



PATIENT

Juniper Estevez

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

10 Months

WEIGHT

35 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Chloe Lowe CVT

HOSPITAL NAME

Budd Lake Animal
Hospital

REFERRING VET

Dr. Welch

INVOICE

14534

DATE

02/23/26

PRESENTING CLINICAL SIGNS

- ADR
- vomiting
- diarrhea
- inappetence for a few days.
- mild ataxia starting last night
- machine 25mgs SID

Abnormal PE/Chem/CBC/UA Results: NBF all WNL CBC/chem/4dx/ lyrtes WNL Cortisol pending- ACTH Stim

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra to a depth of 3.0 cm 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 **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 6.5 cm in length. The right kidney measured 5.91 cm in length.

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. The left adrenal gland measured 1.46 cm x 0.44 cm width at the cranial pole and 0.31 cm width at the caudal pole. The right adrenal gland measured 1.83 cm x 0.52 cm width at the caudal pole and 0.62 cm width at the cranial 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 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.



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Gastrointestinal

The **stomach** was mildly over distended with chyme and some shadowing material measuring approximately 2.4 cm. Cannot rule out foreign matter yet did not appear obstructive at the time of the sonogram. The pylorus was patent. The small intestine was unremarkable. The colon was empty.

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

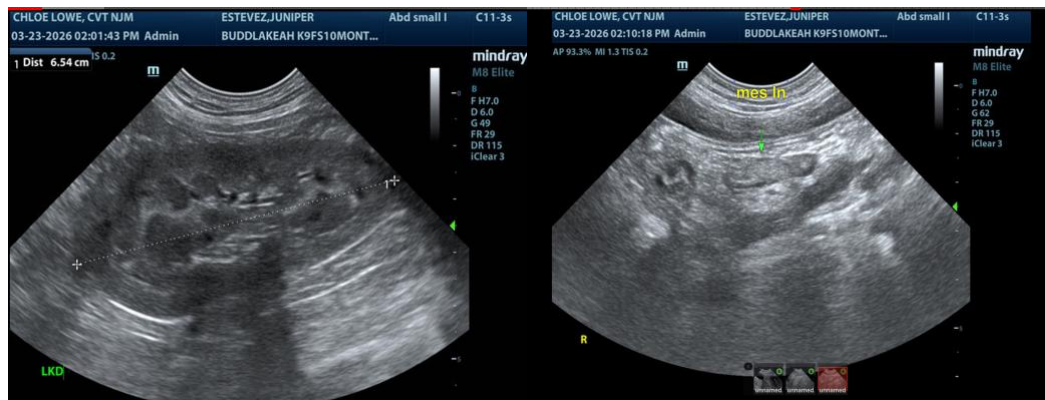
The juvenile mesenteric **lymph nodes** presented normal length to width ratio with slight, swollen contour. There was no loss of parenchymal detail. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia. The lymph nodes measured up to 1.5 cm.

ULTRASONOGRAPHIC FINDINGS

- Delayed outflow gastric pattern with possibly passive gastric foreign. Matter.
- Slight reactive mesenteric lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I recommend medical management in this patient or induction of vomiting. Endoscopy if upper GI signs continue yet no definitive obstructive pattern is present. 24-hour NPO and recheck sonogram could also be considered as an option.





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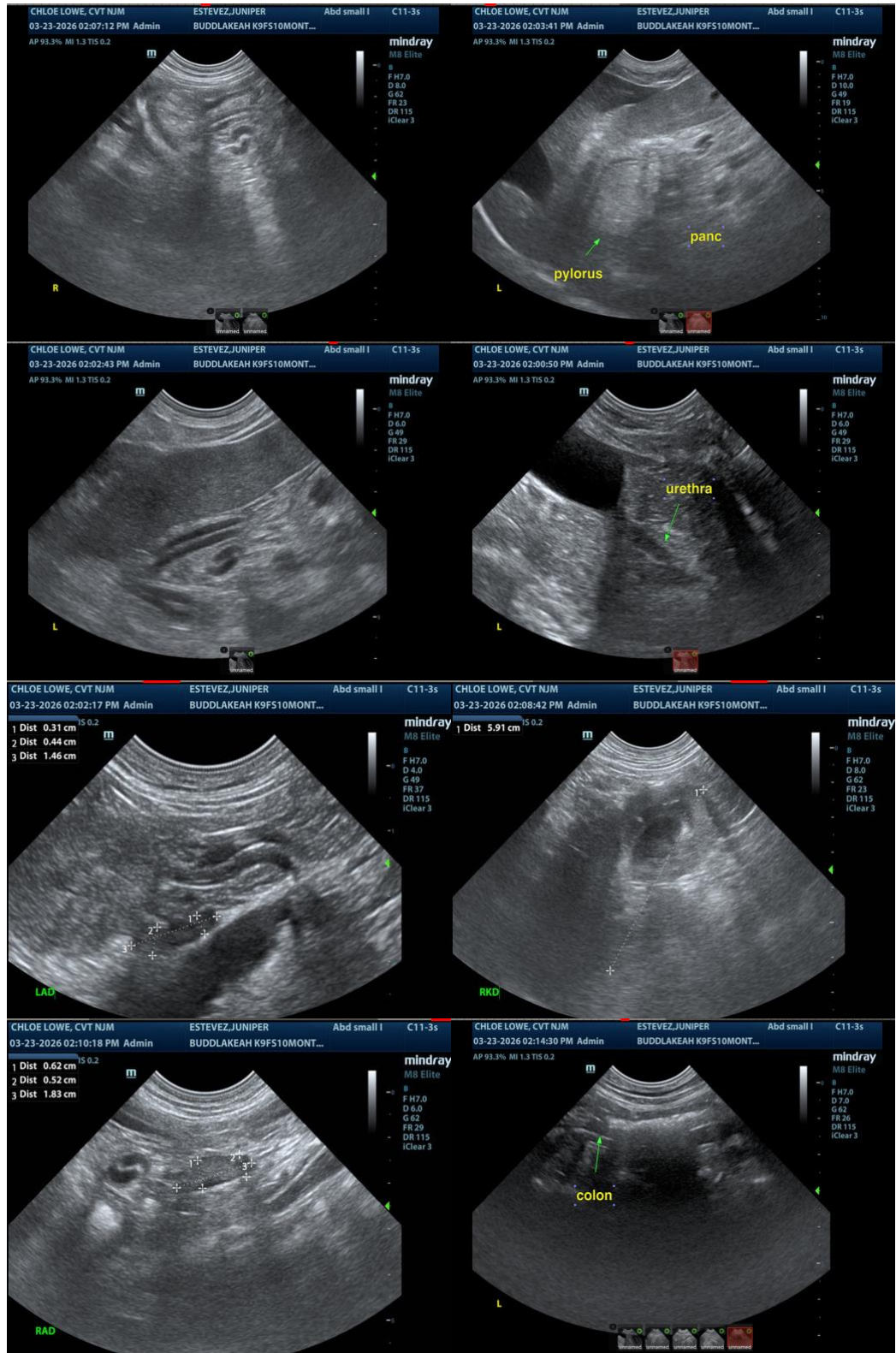
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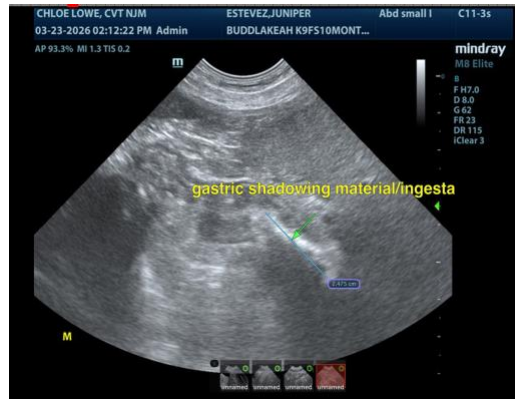
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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