



PATIENT

Wheezy Cutright

SPECIES

Canine

BREED

English Bulldog

SEX

Spayed female

AGE

13 years

WEIGHT

40 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Hollway

HOSPITAL NAME

Valley Green VH

REFERRING VET

Dr. Oberer-Gerber

INVOICE

74744

DATE

4/23/26

PRESENTING CLINICAL SIGNS

History: Presented yesterday as an ER for ADR, V+, with significant unintentional weight loss over the last year. Can't keep food down. Not drinking as much, lethargic QAR. 5% dehydrated. Suspect mid-abdominal mass (VS enlarged kidney vs other) given presence of baseball-sized mass effect at the dorsal-mid abdomen; palpating this mass causes lip-smacking/gagging response. Grade 2 out of 6 heart murmur, only present LEFT side with synchronous pulses. Increased RE. P's taking deep breaths with minimal air move. No obvious crackles. Stenotic Nares, mild. Nasal hyperkeratosis. BCS 2/9 + recent significant unintentional weight loss over the last year; MASS: left lateral/ventral neck firm quarter-sized, haired, non-ulcerative mass. NOT associated with LEFT submandibular LN or salivary gland. FNA attempted yesterday yielded significant blood and was not submitted. Alopecia intermittently from prev areas of allergic dermatitis. Mild bilateral ectropion. Stenotic ear canals; no inflammation or abnormal amounts of debris present. Grade 2 Dental Disease; significant drooling. Lymph nodes are all normal in size

Abnormal PE/Chem/CBC/UA Results: 4/23/26 PCV = 40% -- slightly increased from yesterday; r/o secondary to dehydration 4/22/26 HCT = 35% (non-regenerative) rest of CBC = NSF ALP = 1,019 -- r/o neoplasia vs other Rest of liver values = NSF. Kidney values = NSF. Lytes = NSF T4 = 1.3 normal

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. 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. Slight pinpoint mineralization was noted. The right kidney measured 6.4 cm. The left kidney measured 6.2 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. The right adrenal gland measured 0.9 cm at the cranial pole and 0.5 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 or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of



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congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. A cystic nodule was noted in the right medial liver and measured 3.14 cm and is subjectively benign. 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

The **stomach** was over distended with fluid. The small intestines were unremarkable with normal curvilinear mural patterns and content. Soft stool was noted in the colon.

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.

ULTRASONOGRAPHIC FINDINGS

Cystadenomatous type nodule in the right liver.

Gastric stasis/ileus.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver lesion is likely biliary cystadenoma. This should be monitored, but is not a clinical concern. There was no evidence of neoplasia. The palpable structure may be over distension of the stomach. I recommend management for gastritis. 24 hour n.p.o. and a clinical of the following is indicated. A recheck sonogram is recommended if clinical signs persist.

Helicobacter/Gastritis protocol

A clinical trial of **Zithromax (Dogs: 5-10 mg/kg p.o. q24h. May increase dosing interval to q48h after 3-5 days of treatment)**, **Metronidazole (10-20 mg/kg p.o. b.i.d.)**, **Pepcid (0.5-1 mg/kg s.i.d.)** and **Sucralfate (0.5-2 g/dog PO)** or **Omeprazole (1 mg/kg p.o. s.i.d.)** over the next 3 weeks along with a



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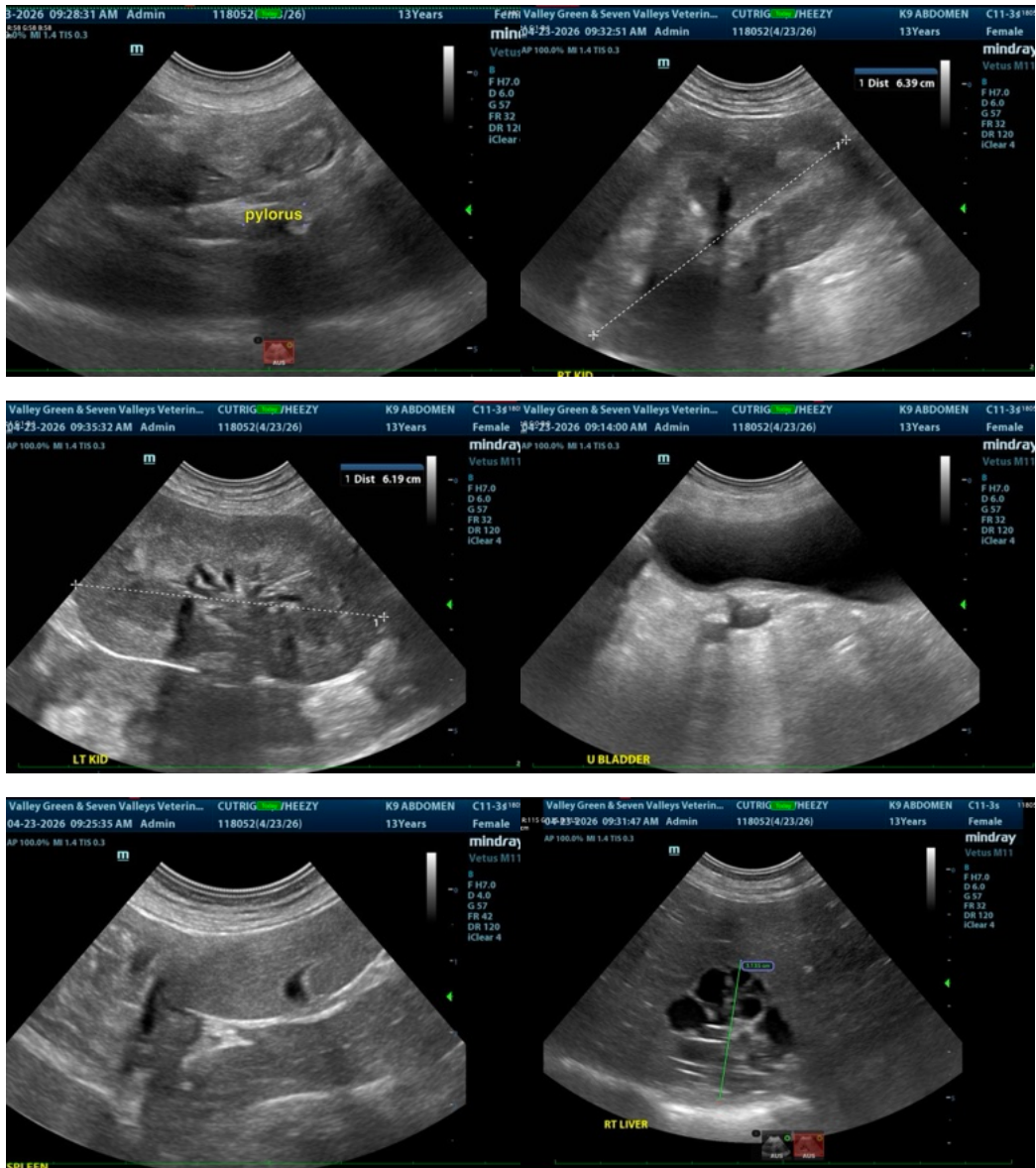
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novel-protein or hydrolyzed diet with slurry feeding b.i.d./t.i.d. over the next 2-4 days and then increase to canned diet bid. Dry food should be avoided over the next 4 weeks. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.





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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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