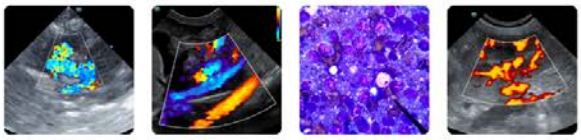


DATE

1/2/26

PATIENT

Juniper Hudson

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

12/4/19

WEIGHT

82.7 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Jones

INVOICE

72925

PRESENTING CLINICAL SIGNS

Patient History: Follow up ultrasound from 12/30- diagnosis with severe pancreatitis and diffuse inflammation noted through out abdomen. recheck liver values on 12/31- ALT- 145; ALP > 2000; T.BIL- 4.7. has been eating and drinking; comfortable on 12/31. Outpatient for AUS 1/2/26.

Current Medications: Discharge on ondansetron, maropitant, omeprazole, metroniazole. Denamarin, gabapentin, proviable
Labwork Results: Labwork attached. Liver values from this morning – increased – attached.
Date of Previous IntraPet Ultrasound: 12/30/2025 – Attached.
Sedation: IV Dexdomitor.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (6.26 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.67 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.63 cm at the cranial pole and 0.60 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.87 cm at the cranial pole and 0.85 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (1.58 cm in width at the level of the hilus) and has a mildly scalloped contour. The blood flow through the hilus and splenic parenchyma appears normal. The focal isoechoic bulge described is not clearly visualized but is likely consistent with scalloped description provided.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder is borderline large with mild intraluminal debris. It measures 2.98 cm x 5.4 cm. The wall of the gall bladder is not thickened and has a smooth mucosal surface. The proximal bile duct is not clearly visualized, as the abnormal pancreas interferes with visualization. There is a structure most consistent with the terminal bile duct visualized at the level of the duodenum that appears slightly echogenic and dilated at 0.56 cm, possibly consistent with intraluminal mucoid debris.

Gastrointestinal

The stomach contains mild fluid. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

Most of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to mild fluid distension. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.80 cm. Jejunum wall measures 0.42 cm. Visualized peristalsis appears appropriate. The proximal duodenum in the region of the right limb of the pancreas appears thickened with intact wall layering most consistent with duodenitis.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of significant regional mesenteric inflammation. Consistent with severe pancreatitis in both limbs. There is a pocket of free fluid visualized near the right limb of the pancreas.

Free Abdomen

There is scant free fluid visualized near the right limb of the pancreas. No significant lymphadenopathy noted. There is severe inflammation visualized around both limbs of the pancreas, particularly in the right cranial abdomen.

PRIMARY FINDINGS

- Severely irregular, hypoechoic pancreas with surrounding reactive mesentery and free fluid (right limb) – Findings are most consistent with severe pancreatitis. No abscess or focal mass lesion is observed at this time. A neoplastic process is less likely but cannot be ruled out.
- Distended gallbladder with questionable mucoid debris at the distal bile duct – Findings could be consistent with a partial post-hepatic biliary obstruction (mucus and swollen pancreas).
- Thickened proximal duodenum – This appears stable from the previous exam on 12/30/25, likely consistent with focal duodenitis secondary to pancreatitis.

SECONDARY FINDINGS

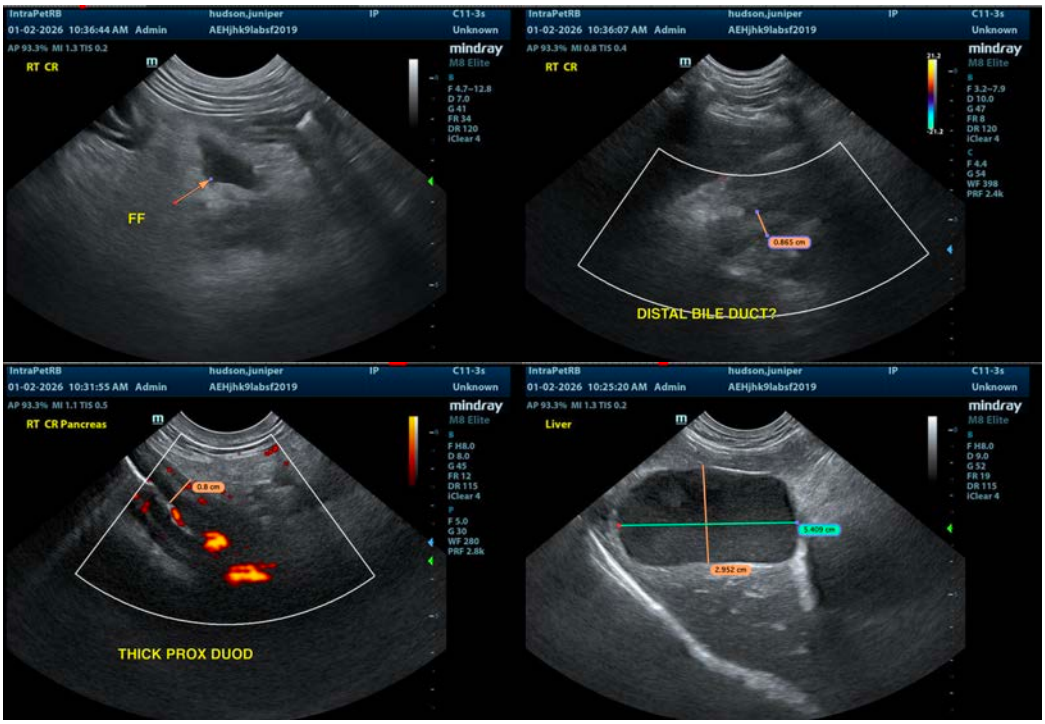
- Mildly prominent/scalloped spleen – This likely represents anatomic variation. Recommend continued monitoring.
- Mildly heterogeneous liver – Findings could be consistent with a vacuolar hepatopathy possibly consistent with the current Phenobarbital use.

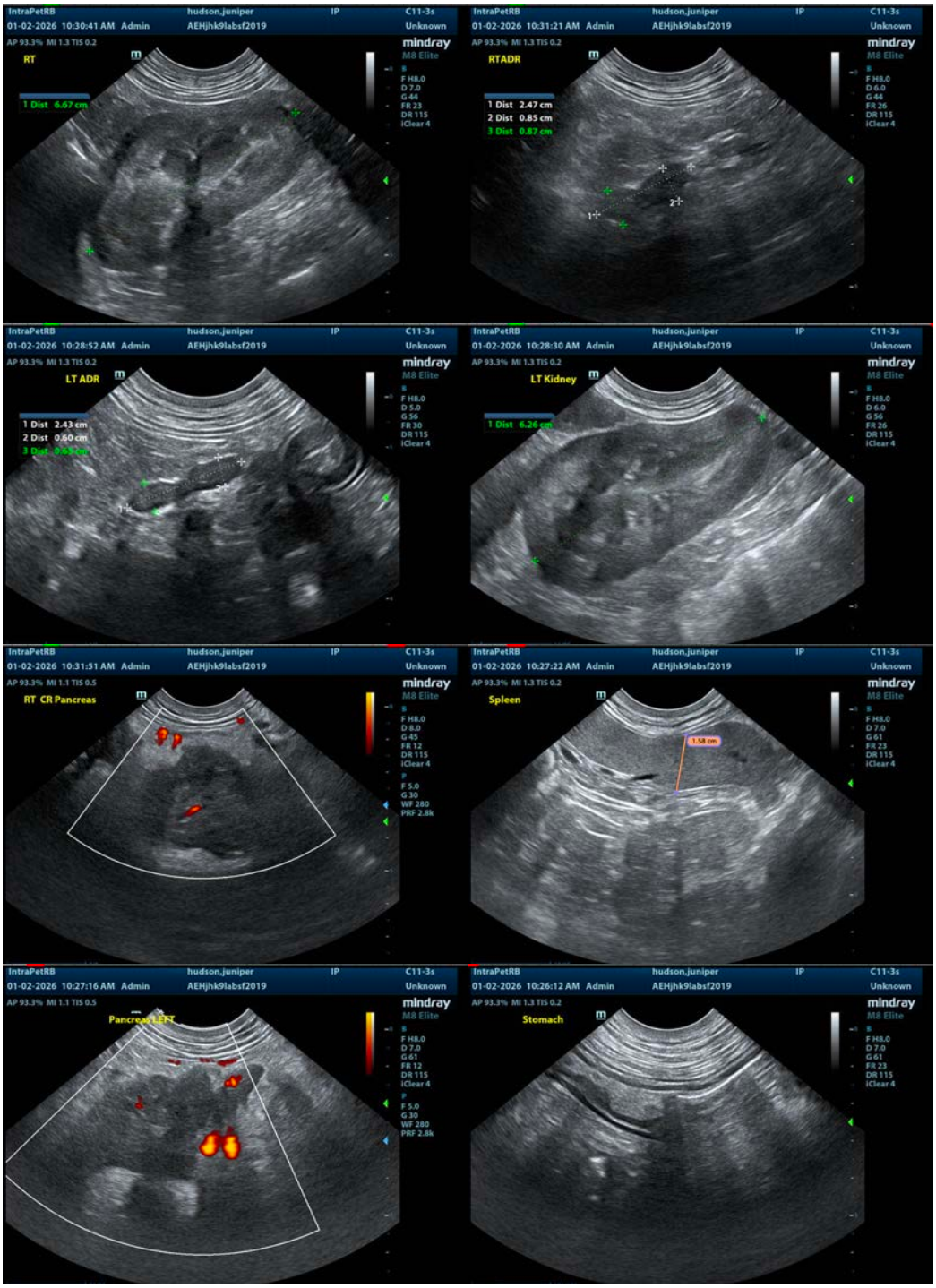
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is moderate to severe inflammation involving both limbs of the pancreas, with more severe inflammation in the right cranial abdomen adjacent to the duodenum and in the region of the bile duct. No focal mass lesions or abscesses are observed, and the appearance is similar to the previous exam from 12/30/25.

A definitive gallbladder obstruction is not visualized, but the gallbladder is large with minimal intraluminal debris, and there is the suggestion of possible prominent distal bile duct. Visualization in this area is challenging due to the large amount of inflammation.
Potential complications to consider include partial post hepatic. Biliary obstruction, cholangitis and/or a concurrent primary hepatopathy. Treatment options could include broad spectrum antibiotics in the case of possible cholangitis and ursodiol therapy in the hopes of thinning biliary secretion (this is a clinical judgement call based on the concern for possible biliary obstruction). Additionally consider the possibility of primary hepatopathy playing a role in bilirubin elevation (chronic Phenobarbital use, etc.).
Depending on how the patient is doing clinically, you could consider rehospitalization for IV fluid therapy and more aggressive support. If the patient is improving you could also hold steady in hopes that with more time values will improve.

Additional diagnostics could include fine needle aspirate of the pancreas and liver (provided coagulation parameters are normal), possibly a contrast CT scan of the cranial abdomen if there is a failure to respond to therapy.

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hudson,juniper
IP
C11-3s
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Unknown
mindray
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RT
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RTADR
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2 Dist 0.85 cm
3 Dist 0.87 cm
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LT ADR
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2 Dist 0.60 cm
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RT CR Pancreas
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Spleen
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Pancreas LEFT
01-02-2026 10:26:12 AM Admin
Stomach

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.

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