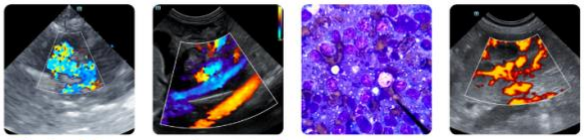

PATIENT

Ammo Knisley

SPECIES

Canine

BREED

Lab

SEX

Male

AGE

12

WEIGHT

81.6 lbs

INTERPRETED BY

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS

IMAGING PERFORMED BY

Stacy Sather

HOSPITAL NAME

Emergency Animal Hospital of Crystal Falls

REFERRING VET

Dr. Higginbotham

INVOICE

16161

DATE

05/13/26

PRESENTING CLINICAL SIGNS

Vomiting, lethargic, not eating, drinking a ton of water, threw up part of a corn cob the other day

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Additional images were submitted of the pyloric material, please see Addendum.

Urinary System

The **urinary bladder**, trigone, and pelvic urethra to a depth of 1.0 cm presented normal thicknesses and normal tone. 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 were noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex. The left kidney measured 5.4 cm in length. The right kidney measured 6.1 cm in length. An anechoic cyst was visualized in the cranial pole of the right kidney measuring 1.77 cm.

Adrenal Glands

Both **adrenal glands** were not visualized.

Spleen

The **spleen** presented enlarged with subtle micronodular changes and swollen contour measuring 2.7 cm.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some mild age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

Gastrointestinal

The **small intestine** was thickened and hyperperistaltic with no loss of mural detail. Increased submucosal echogenicity and thickening was visualized. The intestinal change remains in the upper duodenum. The distal small intestine and colon were remarkable. Some shadowing foreign matter was noted in the stomach and appeared non-obstructive. Gastric wall thickening was noted measuring up to 1.14 cm. The approach on the stomach did not allow for complete visualization of the pyloric outflow as further depth and lower frequency probe technique would be ideal.

Addendum:

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A persistent minor non-obstructive slightly shadowing material was noted in the pylorus measuring up to 2.3 centimeters.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some mild parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

- Gastric luminal material with gastroduodenitis pattern- no overt evidence of neoplasia yet cannot be ruled out.
- Splenic enlargement with micronodular changes.
- Right kidney anechoic cyst.
- Age-related abdominal changes otherwise.

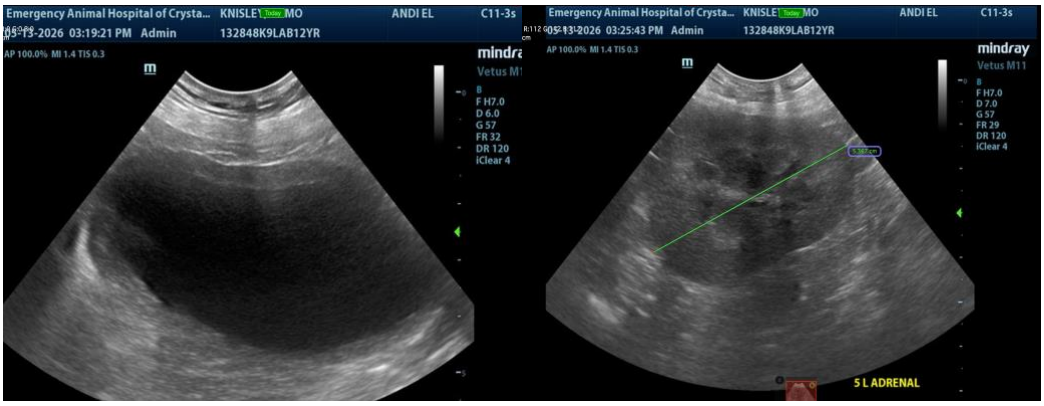
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Options include 24-hour NPO, IV fluid support, GI protectants with recheck sonogram in 24 to 48 hours to assess if the pyloric material is still present. Further imaging with increased depth is warranted on SDEP 11-14, and SDEP 13 position recommend sliding dorsally towards the spine for further imaging of the pyloric outflow.

Otherwise, exploratory surgery with expectation of evacuating the stomach and obtaining gastric and upper duodenal biopsies for long-term management as the bowel and stomach do not appear overtly healthy, yet not overtly neoplastic.

Addendum:

Recommend endoscopy in this patient if the patient was NPO at the time of the sonogram or gastrotomy to remove the material in the pylorus.



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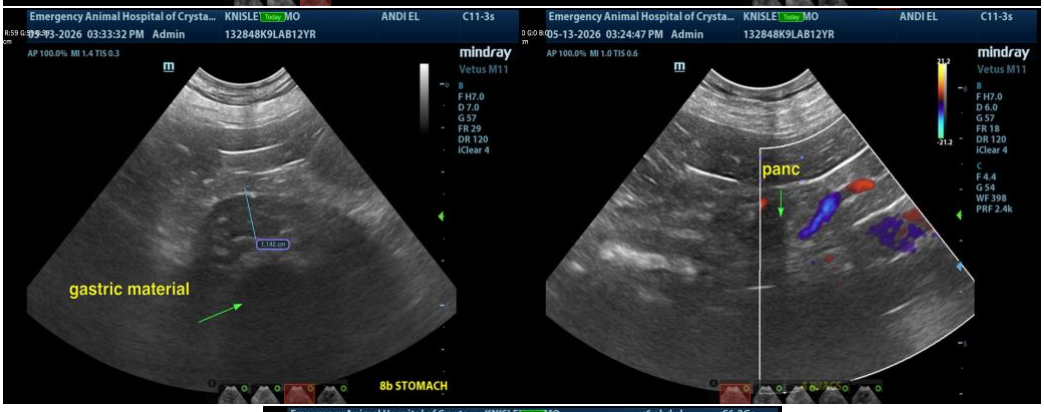

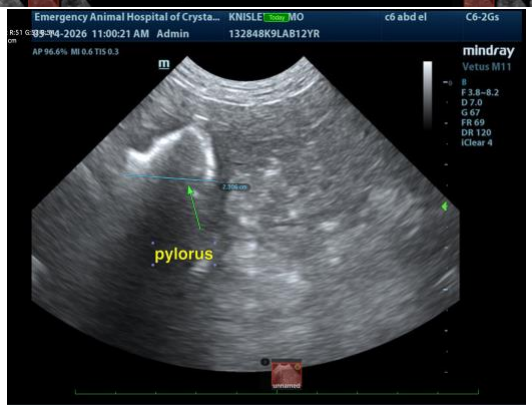

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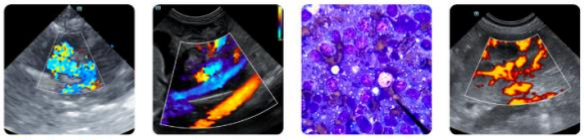

Clinical Sonography & Telecytology
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video 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(CFM), Cert. IVUSS,

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