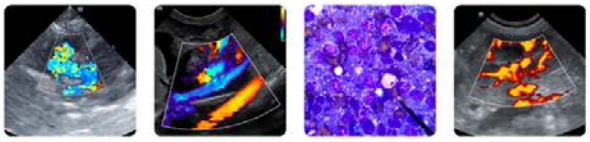
Spleen

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 diffusely hyperechoic and subjectively enlarged, with sharp borders and a homogenous echotexture. 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 bile and a large amount of sludge, and the cystic duct is dilated to 7.2 mm and surrounded by hyperechoic omental fat. There is no visible obstruction present within the duct. The gallbladder wall is thin and continuous with no focal lesions.



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Gastrointestinal

The stomach is moderately distended with gas. The gastric wall is 3.7 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 with intact wall layering. The ileocecal junction is not seen.

Pancreas

The pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic ducts appear normal.

Free Abdomen

There is no free fluid noted within the abdomen. There is hyperechoic, inflamed omental fat noted in the region of the pancreas and bile duct. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Markedly hypoechoic left and right pancreas, with associated steatitis, consistent with acute pancreatitis
- Markedly distended gallbladder and mildly enlarged common bile duct - most typical of extra hepatic biliary obstruction, secondary to pancreatitis
- Diffusely hyperechoic liver, consistent with non-specific or reactive hepatopathy - biopsy would be needed for definitive diagnosis, and should be considered if liver values continue to elevate despite resolution of pancreatitis

SECONDARY FINDINGS

- Minor age-related / degenerative renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes in the pancreas are consistent with acute pancreatitis and secondary extra-hepatic biliary obstruction. Concurrent pancreatic neoplasia, while less likely, cannot be ruled out. While the pancreatitis is the likely cause for the elevation in liver values, doxycycline can cause an idiosyncratic hepatopathy in dogs - thus, if antibiotics are needed for pneumonia, doxycycline should be avoided as a precaution. Additional recommendations include:

- a serum PLI or other quantitative pancreatic marker is recommended for confirmation and monitoring purposes.
- supportive care including fluid therapy, antiemetics, analgesics, appetite stimulants (if needed) are warranted. For dogs, Panoquel-CA1, a newer, novel injectable treatment for canine pancreatitis, is recommended if available.

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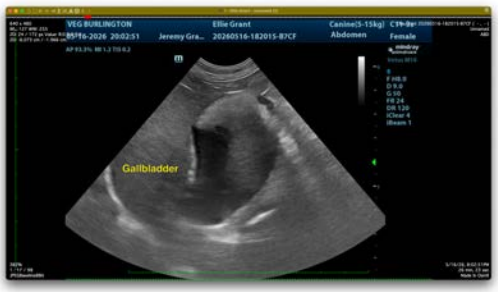
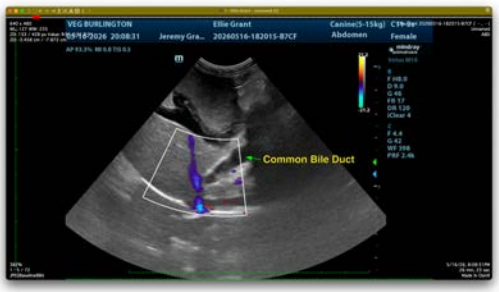
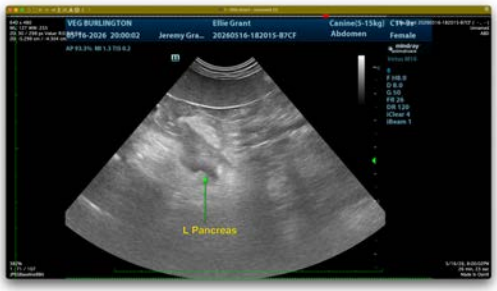
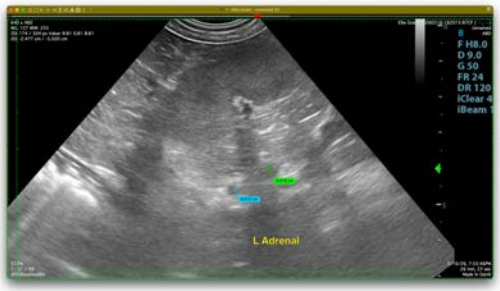
- a highly digestible, low fat intestinal diet should be encouraged as soon as vomiting can be controlled.
- ursodiol at 10-15 mg/ kg PO BID is recommended to address cholestasis
- in one study, an anti-inflammatory dose of prednisone has been shown to shorten recovery time for dogs with pancreatitis and biliary obstruction - this could be considered if the patient is not responding to typical therapies
- if the patient is not responding to medical management, fine needle aspiration of the pancreas with a 25G needle for cytology could be considered after first checking a coagulation profile.
- if cholestatic values are not improving despite otherwise resolving clinical signs, this may indicate scarring of the common bile duct, or another cause for biliary obstruction, and abdominal exploratory may be needed for choledocal stenting or other intervention.









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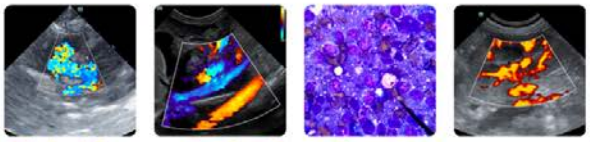

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com