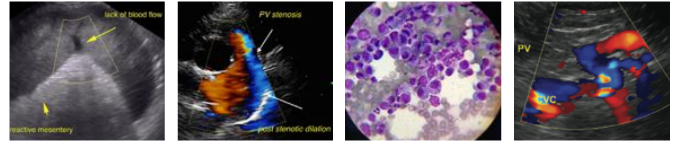
SonoPath

Clinical Sonography & Telecytology



EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Pookie Trahern

SPECIES
Canine

BREED
Pug

SEX
Male

AGE
8 years

WEIGHT
20.8 lbs

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

IMAGING PERFORMED BY
Dr. Brackee

HOSPITAL NAME
Bradenton VH

REFERRING VET
Dr. Brackee

INVOICE
32298

DATE
8/10/22

PRESENTING CLINICAL SIGNS

History: Pancreatitis diagnosis 10 days ago. Picky eater w/partial anorexia. Abdomen Rads taken, fluid dense mass approximately 3cm in cranial abdomen. R/O enlarged ,GB, Liver Mass, splenic mass.
Abnormal PE/Chem/CBC/UA Results: ALK/PHOS:370, TBILI:0.8, PHOS:6.4, CHOL:540, TGS:795, PSL:2549 T4: <0.5, CBC WNL, UA-SPG:1.016, PH:6.5

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, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). The pelvic urethra was visualized 1.0 cm beyond the cystourethral junction and appeared normal. No masses, calculi or mucosal irregularities are noted.

The left kidney is hyperechoic, and exhibits moderately decreased corticomedullary differentiation. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureter is not visible (normal). The left kidney measured 3.8 cm.

The right kidney is hyperechoic, and exhibits mildly decreased corticomedullary differentiation. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureter is not visible (normal). The right kidney measured 3.5 cm.

Adrenal Glands

The adrenal glands are not specifically visualized, but the region of each adrenal gland appears unremarkable.

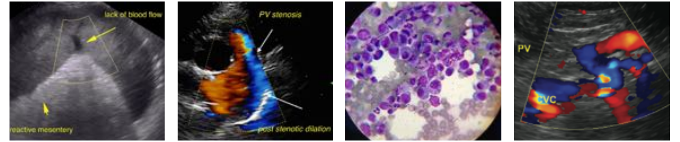
Spleen

There are multiple hyperechoic masses within the splenic parenchyma measuring (up to 0.5) cm in size, with no visible deviation of the splenic capsule. 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 measuring up to 4.6 cm in diameter. The wall was thin and continuous with no focal lesions. The common bile duct is not visible, however, the cystic duct is visualized and dilated up to 0.3 cm. No physical obstruction is seen.



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Gastrointestinal

The stomach is moderately distended with anechoic fluid and normal looking ingesta. The gastric wall is (0.45) cm 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. The duodenal wall measures (0.56) cm. The jejunal wall measures up to (0.27) cm. . Intestinal motility appears normal.

The visible portions of the colon are of normal thickness, up to (0.18) cm, with intact wall layering. The ileocecal junction is visualized and appears normal.

Pancreas

The left and right limb and body of the pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are diffusely hyperechoic especially within the cranial portion of the abdomen. Enlarged abdominal lymph nodes are not observed.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Acute pancreatitis with suspicion for extrahepatic bile duct obstruction.

SECONDARY FINDINGS:

- Chronic renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although a mechanical obstruction of the cystic duct cannot be ruled out, the clinical history and evident pancreatitis support a functional, extrahepatic bile duct obstruction secondary to the pancreatitis.

- Ongoing supportive care including fluid therapy, antiemetics, analgesics and appetite stimulants are warranted.
- Highly digestible low fat intestinal diet should be encouraged as soon as vomiting can be controlled.
- The history of elevated cholesterol and triglycerides along with a low T4 raise the possibility of concurrent hypothyroidism. Canine TSH level is recommended.

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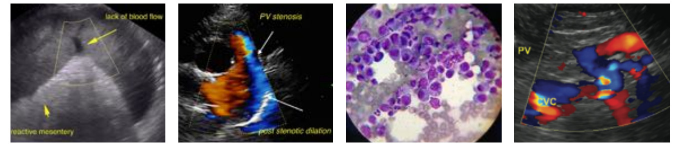

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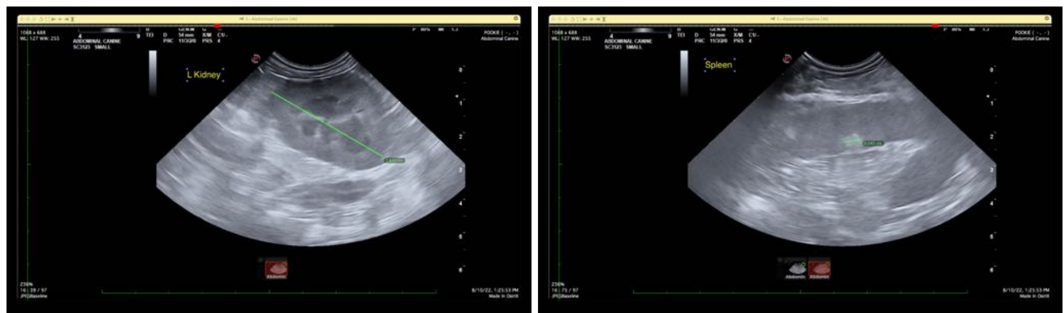
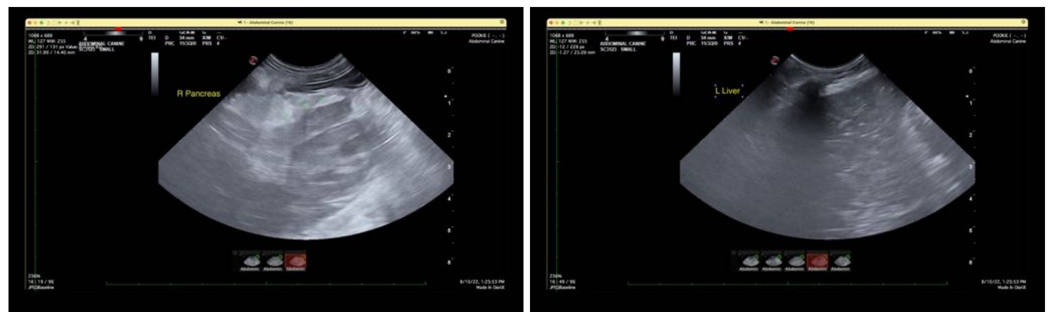
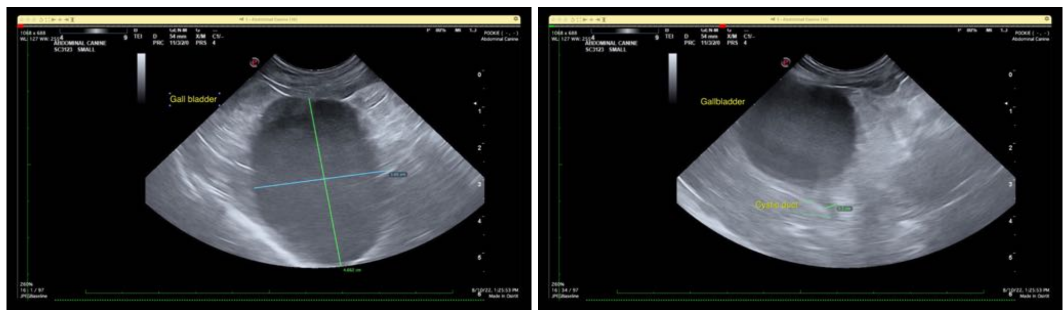
- If the triglycerides remain elevated while fasted then additional therapy for hyperlipidemia such as omega 3 fatty acid therapy at 10-30 mg/kg s.i.d. is recommended in addition to the low fat diet.
- While most cases of extrahepatic bile duct obstruction resolve over several weeks with medical management of the pancreatitis, a small number of dogs have ongoing cholestasis and may benefit from stenting of the cystic duct.

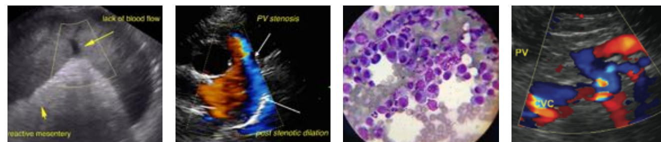
The changes in the kidneys are consistent with chronic renal disease. Recommendations include:

- ❖ a CBC, chemistry panel, urinalysis, urine protein creatinine ratio and blood pressure measurement are recommended
- ❖ urine culture should also be considered, particularly if urine sediment is active
- ❖ dietary and supportive care recommendations can be made, based on the staging of the disease as outlined in the IRIS guidelines









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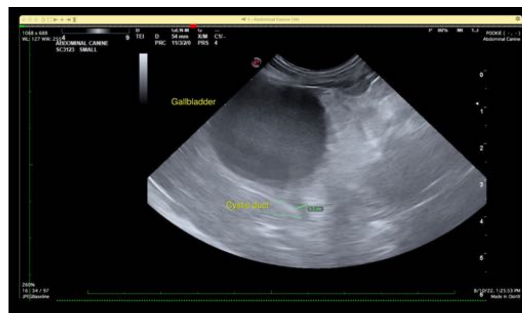

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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