



**PATIENT**

Henry Gammon

**PRESENTING CLINICAL SIGNS**

H/O not as active and ADR.

**SPECIES**

Canine

Abnormal PE/Chem/CBC/UA Results: PE: abdomen mild distension and tense cranial abdomen, concern about possible mass in cranial abdomen CBC- MCV>, MCHC> CHEM- ALT 1151, AST 104, ALP 242, GGT 34, alb 4.0, glob 3.6 UA- 1.030, pH 7.0, rest WNL FF- many Giardia cysts Abd Rads- hepatomegaly, possible mass on lat in caudal ventral abdomen next to liver

**BREED**

Fox Terrier

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

**SEX**

Neutered Male

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 pelvic urethra was imaged 3.0 cm beyond the cystourethral junction.

**AGE**

13.4 Years

The residual prostate measured 5.0 mm.

**WEIGHT**

10.4 lbs

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. Right kidney measured 3.73 cm. Left kidney measured 3.4 cm with slight pyelectasia noted. Blood flow to the kidneys appeared adequate.

**INTERPRETED BY**

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

**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. Right measured 1.83 cm x 0.50 cm at the cranial pole and 0.51 cm at the caudal pole. Left measured 0.57 cm at the cranial pole and 0.67 cm at the caudal pole.

**IMAGING PERFORMED BY**

Ginny Dodd, DVM, D,  
 ABVP (CFP)

**Spleen**

The **spleen** revealed a slight hypoechoic nodule at the mid body measuring 0.60 cm.

**HOSPITAL NAME**

Monroe Road Animal  
 Hospital

**Liver**

The **liver** presented non-specific coarse architecture with hypoechoic nodular changes without disruption of architecture. The gallbladder was unremarkable.

**REFERRING VET**

Dr. Kylie Fackrell

**INVOICE**

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**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. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

**DATE**

1/15/26



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**Pancreas**

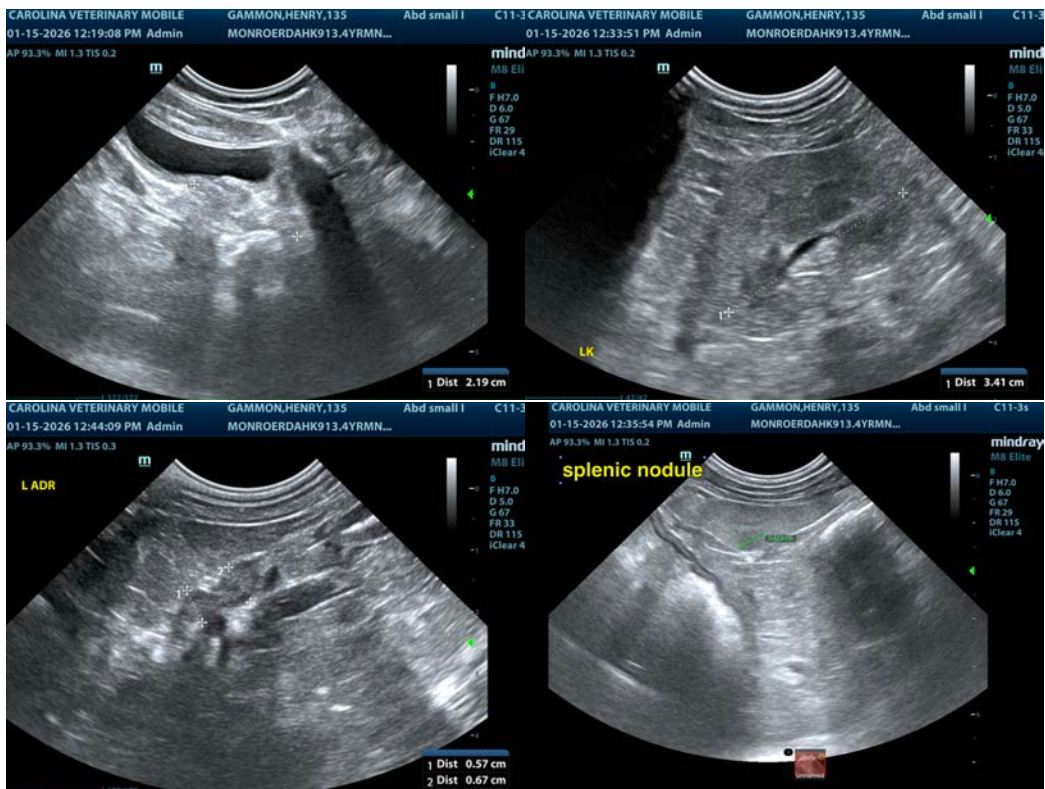
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

**ULTRASONOGRAPHIC FINDINGS**

- Acute on chronic inflammatory hepatopathy.
- Focal splenic nodule, likely hyperplasia.
- Age related renal changes.
- Partially full stomach.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Structurally, the liver changes were fairly mild. Leptospirosis titers indicated. Management should be based on further diagnostics and cytology. Antibiotic trial would be appropriate such as Enrofloxacin/Metronidazole combination and reassess after one week.





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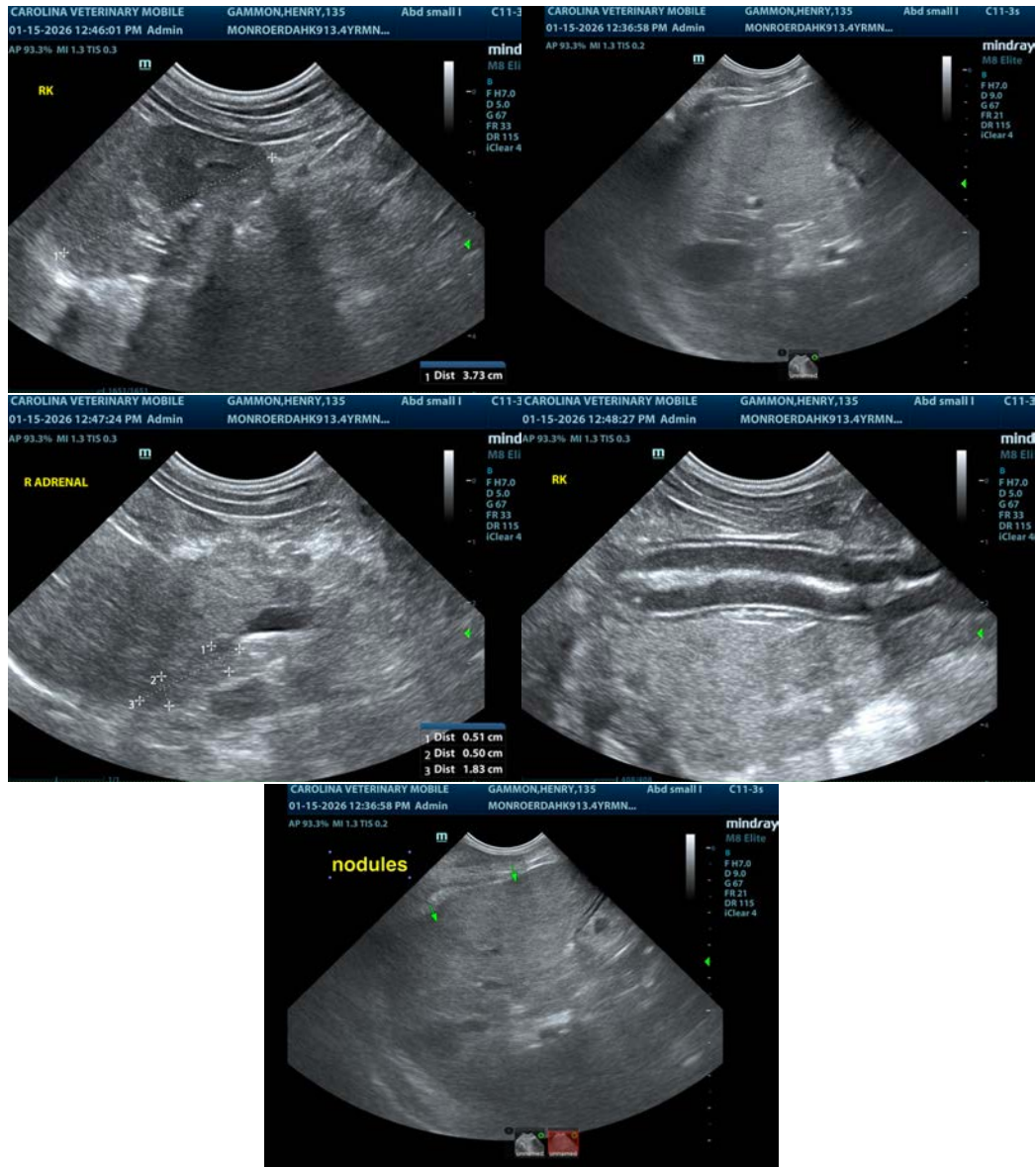
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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(CFM), Cert. IVUSS,  
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