



PATIENT

Hunter Bowers

SPECIES

Canine

BREED

Labrador Retriever

SEX

Neutered male

AGE

11 years

WEIGHT

101.2 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Neuhaus

HOSPITAL NAME

Willamette VH

REFERRING VET

Dr. Neuhaus

INVOICE

42337

DATE

11/5/22

PRESENTING CLINICAL SIGNS

History: Anorexia for 3 days, vomiting for 3 days. Lethargy and reluctance to walk. Vomit on Tuesday morning was the pts meal & the next day O described it to look like bile looking & hasn't V+ again until last night. Urination and defecation normal per O. Drinking water normally per O. O gave 300 mg gabapentin for pain last night. UTD on vx's per O. History of a right CrCL tear. Owner declined bloodwork and radiographs with us due to wellness plan with rdvm.
Abnormal PE/Chem/CBC/UA Results: Lethargic, mm pnk/ mst, crt <2, heart and lungs auscult wnl, Abd tense on palpation, abd distension

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction and appeared normal. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 8.6 cm. The right kidney measured 7.6 cm.

Adrenal Glands

The left **adrenal gland** was enlarged at the cranial pole and measured 1.61 cm, 0.84 cm at the caudal pole and 4.4 cm in length. The right adrenal gland measured 0.8 cm at the cranial pole and 0.4 cm at the caudal pole.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** was uniform with mildly increased portal markings and slight, irregular contour. Minor gallbladder congestion was noted without full post hepatic obstruction.



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Gastrointestinal

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The pyloric outflow was enveloped by the pancreatic pathology. Mesenteric adhesions were noted upon the upper GI tract.

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Pancreas

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Mixed, echogenic parenchymal changes were noted throughout the base of the pancreas and partially left limbs. Mixed, hypoechoic parenchymal changes with ill-defined, hyperechoic omentum. This enveloped the upper duodenum, which was also thickened without loss of mural detail. Mesenteric adhesions were noted upon the upper GI tract.

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Free Abdomen

Slight areas of free fluid were noted.

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ULTRASONOGRAPHIC FINDINGS

Extensive pancreatitis presentation with localized peritonitis and pyloric outflow envelopment. There is a possibility of underlying pancreatic carcinoma.

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101.2 lbs

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

INTERPRETED BY

Eric Lindquist, DMV
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FNA of the pancreas is recommended. FNA of the hypoechoic portion of the pancreas is recommended to assess for underlying carcinoma. Aggressive treatment for pancreatitis is warranted. 24-hour n.p.o. and eventual slurry feeding is indicated given the tethered pyloric outflow pattern. The patient should also be monitored for potential emerging post hepatic obstruction. Given the position of the pancreatic pathology the common bile duct was not able to be visualized and is likely impinged upon or tethered by the pancreatic pathology. The prognosis is guarded. Eventual surgical intervention with debridement and liberation of the pyloric outflow and portal hilus may be necessary.

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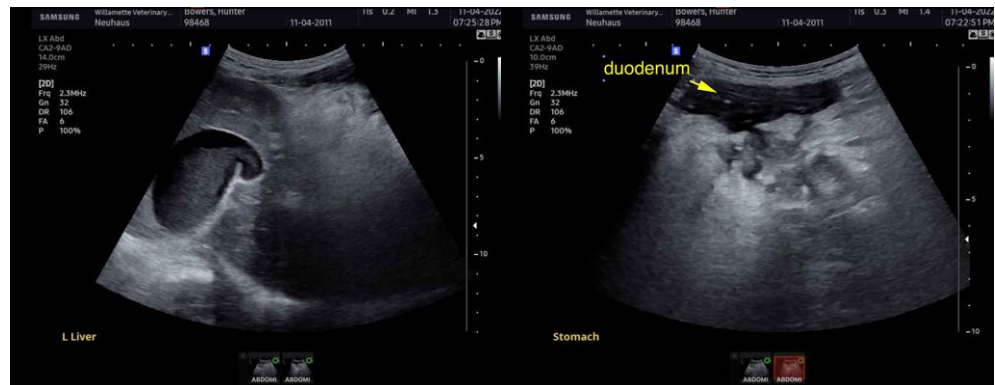
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com