



PATIENT

Lobo King

SPECIES

Canine

BREED

Husky

SEX

Neutered Male

AGE

10.5 Years

WEIGHT

60.3

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Neuhaus

HOSPITAL NAME

Willamette VH

REFERRING VET

Dr. Neuhaus

INVOICE

45462

DATE

2/24/23

PRESENTING CLINICAL SIGNS

Pt has been seen here 3 times in past 36 hours for increasing abdominal pain and inappetance. Pt Dx'd with pancreatitis yesterday 2/22, O opted for outpatient plan at that time. Pt has been regurgitating frequently since last night and has not been able to keep medications down. NGT placed 2/23/23. Abnormal PE/Chem/CBC/UA Results: EPOC = K 4.1, Na 152, pCO2 28.9, pO2 77.8. lactate wnl 0.83 PCV/TS = 40%, 5.8

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal in size (5.66 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (6.24 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The area of the right adrenal gland is examined without evident adrenal gland pathology.

The left adrenal gland is normal in size (0.52 cm at the cranial pole and 0.55 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is markedly overdistended with primarily fluid as well as echogenic non-shadowing luminal contents, consistent with kibble as well as echogenic fluid or similar appearing contents within the pylorus. No definitive foreign material or infiltrative disease is visible.



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The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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Pancreas

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The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

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There is no evidence of free peritoneal effusion noted in these images.

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There is no apparent lymphadenopathy noted in these images.

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ULTRASONOGRAPHIC FINDINGS

- Marked gastric distention without an evident visible obstruction. However, an obstruction cannot be definitively ruled out. Other more likely differentials are gastric stasis/ileus secondary to underlying metabolic disease.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

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A complete metabolic health screen is recommended if not recently evaluated in the form of a CBC/Chem panel, electrolytes, a urinalysis and, if indicated based on urinalysis results, urine culture. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

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Additionally, as was reportedly already done, a nasogastric tube placement for potential gastric suction as well as nutritional support is recommended, and if clinical signs persist beyond alleviating the gastric distention, recheck imaging with a smaller, less distended stomach may be beneficial to potentially see any subtle pathology that may have been obscured by the marked gastric distention.

REFERRING VET

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There is no other visible evidence of gastrointestinal or pancreatic disease. However, they cannot be ruled out with a normal ultrasound. Therefore, especially if there is any chronicity or intermittent chronicity to these clinical signs, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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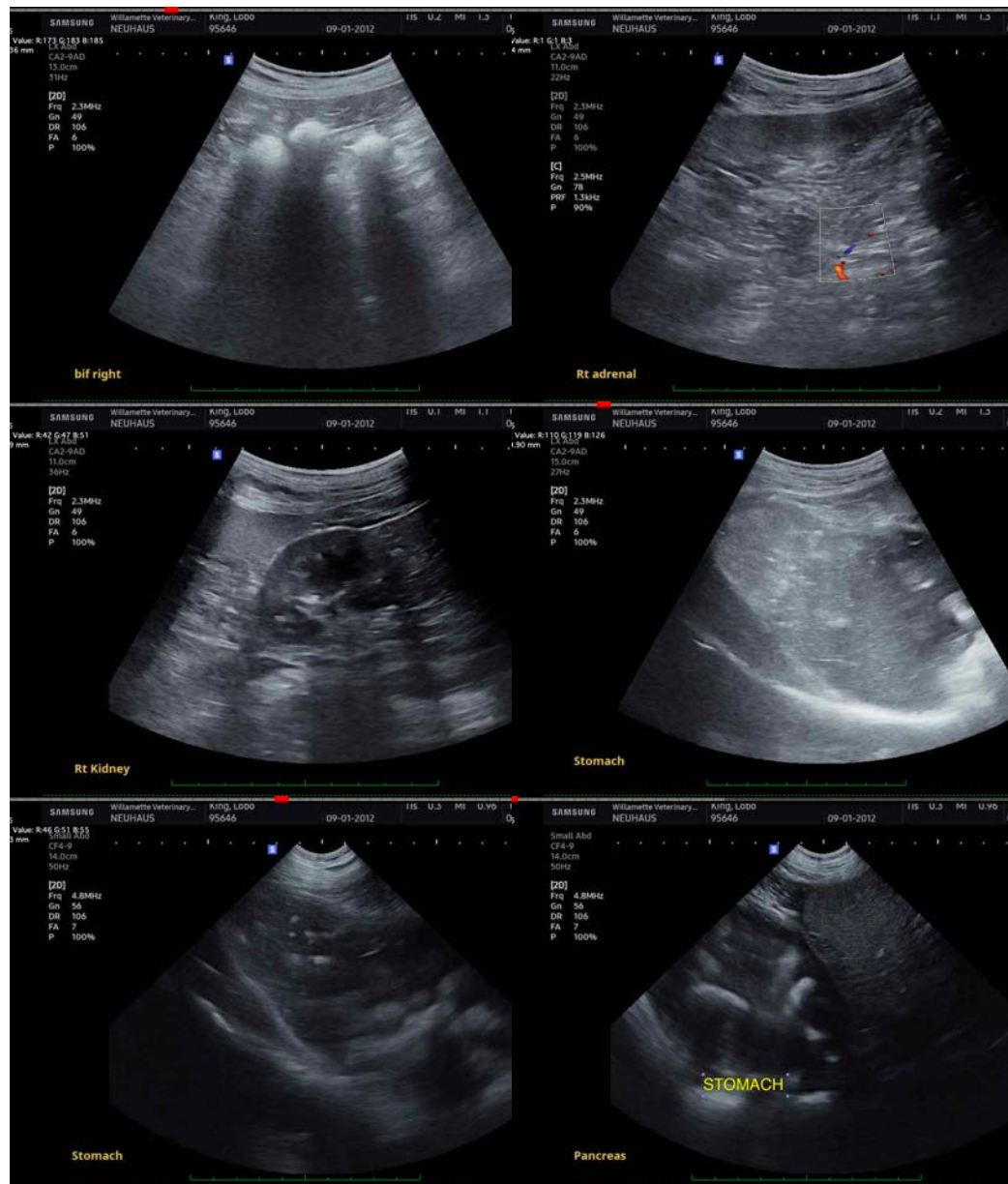
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com