



PATIENT

Ruger Smith

SPECIES

Canine

BREED

Hound Mix

SEX

Neutered Male

AGE

8 Years

WEIGHT

100 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Chlow Lowe, CVT

HOSPITAL NAME

Newton VH

REFERRING VET

Dr. Chan

INVOICE

36823

DATE

4/27/26

PRESENTING CLINICAL SIGNS

History: Vomiting, diarrhea, weight loss.

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. This is a minor change. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction.

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 right kidney measured 6.5 cm. The left kidney measured 6.5 cm.

Adrenal Glands

The **right adrenal gland** was normal in size and contour. The right adrenal gland measured 3.02 cm x 1.5 cm at the cranial pole and 0.46 cm at the caudal pole.

The **left adrenal gland** was somewhat flattened. The left adrenal gland measured 3.8 cm x 0.48 cm at the cranial pole and 0.56 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 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

The **stomach** was empty in this patient. The small intestine presented progressively dilated lumen, continuing into the ileocecal. The colon was also fluid filled. This change is consistent with enterocolitis. Enterotoxin is a strong potential in this patient.

Pancreas



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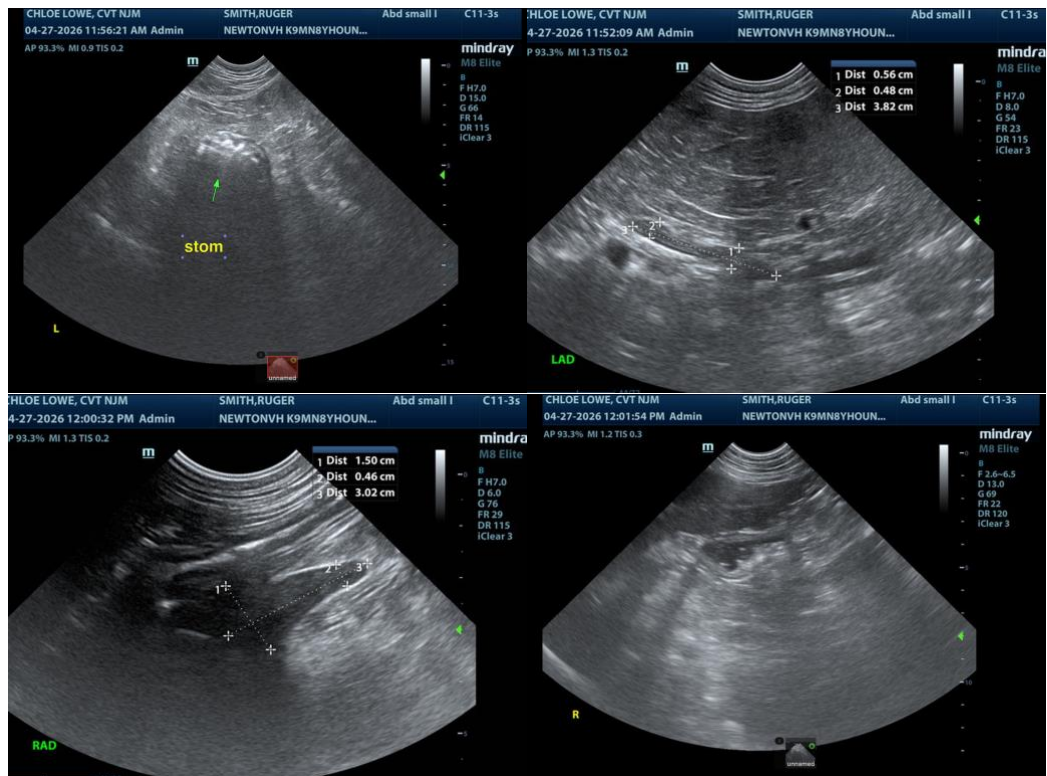
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

- Enterocolitis pattern
- Somewhat flattened left adrenal gland
- Age-related urinary bladder changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Medical management should prove effective. If the patient has persistent clinical signs over the next 36-48 hours, then recheck sonogram is indicated. IV fluid support, parasite assessment and broad-spectrum antibiotics to treat for enterotoxins would all be valid.





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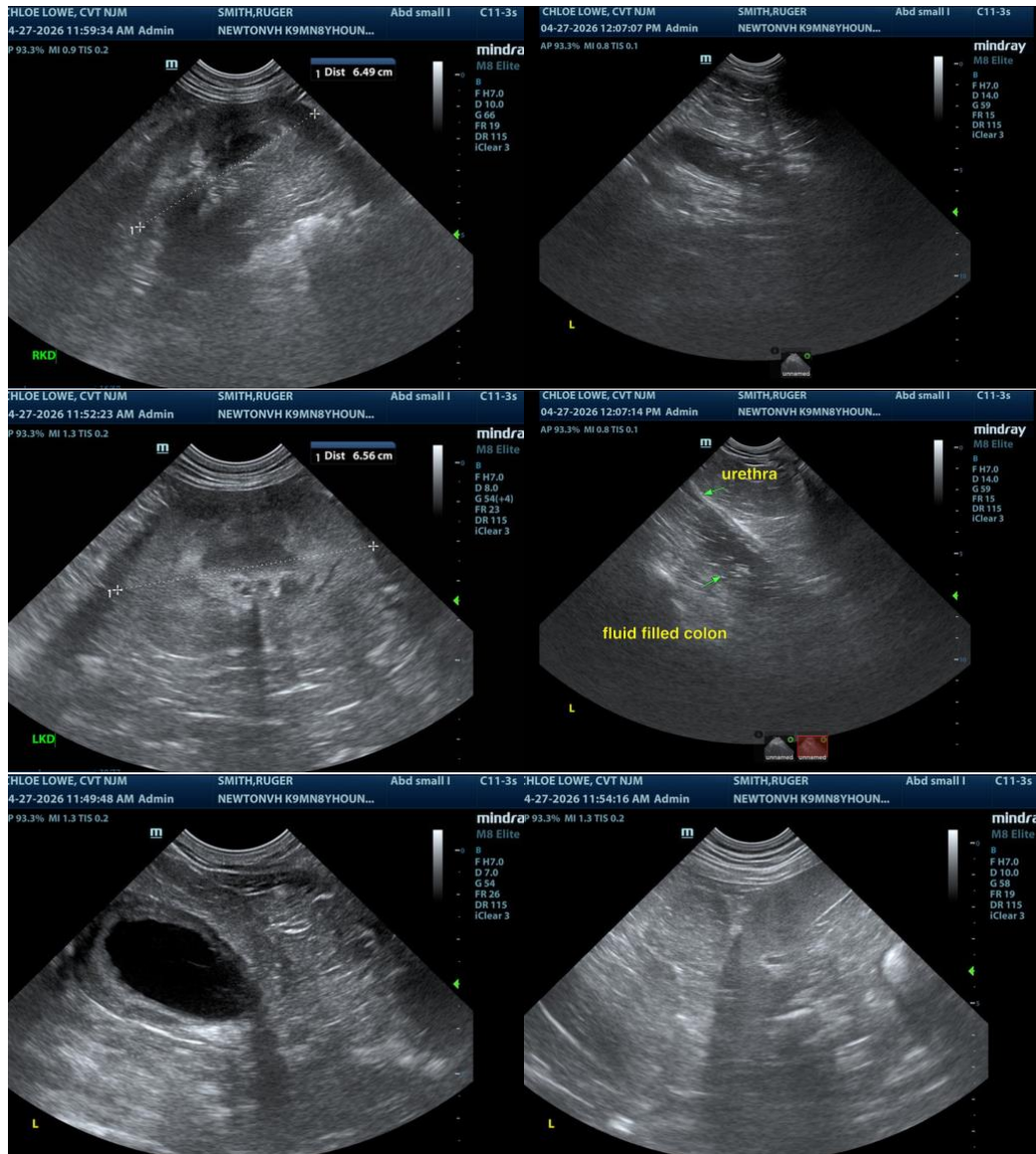
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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