



PATIENT

Brewski Petit

SPECIES

Canine

BREED

Miniature Australian Shepherd

SEX

Neutered male

AGE

12 years

WEIGHT

30.8 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Jessica Bailes

HOSPITAL NAME

All Creatures Great
and Small VC Corvallis

REFERRING VET

Dr. Bailes

INVOICE

69345

DATE

12/4/25

PRESENTING CLINICAL SIGNS

History: acute onset lethargy, decreased appetite and abdominal effort. Symptoms initially noted 2 weeks ago; have been waxing/waning since then. Chronic hx of 4/6 systolic murmur SRR WNL Thoracic rads taken 8/2025 - cardiomegaly noted so has been on vetmedin since then.

Abnormal PE/Chem/CBC/UA Results: Tense/painful cranial/central abdomen, heart murmur on PE Thoracic rads (2 view): cardiomegaly w/ LA bulge, otherwise NSF Abdominal rads (2 view): splenomegaly w/ enlarged, irregular contours, otherwise NSF. Adequate serosal detail CHEM/CBC: CHEM: Increased ALP (224), increased Amylase (2209), hypoglycemia (57), increased PSL (446), increased TBILI (0.5) CBC: Leukocytosis (16.6) w/ neutrophilia (12,948), HCT low normal @ 36%. Increased NRBC's (15/100 WBC's), thrombocytopenia (87K) w/ decreased estimate Recheck BG today: WNL @ 86 mg/dl

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 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. Microcystic cortical changes were noted in the kidneys. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The right kidney measured 5.3 cm. The left kidney measured 4.83 cm.

Adrenal Glands

The right **adrenal gland** revealed a swollen cranial pole measuring 1.6 cm, the caudal pole measured 0.47 cm and 2.5 cm in length. The left adrenal gland was mildly heterogenous measuring 2.52 x 0.78 cm. Nodular changes were noted in the adrenal glands.

Spleen

The **spleen** revealed expansive, mixed, hypoechoic 6.0+ cm cavitated and parenchymal mass with other separate coalescing masses on the spleen with regional inflammation.

Liver

The **liver** revealed multi-focal, nodular changes with areas of cavitation, strongly suggestive for metastatic disease. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. Regional, hyperechoic inflammatory pattern was noted adjacent to the liver and splenic pathology.



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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. 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

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

Free Abdomen

A minor amount of free fluid was noted.

ULTRASONOGRAPHIC EXAMINATION OF THE HEART

The echocardiogram in this patient demonstrated enlarged **left atrial** size based on 3 different LA measurement methods. Chamber volumes and echogenicity were normal. The cranial and caudal **mitral** valve leaflets presented vegetative thickening consistent with endocardiosis. Prolapse of the anterior mitral valve leaflet was noted. Doppler indicated measurable insufficiency. The **left ventricle** presented normal 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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CANINE CARDIAC PARAMETERS	MR VMAX (m/s)	TR VMAX (m/s)	LA/AO	LA/AO (Heart Base)	FS (%)	EF (%)	EPSS (cm)
NORMAL PARAMETER	4.5-5.5	<2.7	1.3	<1.6	28-40	40-100	<0.6
PATIENT	5.24	2.2	1.5	1.9	43	76	0.1
CANINE CARDIAC PARAMETERS	HR (BPM)	AV VMAX (m/s)	PV MAX (m/s)	BODY WEIGHT	LA 2D short axis Base view (cm)	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	BELOW	BELOW	BELOW	BELOW
PATIENT	110	1.44	-	30.8 lbs	4.0	3.23	

ULTRASONOGRAPHIC FINDINGS

Ruptured and cavitated splenic masses and nodular hepatic changes with disruption of architecture. Strong concern for metastatic disease.

Nodular adrenal glands, likely benign.

Stage B2 valvular disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is mild anesthetic risk; however, given the abdominal pathology immediate exploratory surgery is necessary. However, the surgeon should not be surprised by potential metastatic disease in the liver. The prognosis is very guarded to poor long term depending upon underlying histopathology. Hemangiosarcoma, round cell neoplasia, histiocytic sarcoma or similar is suspected. Chest radiographs are warranted if not already performed to assess for metastatic disease in the lungs.

The heart has minor volume overload and is working to compensate for the valvular insufficiency. Target respiratory rate is < 20 resp/minute after therapy. After initiating or adjusting therapy, I recommend recheck on the clinical exam, BUN, Creatinine, USG, Chest radiographs & Blood pressure in 5-7 days. Recheck echo in 3-6 months, earlier if clinical decompensation is occurring. Minor anesthetic risk for a brief procedure at this time. Repeat preanesthetic echo is ideal if anesthesia is eventually necessary. A suggested anesthetic combination would involve Torbutrol premed, propofol induction, Isoflurane maintenance or equivalent protocol.



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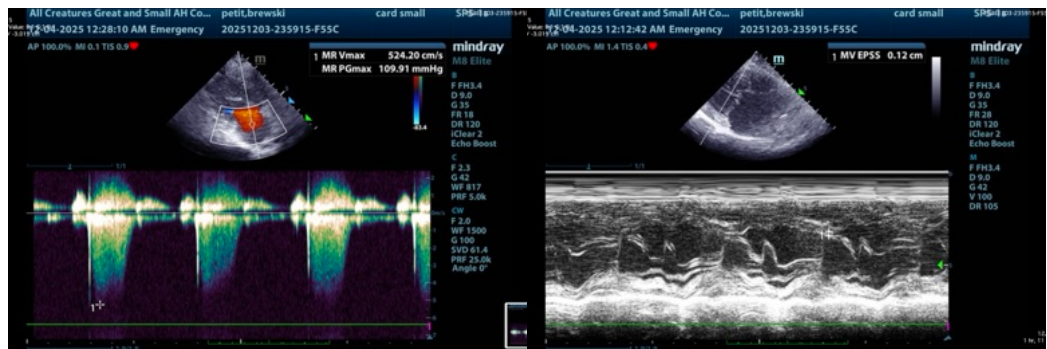
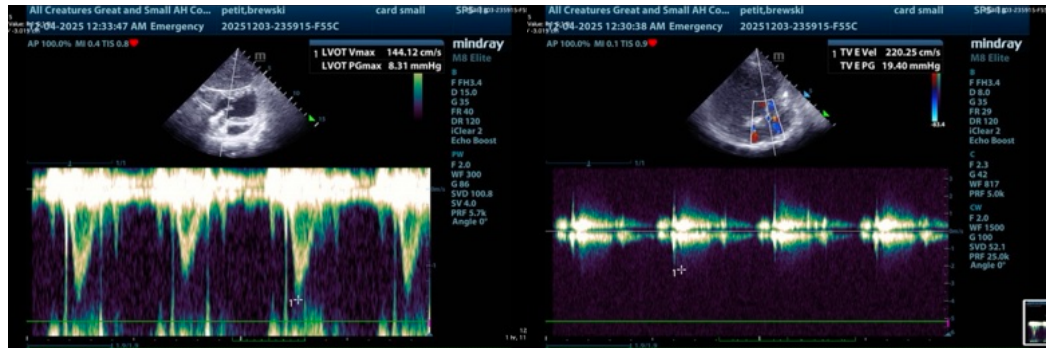
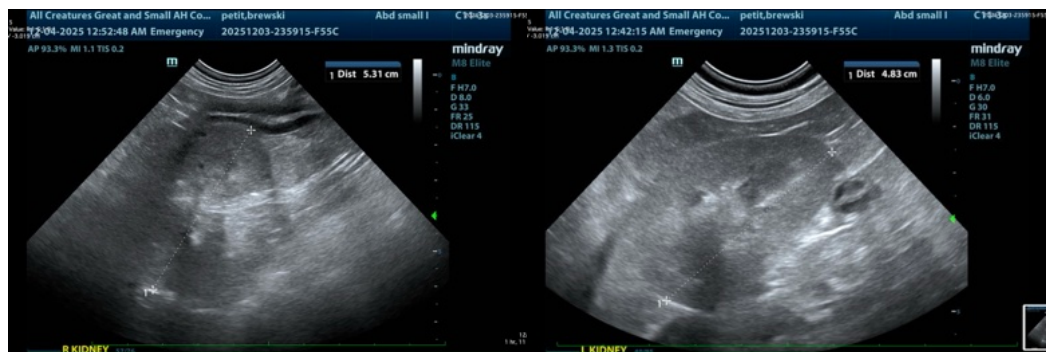
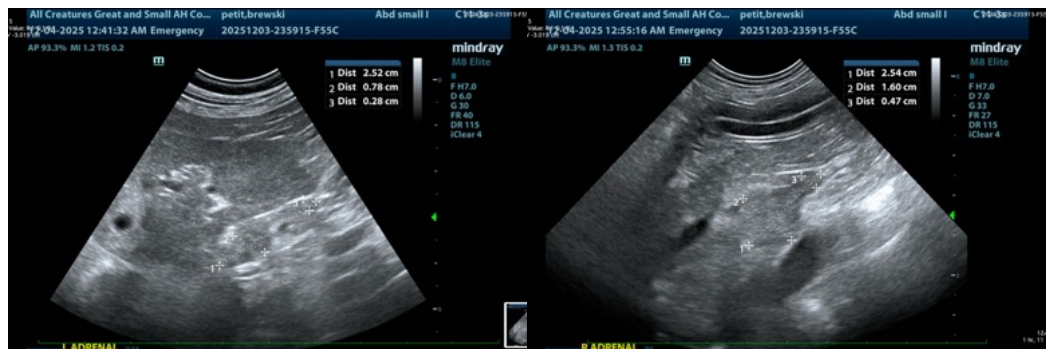
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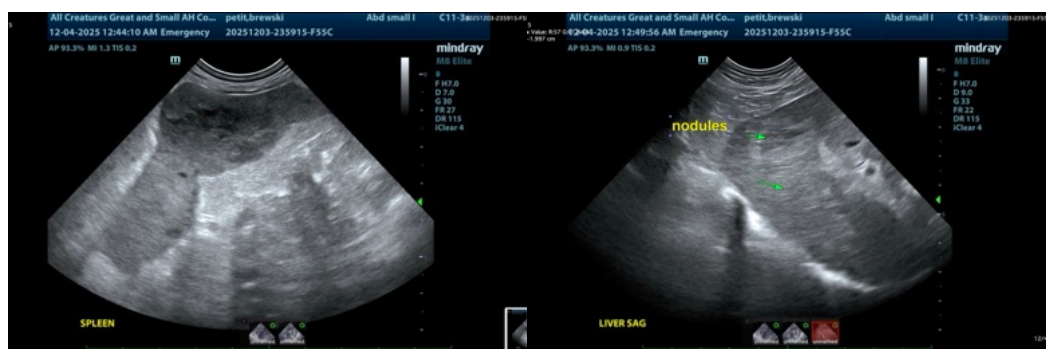
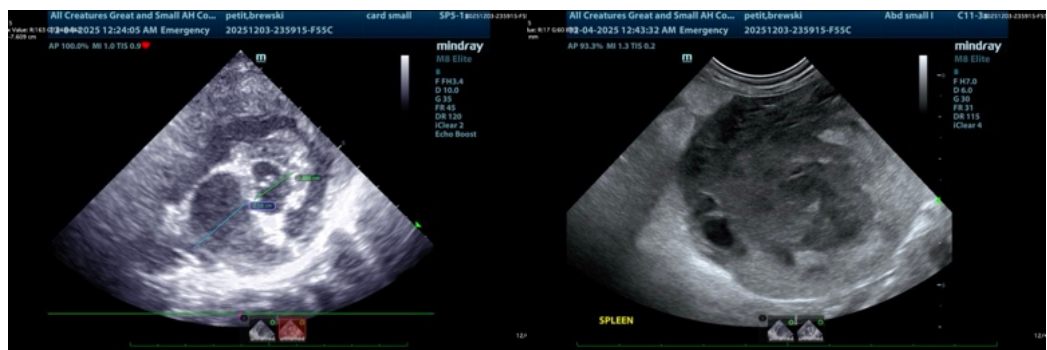
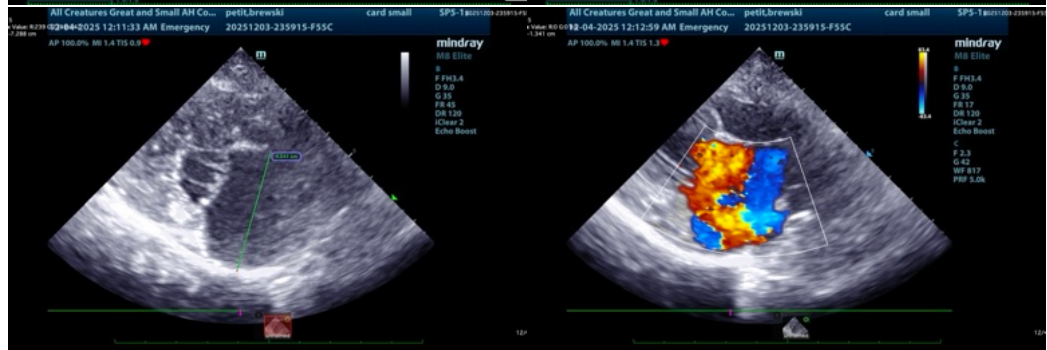
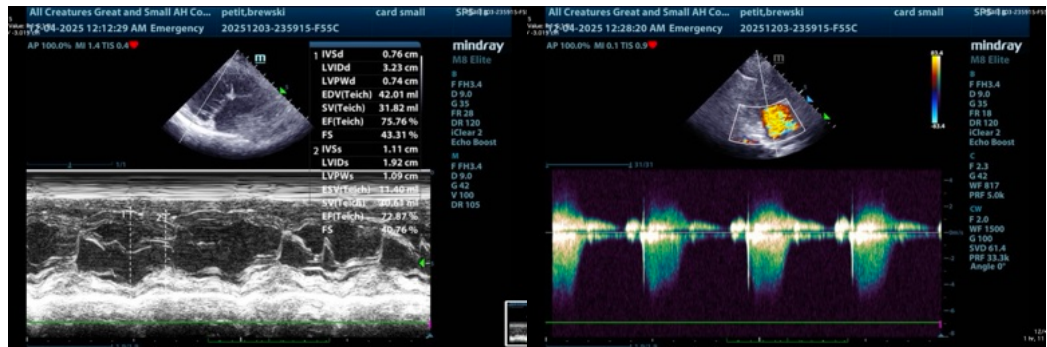
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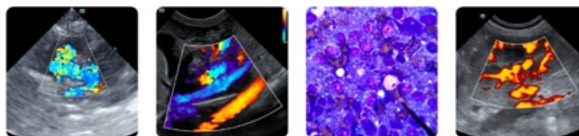
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 of SonoPath.com

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