



PATIENT

Rascal Miller

SPECIES

Canine

BREED

Australian Cattle Dog

SEX

Male

AGE

9 Years 5 Months

WEIGHT

48 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Shelley Lenz

HOSPITAL NAME

State Avenue Vet Clinic

REFERRING VET

Dr. Shelley Lenz

INVOICE

73034

DATE

2/18/26

PRESENTING CLINICAL SIGNS

Acute onset lethargy, inappetence, and decreased activity since yesterday. Previously normal two days ago. Possible ingestion of used tampon from bathroom trash on Sunday night/Monday morning. Not eating well; only interested in cottage cheese. Decreased water intake; urinating less frequently. Last bowel movement at home ~Monday; had diarrhea in clinic lobby today. No vomiting reported. Weight loss noted over past several weeks; ~15 lb loss since late fall (from 66 lb in November to 48 lb currently), Client reports chronic dry nose

Abnormal PE/Chem/CBC/UA Results: BCS 4.5/9 (thin), infected tooth on lower left mandible; one tooth noted as "a little bad", left submandibular lymph node mildly enlarged USG 1.014, Total T4 4.7, Amylase 1658, BUN 36, Creatinine 2.1, WBC 18, NEU 14.96, PLT 142

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** presented a relatively uniform thickening (0.85 cm) of the cranioventral and craniodorsal mucosae with micropolypoid mucosal changes without involvement of the submucosae. The urine presented some echogenicity consistent with suspended debris. No evidence of urethral pathology was present. This presentation is most consistent with chronic cystitis. Technically transitional cell carcinoma cannot be ruled out without histopathological review but is not overtly suspected based on this pattern. Cystocentesis and urine culture +/- pathological review of urine cytology would be warranted. No overt calculi were present at this time.

The **prostate** was uniformly enlarged (3.1 cm) with lobar swelling appeared to impinge upon the urethra and mildly deviate the descending colon. 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. Large cyst measured 0.60 cm. Some parenchymal striations were noted. 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 **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. Some remodeling and cortical infarcts noted. The left kidney measured 5.4 cm. The right kidney measured 6.4 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. Left measured 0.70 cm. Right measured 1.1 cm at the cranial pole and 0.75 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 were noted.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, and acceptable curvilinear mural detail. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. Some hyperperistalsis noted in the small intestine without evidence of foreign bodies. 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. 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

- Moderate chronic degenerative renal changes.
- Chronic cystitis bladder pattern.
- Empty gastrointestinal tract.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of foreign bodies. No overt evidence of neoplasia. Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered. Full urinary workup warranted. Blood pressure measurement indicated. I'm concerned about long-term viability of the kidneys in this patient. Emerging renal failure suspected depending upon urinalysis results. Complicating factors such as UTI and hypertension, hydration status should all be managed.



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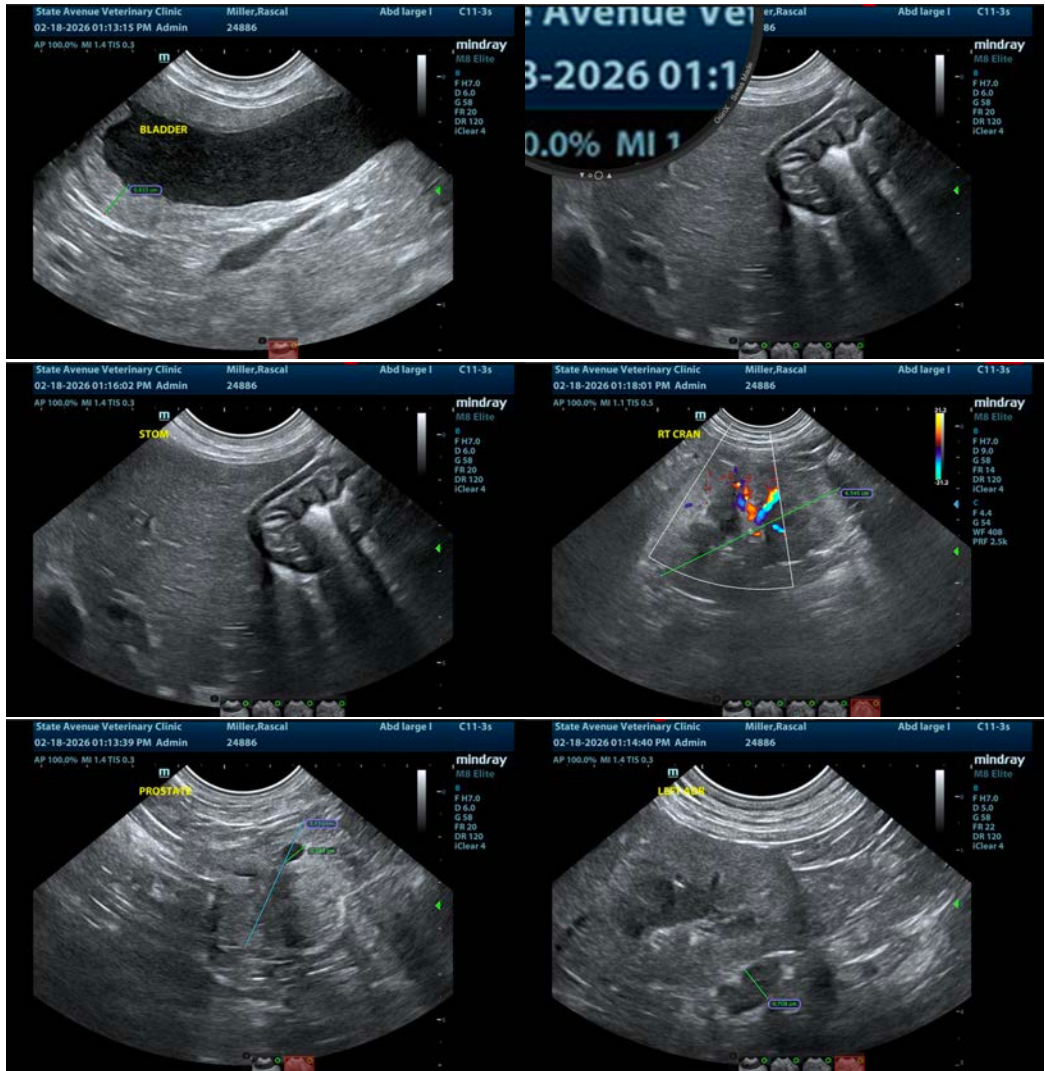
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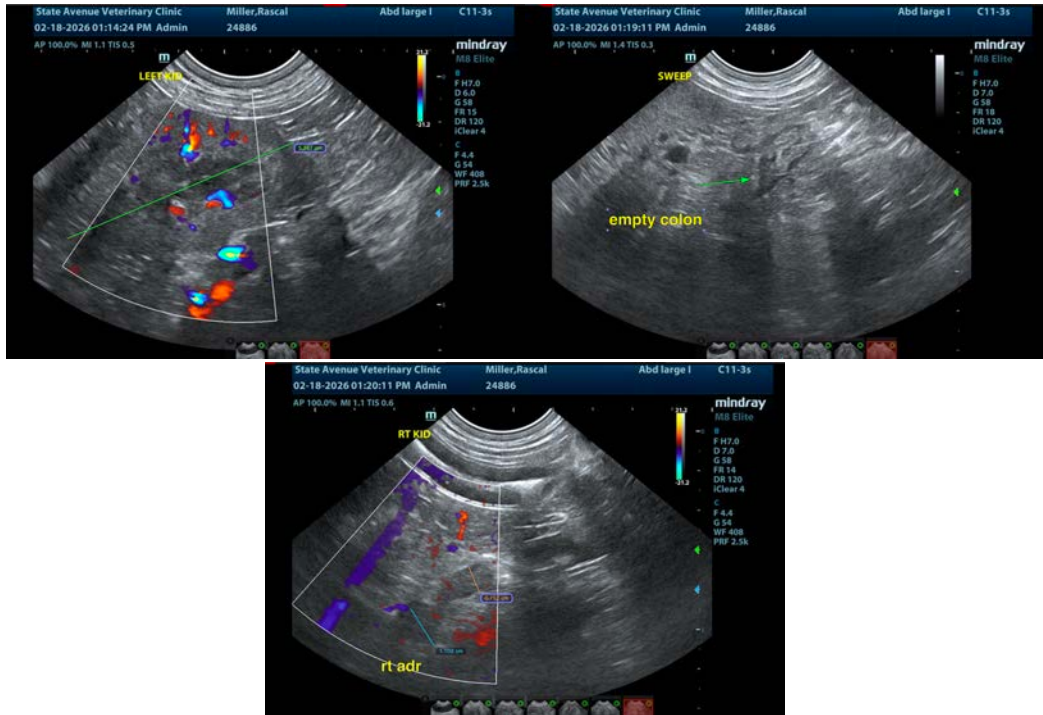
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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,
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