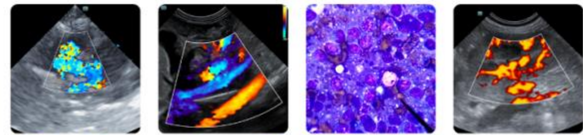


PATIENT
Becket Armstrong

SPECIES
Canine

BREED
Poodle

SEX
Neutered male

AGE
8 ½ years

WEIGHT
71.2 lbs

INTERPRETED BY
Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Kathleen Byrnes

HOSPITAL NAME
Animal Hospital of Boone

REFERRING VET
Dr. Shutt

INVOICE
37423

DATE
6/8/26

PRESENTING CLINICAL SIGNS

History: P presented for US due to not eating in 48 hours, vomited bile on Saturday AM and hasn't eaten since. lethargic, ADR, Rads showed gas in stomach and few very small radiopaque areas in pylorus/duodenum. P is a well controlled Addisonian

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra 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 was noted. Ureteral papillae were normal. The residual prostate measured 1.01 cm.

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 right kidney measured 7.0 cm. The left kidney measured 6.74 cm.

Adrenal Glands

The **left adrenal gland** was flattened and isoechoic, measuring 1.7 cm x 0.2 cm.

The **right adrenal gland** was flattened and measurably normal, measuring 2.5 cm x 0.5 cm.

Spleen

The **spleen** was mildly enlarged and folded upon itself cranially.

Liver

The **liver** was swollen, hypoechoic and mildly irregular. Trace amounts of free fluid were noted between the liver lobes. The gallbladder and common bile duct were unremarkable.

Gastrointestinal

The **stomach** was fluid filled. Hyperechoic shadowing structure was noted in the pylorus, measuring 1.6 cm. This is likely medications. Mild pyloric hypertrophy was noted without overt ulcerative changes. Significant reactive mesentery was noted around the pyloric outflow. The upper duodenum was dilated. Much of the upper duodenum presented obscured visibility owing to the pancreatic presentation and regional peritonitis. The colon was unremarkable.

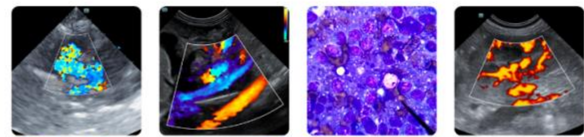
Pancreas

The right **pancreatic** limb was hypoechoic and irregular with enhanced surrounding mesentery. This was void of color doppler signal on doppler assessment.

Free Abdomen

Enhanced mesentery was noted in the cranial abdomen around the stomach and pancreas.

ULTRASONOGRAPHIC FINDINGS



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- Extensive pancreatitis and pancreatic necrosis pattern
- Delayed outflow gastric pattern- I cannot rule out foreign matter, however, adhesions and tethering of the upper intestinal tract is likely the cause of the delayed outflow pattern.
- Flattened adrenal glands, right adrenal measurably normal in size
- Mildly enlarged folded spleen
- Swollen, mildly irregular liver

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

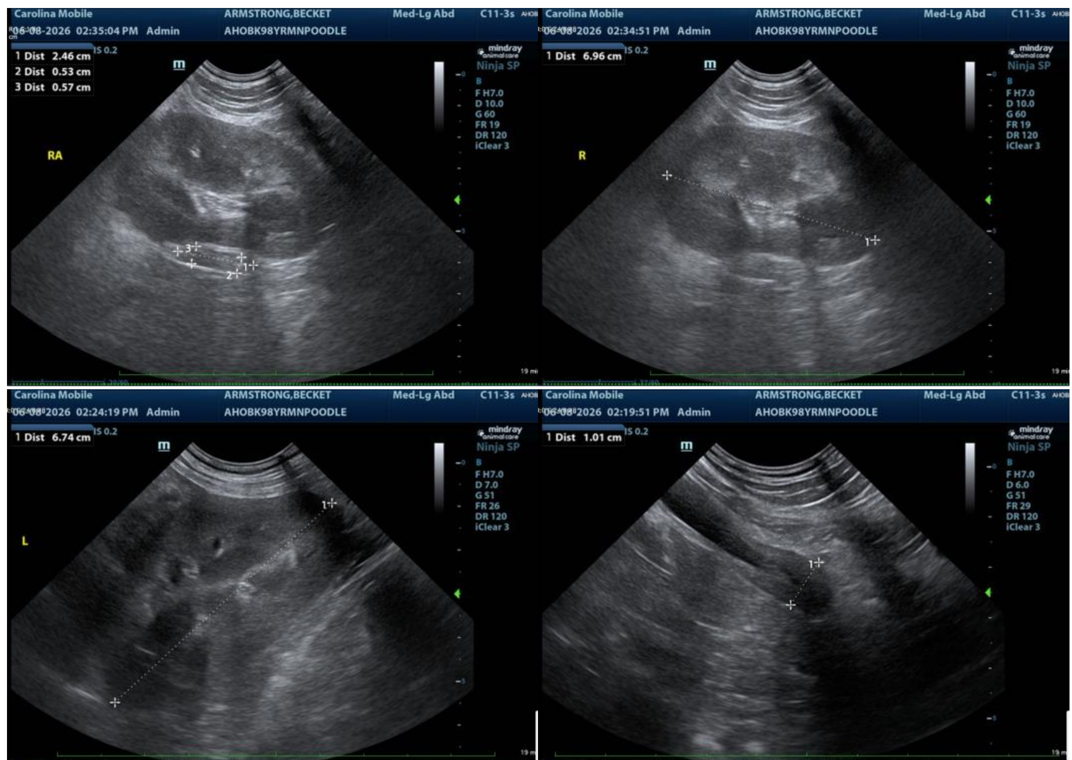
The hypoechoic enlarged 5.0+ cm region of the right pancreatic limb that was void of blood flow is most consistent with pancreatic necrosis. This appears to be tethering the upper duodenum; however, I cannot rule out another cause of obstruction.

Given the breed predisposition, screening for underlying Addison's is indicated, however, there is extensive pancreatitis and pancreatic necrosis pattern with delayed outflow gastric pattern.

Exploratory surgery with expectations of debridement of necrotic pancreas would not be incorrect in this patient, as well as inspecting the stomach for the hypoechoic structures, however, I'm concerned for possible small foreign matter. I do not see any tethering from a linear foreign body.

24-hour NPO, IV fluid support, plasma expanders, and pain management are all indicated. However, exploratory surgery should be in the short-term potential, given the pancreatic necrosis that will likely necessitate debridement, as well as inspection and biopsies of the GI tract.

There is mild potential for underlying neoplasia, but prior to any intervention, I strongly recommend eliminating the potential of underlying Addison's in this patient, given the flattened left adrenal gland,



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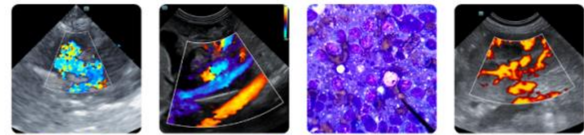

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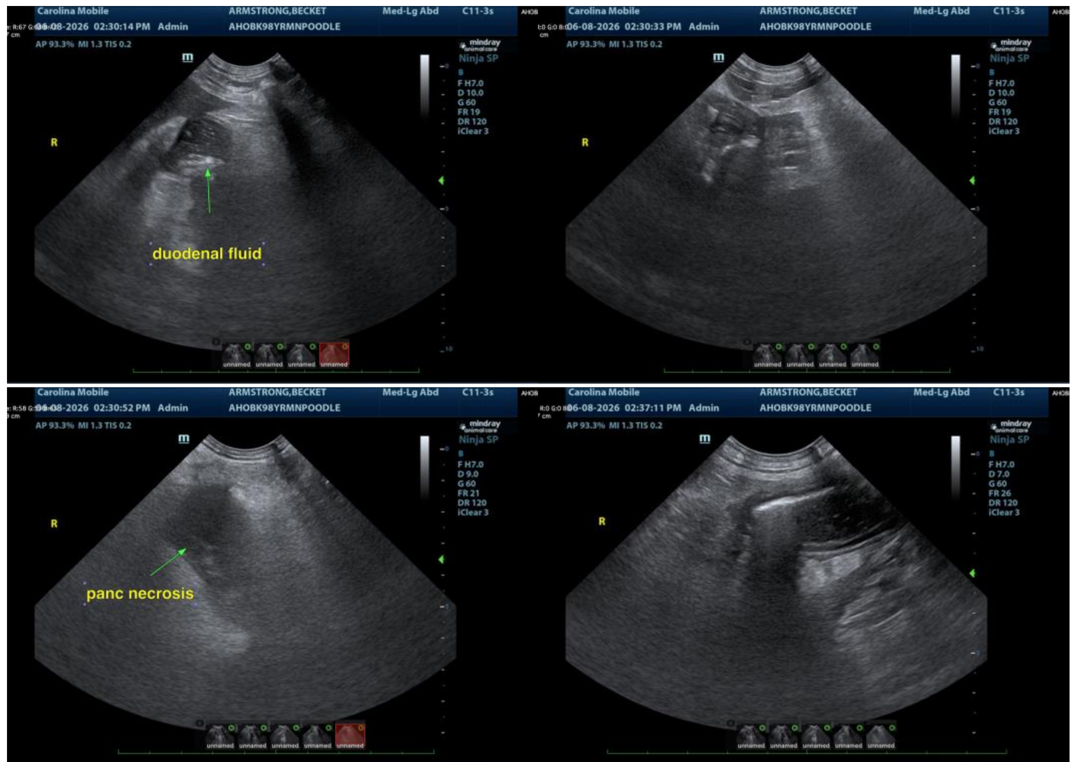

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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