



PATIENT

Baxter Brown

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

4 Years 8 Months

WEIGHT

84.1 Pounds

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

**IMAGING
PERFORMED BY**

Dr. Liz Gray

HOSPITAL NAME

Brookwood AC, LLC

REFERRING VET

Ruth Loomis

INVOICE

23677

DATE

7/28/23

PRESENTING CLINICAL SIGNS

P presents for progressing lethargy, increased panting and today P refused breakfast. O reports he seems to struggle to get comfortable at night. O reports P energy has been waning since April but much more lethargic in the last 2 weeks. Appetite also has been decreased - in the past P would eat anything and they have been having to add tasty food to get P to eat and then this am would not eat at all. Drinking large volumes and urinating large volumes.

Abnormal PE/Chem/CBC/UA Results: P was seen 10 days ago and full sr panel run - mod liver enzyme elevations (Alt 186/ Alkpt 958/ Ast 124), elevated globulins (5.8)/ mild neutrophilia (10,902) and monocytosis (1104)/ mod elevated amylase (1603). UTI was noted (Cocci 25-50) as well but no significant inflammation in urine. Low USG (1.005). Persistent low T4 despite increasing thyroid meds (<0.5) *P was diagnosed with hypothyroidism in 2019 with full thyroid panel. P was put on Antibiotics for UTI (amoxicillin) and gabapentin after the appt on 7/18. O thought P might have started to improve but then starting getting worse rapidly. Repeated CBC today: neutrophilia (14,020) and monocytosis (1,890) Chem: elevated globulins (6.0) *Liver values now WNL* UA pending

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 were 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. A minor infarct was noted at the dorsal cortex of the right kidney with minor inflammation, suggestive for recent infarct. The left kidney measured 8.4 cm. The right kidney measured 8.5 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 0.82 cm. The left adrenal gland measured 0.57 cm at the caudal pole and 0.4 cm at the cranial 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 were noted.

Liver



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The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

There was some residual chyme and gas was noted in the **stomach**, yet not pathological. This is consistent with end post prandial presentation. Transit of chyme into the small intestine was normal. Curvilinear patterns were maintained throughout the GI tract. No evidence of pathology. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. **See Free Abdomen section.

Pancreas

**See Free Abdomen section.

Free Abdomen

The **left cranial abdomen** revealed multifocal hypoechoic nodular changes with enhanced surrounding mesentery, likely deriving from the pancreas, however, lymphatic origin could not be ruled out. The pathology appeared to occupy the majority of the left limb. Trace pockets of free fluid were noted. The mesenteric inflammation enveloped portions of the spleen and occupied the majority of the region of the left pancreatic limb and appeared to impinge upon the gastric fundus and right limb of the pancreas. The ileocecal junction revealed hypoechoic structures, possibly distorted lymph nodes.

ULTRASONOGRAPHIC FINDINGS

- Pancreatitis/steatitis pattern with possible suppurative pockets or pancreatic carcinomatosis possible.
- Partially full stomach
- Right kidney infarct.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

FNA cytology and culture of the hypoechoic nodular changes are warranted for further definition. Prognosis is guarded. Treatment for pancreatitis and suppurative pancreatitis is warranted in the meantime with IV fluid support, pain management, aggressive antibiotics, such as enrofloxacin, clindamycin or similar, until cytology and culture could be evaluated. Urinalysis is warranted to assess for inflammatory sediment given the infarct in the right kidney, which appears to be recent. Assessment for systemic inflammation, possible emerging sepsis may be an issue.



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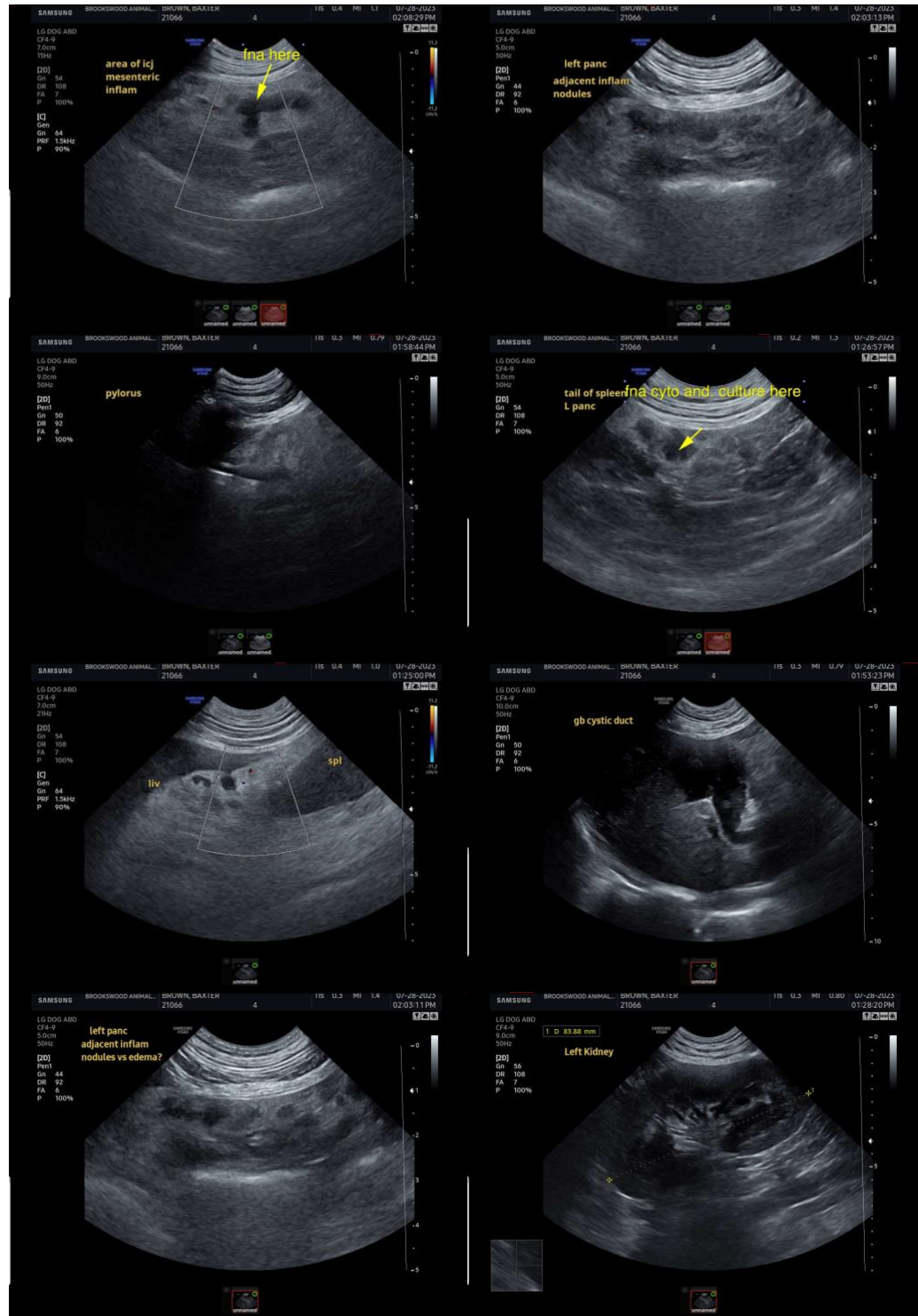
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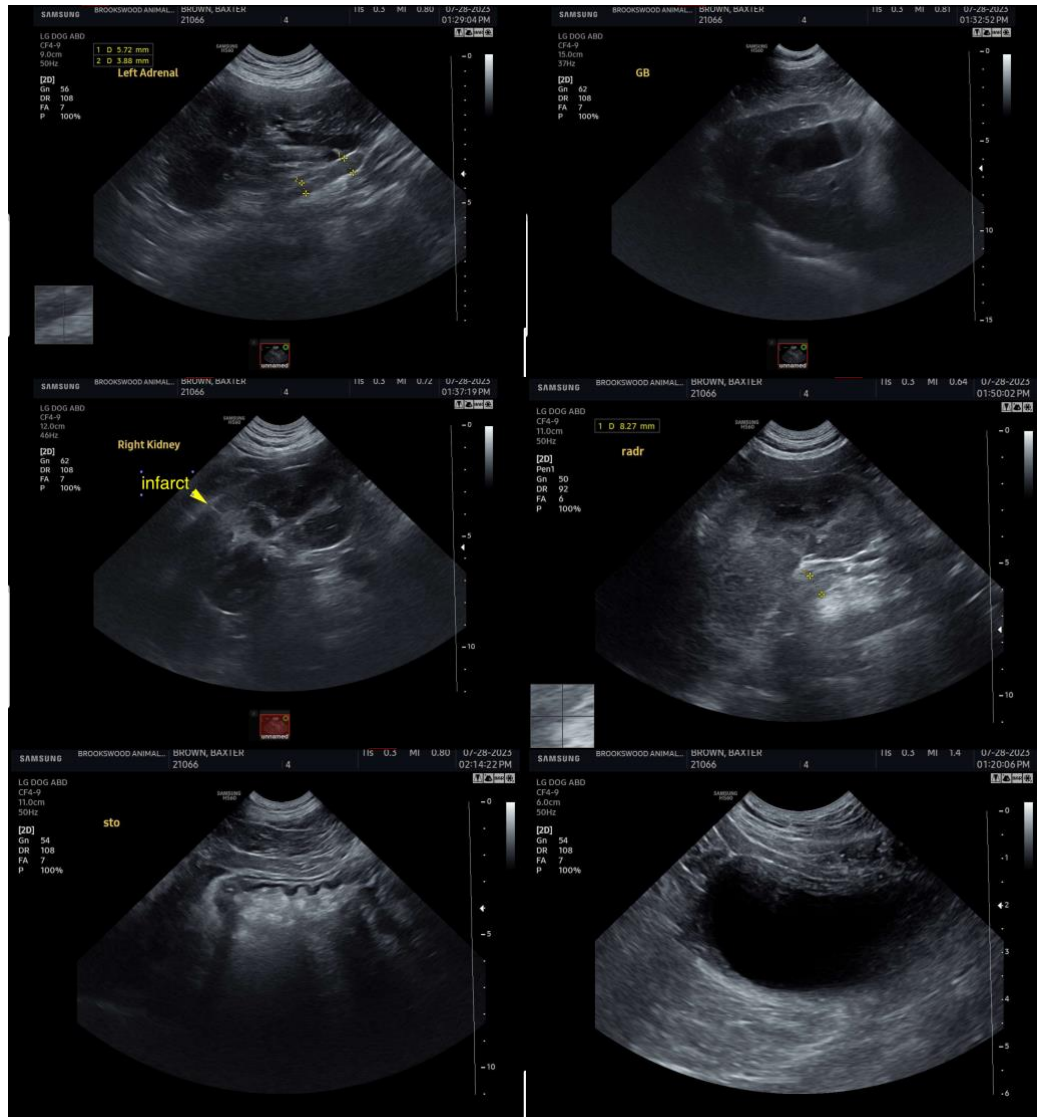
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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