



PATIENT

Slim Vavasis

SPECIES

Canine

BREED

Pitbull Mix

SEX

Neutered male

AGE

13 years

WEIGHT

62 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Ryan Bergner

HOSPITAL NAME

Waterville VC

REFERRING VET

Dr. Gilchrist

INVOICE

71131

DATE

2/2/26

PRESENTING CLINICAL SIGNS

- Slim, a 14-year-old male neutered (with zeuterin < 2yrs old) canine, presents for follow-up on chronic gastrointestinal issues. The owner reports that Slim has an intermittent appetite and vomits bile approximately one to two times per week. The last episode of vomiting undigested food was a earlier this morning. There has been no diarrhea for several weeks. Slim has a significant medical history, including a diagnosis of hypothyroidism approximately four years ago. In January 2024, he underwent surgery at a specialty hospital for the removal of two malignant parathyroid tumors after being diagnosed with hypercalcemia. A cervical mass was discovered in May 2024 and was determined to be a MCT - O decided to not put P through another surgery. His left testicle is slightly smaller and more firm than the R testicle.
- Today's labwork showed a very mild microcytic, hypochromic, non-regenerative anemia. Chemistry was all normal. Recent Texas GI panel showed a mild cPLI elevation.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **bladder** in this patient was mildly thickened with slight echogenic mural changes. No calculi or masses were noted. Slight micropolypoid changes were noted. This is a frequent finding in older animals and may be linked to a history of chronic urinary tract infection or active urinary tract infection. Urinalysis would be recommended with culture if any evidence of inflammatory sediment is present. The region of the trigone and visible pelvic urethra 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. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 4.8 cm. The right kidney measured 6.3 cm.

The **prostate** was uniformly enlarged 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. 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 prostate measured 3.4 cm.

Adrenal Glands

The left **adrenal gland** was enlarged, hypoechoic and irregular with a swollen caudal pole measuring 2.06 x 1.06 cm at the caudal pole and 0.76 cm at the cranial pole. The right adrenal gland was uniform and measured 0.95 cm at the cranial pole and 0.55 cm at the caudal pole.



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Spleen

The **spleen** revealed an overt, mixed hypoechoic mass. The splenic mass measured 4.3 cm with hypoechoic undifferentiated changes.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. An anechoic cyst was noted in the right liver and measured 8.0 cm. 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.

Gastrointestinal

Gastric stasis and gastric thickening measuring 1.1 cm was noted with some loss of mural detail. Focal intestinal thickening was noted in the midabdomen. This is consistent with jejunum. Overall thickness measured 2.9 cm and comprised an intestinal mass. Other areas of spastic small intestine were noted. The ileocecal junction and variable areas of intestinal thickening were 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.

Free Abdomen

Regional lymph nodes were enlarged and measured up to 1.0 cm.

ULTRASONOGRAPHIC FINDINGS

Bladder thickening, history of cystitis is likely.

BPH prostate.

Gastric stasis. Variable GI thickening with overt small intestinal mass, appears to be jejunal.

Enlarged, irregular left adrenal gland. Differentials include adenoma, adenocarcinoma or pheochromocytoma.



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Subjectively benign hepatic cyst.

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Splenic mass.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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There is a strong concern for multi-centric round cell neoplasia. Surgical exploratory with expectations towards splenectomy, GI biopsies and/or GI resection optimally guided by intraoperative ultrasound would be warranted or ultrasound-guided FNA of the splenic mass may provide a definitive diagnosis. FNA of the intestinal thickening can be considered, but may be difficult to exfoliate adequate tissue for a definitive diagnosis of the intestine. Chest radiographs and echocardiogram are warranted to assess for comorbidities/metastasis.

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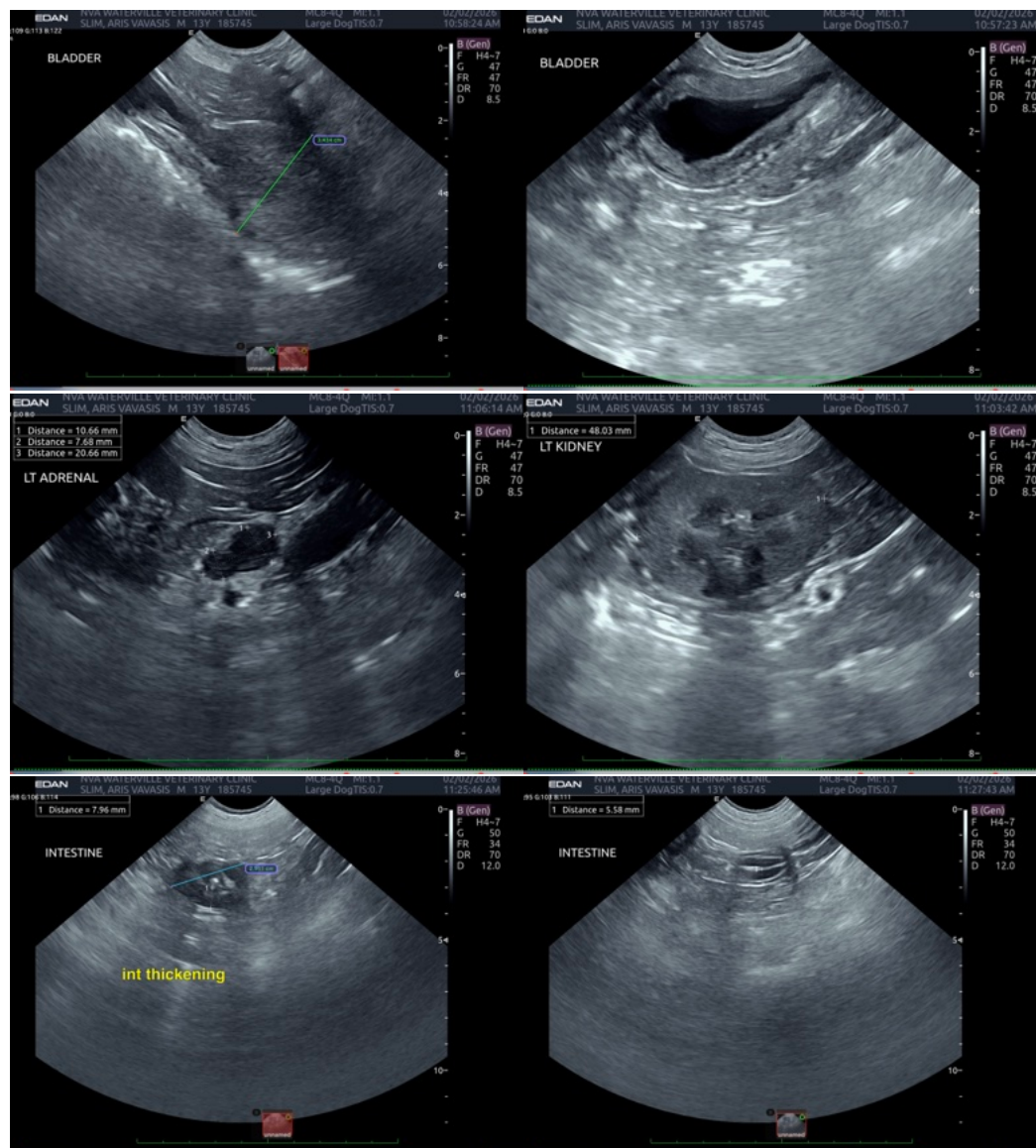
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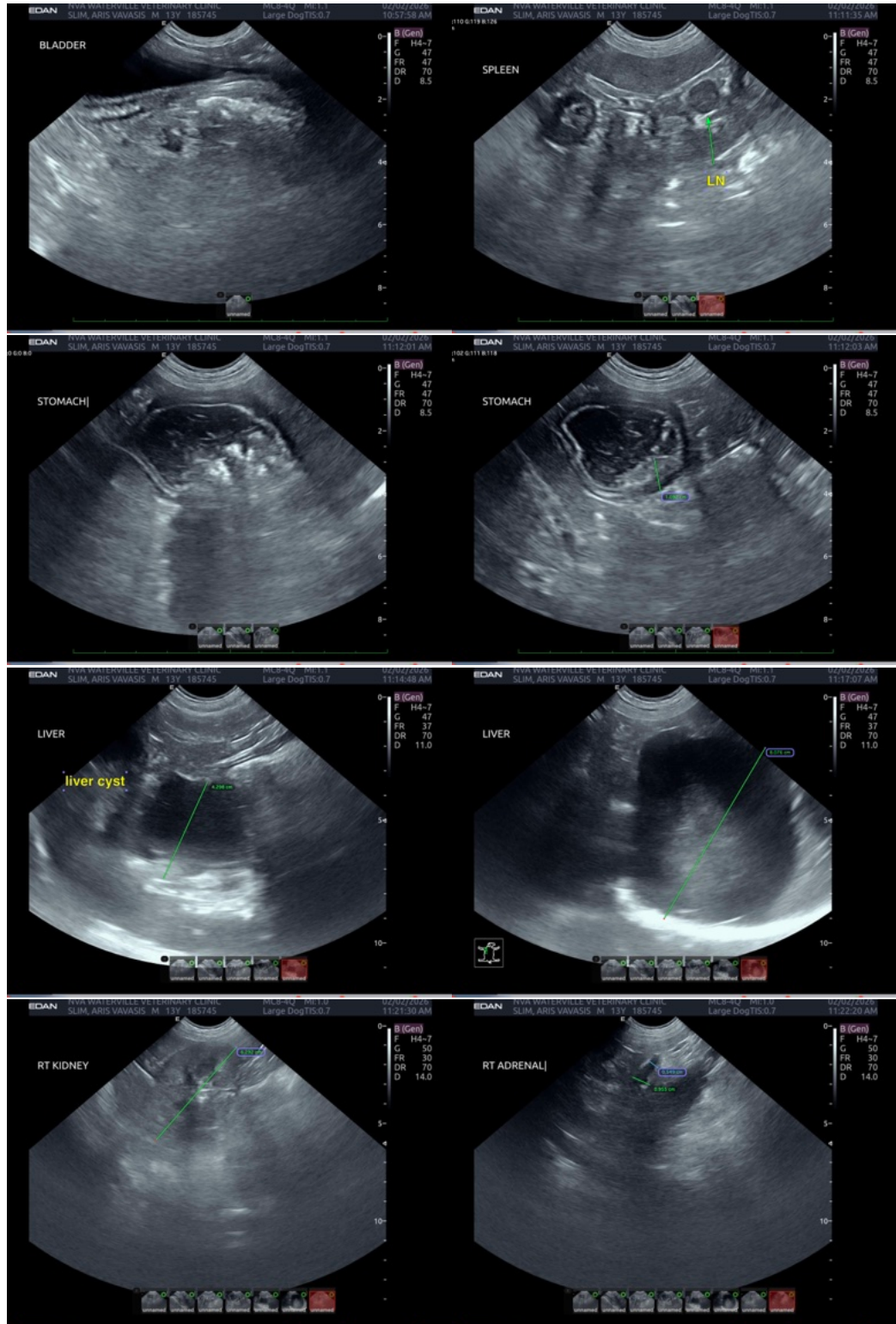
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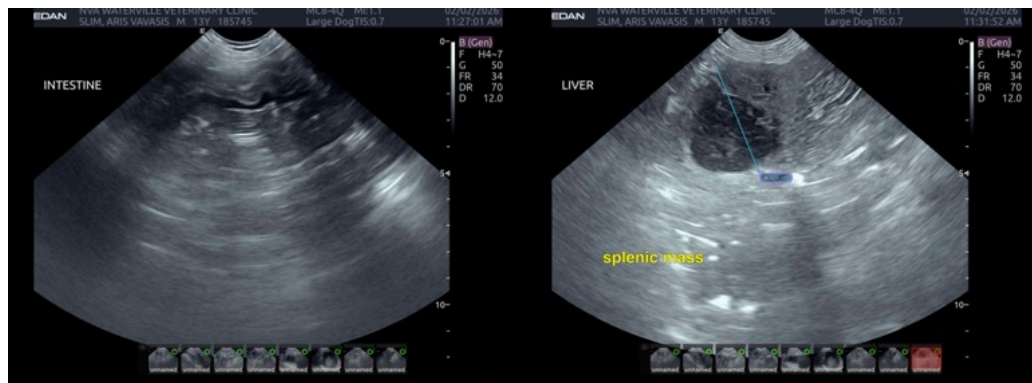
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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