



**PATIENT**

Chef Alfredo Skalski

**SPECIES**

Canine

**BREED**

Dachshund

**SEX**

Neutered Male

**AGE**

14 Years

**WEIGHT**

14.1 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Black River Veterinary  
Hospital

**REFERRING VET**

Dr. Vex

**INVOICE**

72663

**DATE**

12/17/25

**PRESENTING CLINICAL SIGNS**

Please evaluate for surgery to remove splenic mass. New cough, new abdomen mass, Hx of kennel cough in household. Rescue on Pimobendan- no prior records available. Meds Enrofloxacin, Cough tabs, Vetmedin 2.5 mg

Abnormal PE/Chem/CBC/UA Results: Please add xrays of chest to scan for evaluation. no metastatic lesions noted. Neutrophils high, Eos high, MPB 15.5 high, Retic- hgb 19.1 low.

**ULTRASONOGRAPHIC EXAMINATION OF THE HEART & ABDOMEN**

CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO (M-Mode)	LA/AO (Heart Base; Swe)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	Up to 1.6	28-40	40-100	<0.6
PATIENT	6.0	2.5	1.77	1.8	48	80	NM
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT (lbs)	LAD LA MAX 4 Chamber	LVIDd Avg; 2D and m-mode short axis (cm)	LVIDs Avg; 2D and m-mode short axis (cm)
NORMAL PARAMETER	50-100	0.7-1.7	0.7-1.6				
PATIENT	86	2.0	1.0	14.1	4.7	3.9	--

E-wave velocity = 1.1

**Cardiac Presentation**

The echocardiogram for this patient presented excessive **left atrial size** expressed both in the LA/AO and LA max measurements Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Doppler indicated measurable insufficiency. The **left ventricle** presented thicknesses with linear contour and was not dilated nor restricted. The **myocardium** presented normal echogenicity without subjective evidence of significant fibrotic or ischemic disease. **Contractility** of the ventricular walls was adequate and in normal range for this patient evidenced by the fractional shortening measurement and subjective evaluation of the different regions of the myocardium. The **left ventricular outflow** tract demonstrated normal laminar flow and subjective structural integrity. The **right atrium** and auricle revealed normal size, structure and content. No evidence of masses was noted or chamber overload. **Tricuspid** valvular assessment demonstrated adequate linear morphology. The **right ventricle** was of normal size (1/3 diameter of LV), chordae structure, myocardial echogenicity and thickness. **Pulmonic** tract assessment revealed normal valve structure, laminar flow, and diameter (approx.1:1 pa/ao ratio). No visible **pericardial** or free pleura fluid was noted. No echographically detectable evidence of infiltrative disease was visible. The cranial **mediastinum and pericardial regions** were free of masses in the visible window.



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**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 **prostate** was uniformly enlarged (3.0 cm) with lobar swelling appeared to impinge upon the urethra and mildly deviate the descending colon. Some heterogeneous parenchymal changes noted, suggestive for potential low-grade inflammation. The prostatic tissue was hyperechoic containing focal areas of decreased echogenicity. These changes are suggestive of either chronic inflammatory episodes, benign cystic pathology or both. Underlying neoplasia cannot be completely ruled-out but is lower on the differential list. This presentation is most consistent with benign prostatic hyperplasia with possible active prostatitis. Neutering or off-label Finasteride (Propecia) (0.1-0.5 mg/kg Sid) treatment is indicated +/- FNA or prostatic wash cytology and culture.

The testicles were imaged and found to be uniform, no evident pathology.

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 and no evidence of pelvic dilation was present. Mineralization noted in both kidneys, non-obstructive. Right kidney measured 4.58 cm. Left kidney measured 4.72 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. Right measured 1.95 cm x 1.08 cm at the cranial pole and 0.58 cm at the caudal pole. Left measured 1.92 cm x 0.43 cm at the cranial pole and 0.52 cm at the caudal pole.

**Spleen**

The **spleen** revealed a large, mixed echogenic, microcystic mass measuring approximately 5.0 cm with moderate vascularity. A separate splenic nodule was noted.

**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. No overt evidence of metastatic disease.



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**Gastrointestinal**

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Some fluid filled gastric lumen noted. 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.

**Pancreas**

Diffuse hyperechoic changes were present in the area of the **pancreas**. The pancreatic remodeling was evident with multifocal to diffuse hyperechoic changes. These changes are consistent with fibrosis, amyloid, saponification of fat and may contain areas of low-grade chronic active inflammation especially if pain on imaging (+ Murphy sign) was present +/- focal subxyphoid palpation reveals pain response. No overt masses were noted.

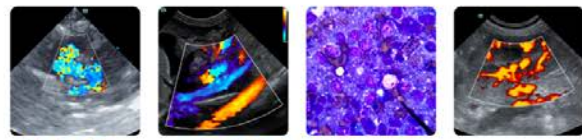
**ULTRASONOGRAPHIC FINDINGS**

- Mitral insufficiency and mild left atrial enlargement.
- BPH/minor prostatitis pattern.
- Pancreatic remodeling.
- Moderate degenerative renal changes with nephrolithiasis, non-obstructive.
- Splenic mass and nodular changes - hemangiosarcoma, non-neoplastic abscessation or hyperplasia possible.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Anesthetic risk is mild in this patient. However, to refine the cardiac presentation, recommend adding ACE inhibitor 0.5 mg/kg SID progressing to BID and Spironolactone 1-2 mg/kg SID. Torbutrol pre-med, Propofol induction, Isoflurane maintenance or similar recommended. Recommend splenectomy and neutering in this patient. Serial blood pressures indicated if not already performed. Chest radiographs warranted. No evidence of metastatic disease or rupture.





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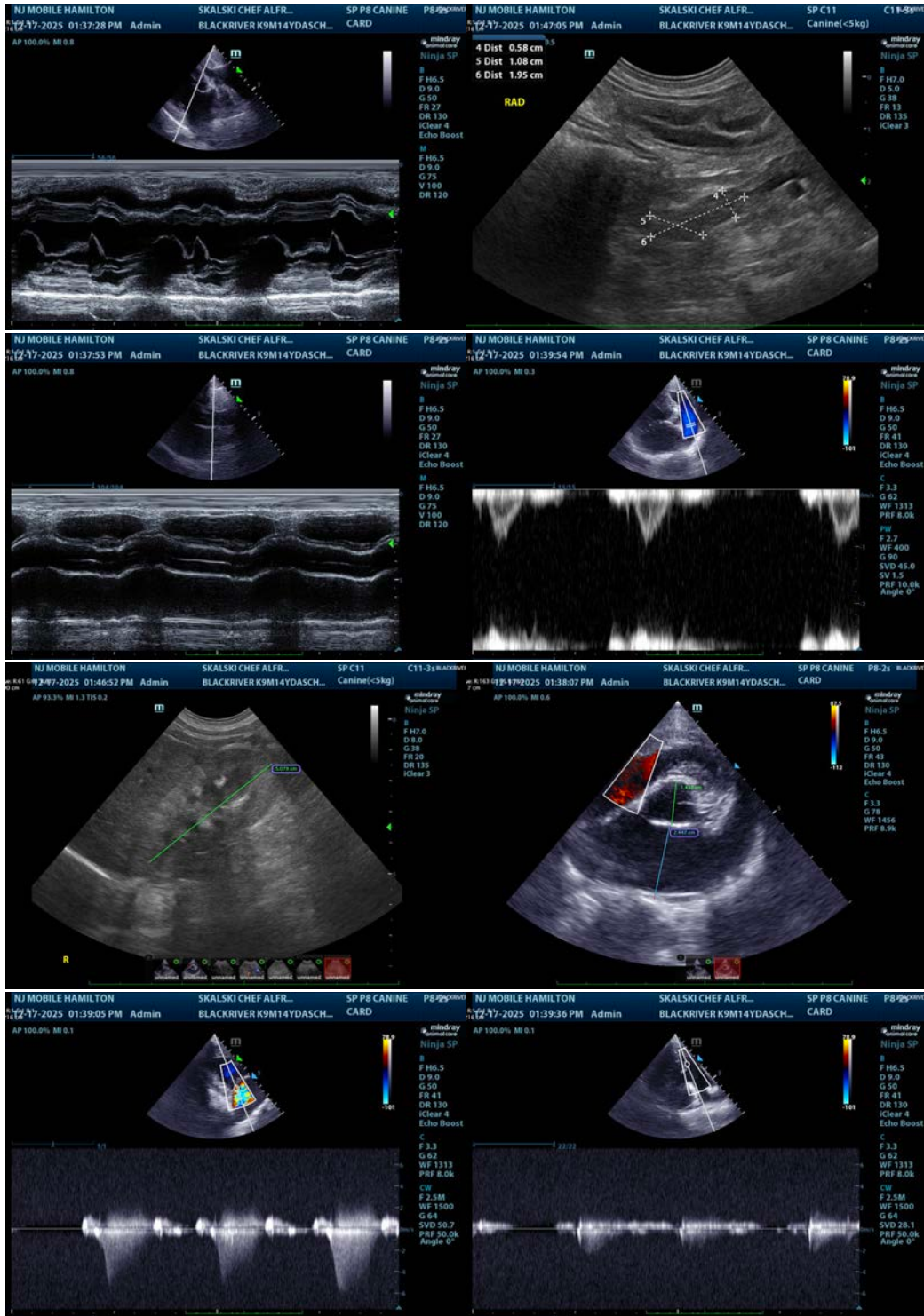
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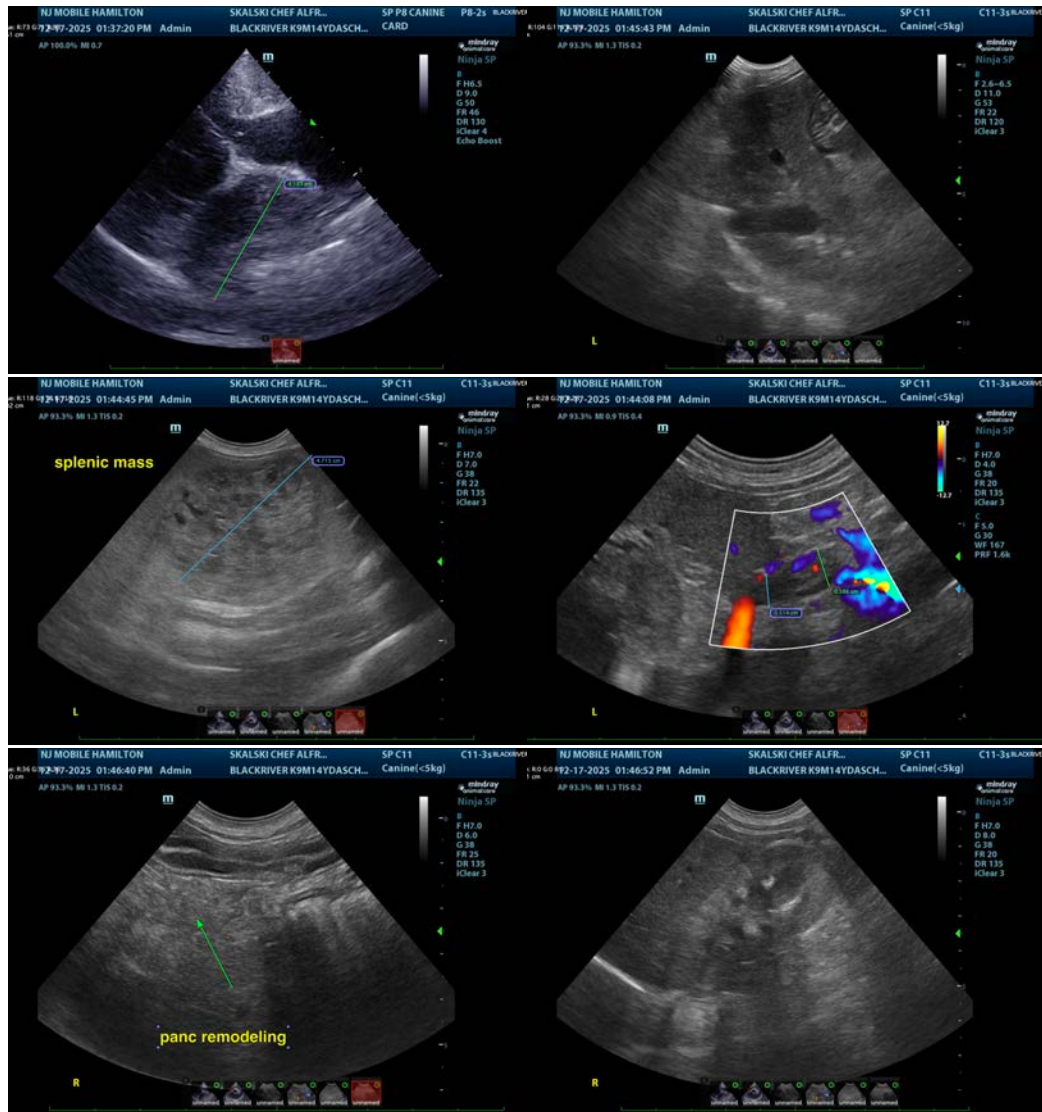
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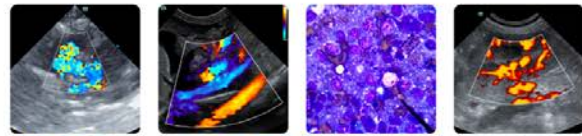
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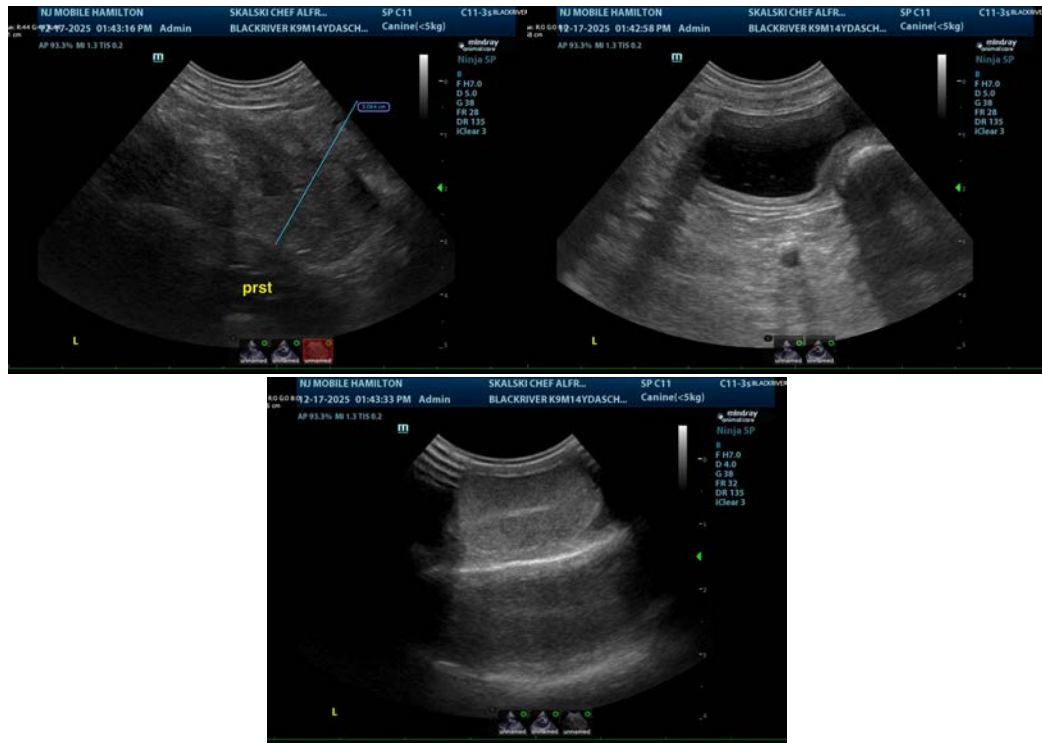
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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,**  
CEO, Owner, Founder -- SonoPath.com  
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