



PATIENT

Molly Jackson

SPECIES

Canine

BREED

Border Collie Cross

SEX

Spayed Female

AGE

11 years

WEIGHT

31 lbs

INTERPRETED BY

Eric Lindquist, DMV,
DABVP, Cert. IVUSS

**IMAGING
PERFORMED BY**

Jenna Walsh, CVT

HOSPITAL NAME

Pleasant Hill AH

REFERRING VET

Dr. Sleyer

DATE

2/22/22

Invoice
96213

PRESENTING CLINICAL SIGNS

Recommend abd US to evaluate for possible FB vs neoplastic mass. Discussed with Shannon that end on ingesta in the pylorus is theoretically possible but I have not seen it show up this way on radiographs. Eyes-LS OU Oral Cavity-gums tacky Abdomen-abdomen palpates tense. no masses palpated Primary Question/Differential to Be Answered in This Exam Recommend abd US to evaluate for possible FB vs neoplastic mass.

Abnormal PE/Chem/CBC/UA Results: **ABNORMAL** Laboratory Findings CBC - moderate leukocytosis (28k), mild lymphopenia (0.8k), moderate monocytosis (2k) and neutrophilia (25k) A - both chronic and acute inflammation likely consistent with IBD flare ddx - other infection, neoplasia, autoimmune Chem - mild elevation of ALP (227), elevated AMY (consistent with GI inflammation), mild hyperglycemia (stress response) P - continue as per initial TP. Radiographic Findings Lat - SI with mild gas expansion in the jejunum and moderate increased wall thickness. No obstructive pattern seen in the SI. The spleen is prominent, moderately increased in size. urinary bladder is medium sized and normal location. There is a round figure 55 x 51mm, caudal to the liver and ventral to the stomach. V/D - I am unable to locate the round mass. There is a moderately gastric distension from gas. Mild gas in the SI. kidneys appear normal size and location. A - round mass effect is concerning. it may represent a gastric FB at the pylorus, end on ingesta in the distal stomach, or neoplasia P - recommend abd US. option to send out rads for consult. Discussed with Shannon that end on ingesta in the pylorus is theoretically possible but I have not seen it show up this way on radiographs.

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 3.0 cm beyond the cystourethral junction. 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 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 this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 5.4 cm. The right kidney measured 5.55 cm.

Adrenal Glands

The right adrenal gland was slightly swollen at the caudal pole measuring 0.77 cm, 0.29 cm at the cranial pole and 2.15 cm in length. The left adrenal gland was normal in size and contour measuring 2.03 x 0.3 cm at the cranial pole and 0.71 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



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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.

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Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some 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.

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Gastrointestinal

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The **stomach** was over distended with fluid. The pylorus was free of evident pathology. Some loss of mural detail was noted in the duodenum. Wall thickness measured up to 1.0 cm. However, this blended in with the hypoechoic, necrotic type pancreatic tissue. The small intestines and colon were unremarkable.

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Pancreas

The right limb of the **pancreas** revealed mixed, hypoechoic parenchymal changes enveloping the upper duodenal outflow. This is likely the cause of gastric stasis. Enhanced surrounding mesentery was noted. The pathology extended for approximately 6.0-8.0 cm. Regional steatitis pattern is noted.

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Free Abdomen

A large amount of abdominal fat was noted.

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ULTRASONOGRAPHIC FINDINGS

Acute on chronic pancreatitis with duodenal envelopment and delayed upper GI outflow. There is a mild potential for underlying duodenal or pancreatic neoplasia.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Ultrasound-guided FNA of the hypoechoic portions of the pancreas would be ideal to assess for underlying neoplasia. Aggressive treatment for pancreatitis is warranted. No obvious foreign body is noted. However, I cannot rule out penetrating material such as toothpicks or similar as the hyperechoic changes around the upper duodenum appear to obscure potential linear foreign matter. There is a portion of the duodenum with luminal linear material. However, these may be artifactual or gas lines.

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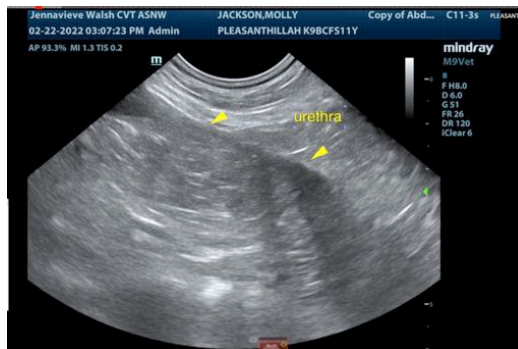
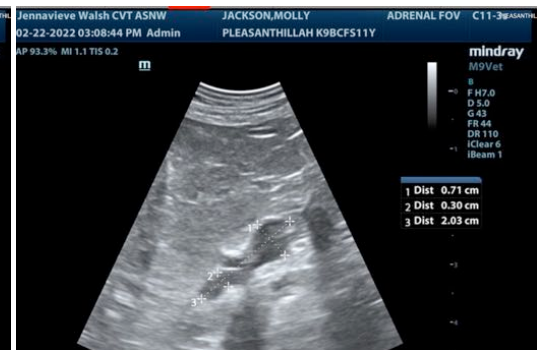
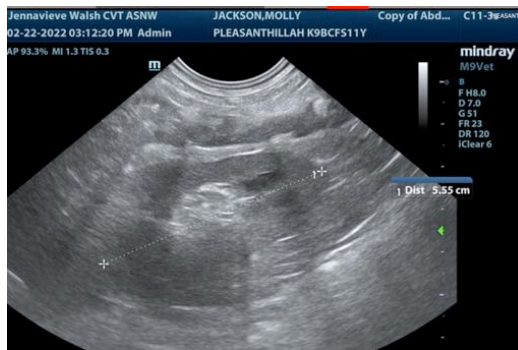
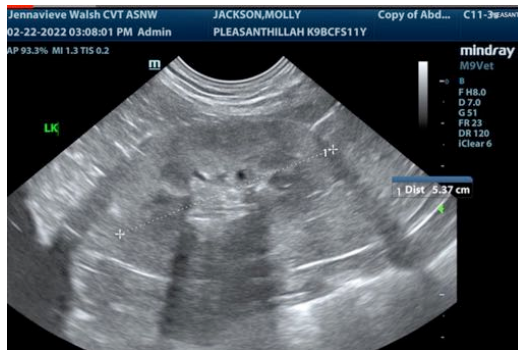
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Surgical intervention may be the best option after initial stabilization in this patient with primary objective to obtain biopsies and explore the duodenal lumen. However, aggressive treatment for pancreatitis with plasma expanders, broad spectrum antibiotics, GI protectants over the next 24 hours would be a valid approach with a recheck sonogram in 24-48 hours depending upon response to therapy. This is a delayed outflow pattern without overt foreign body obstruction; however, some minor, linear luminal material in the duodenum may represent minor non-obstructive foreign matter. The delayed outflow can be completely justified by duodenal adhesions. Recurrent history of pancreatitis is likely in this patient.





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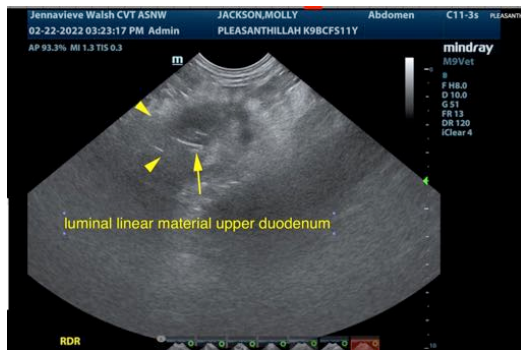
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.



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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.

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