



PATIENT

Mark Cozart

SPECIES

Canine

BREED

Yorkie

SEX

Neutered Male

AGE

16

WEIGHT

8.16

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Betsy LaCroix

HOSPITAL NAME

Inspire AH-Highlands
Ranch

REFERRING VET

Dr. Betsy LaCroix

INVOICE

37088

DATE

5/12/26

PRESENTING CLINICAL SIGNS

History: Patient has been having chronic melena for 1 month. HCT has waivered significantly over the last month, lowest was low 30's, no spherocytes nor agglutination. Chronic paraphimosis, trouble passing U cath yesterday, rad review showed possible free gas in abd versus colonic pneumonitis. Patient stopped having melena while on sucralfate and then immediately started again when sucralfate was stopped. hospitalized 4/22 for bloody stool, hyporexia, and vomiting. Diagnostics included: CBC: Hct 45%. Chemistry: BUN 98 mg/dL, Albumin 2.5 g/dL. Abdominal Ultrasound: hepatopathy with nodules, mild chronic renal changes, and diffuse small intestinal and colonic wall thickening, with differentials of inflammatory bowel disease versus gastrointestinal lymphoma. Resting cortisol: 5.1 mcg/dL. history of lymphoplasmacytic enteritis from previous GI biopsies. A

Meds: Vetmedin 1.25mg 1 tablet in the AM and 1/2 tab in the PM, Trilostane 10mg every 8 hours, Fenofibrate 28mg 1/2 tablet q 24h, Ursodiol 75mg q 24h, omeprazole, sucralfate.

liver biopsy 1/10/23: revealed vacuolar hepatopathy, glycogen-type, moderate, diffuse with few lipogranulomas, incidental stomach mass on abdominal explore 1/10/23, endoscopic stomach biopsy 1/10/23: proprial fibrosis with lymphoplasmacytic mild, focal, gastritis

Abnormal PE/Chem/CBC/UA Results: Problem list: Chronic degenerative valve disease (ACVIM Stage B1, borderline B2), Mild pulmonary hypertension, Atypical Cushing's disease, Hyperlipidemia, Liver mineralization, Grade IV/VI left systolic heart murmur Age related changes, chronic ocular issues. normally rather aggressive, not today. Melena on rectal yesterday. 4/28- 33.2 HCT 4/29- 33.3 HCT 5/4- 36.1 HCT 5/11- 34.3 HCT Not painful on abd palpation. Able to pass urinary catheter while standing, but not laying down. Chronic paraphimosis.

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 were noted. Ureteral papillae were normal. The pelvic urethra was imaged 1.0 cm beyond the cystourethral junction.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some mild 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. The right kidney measured 3.56 cm. The left kidney measured 4.06 cm. Slight microcystic cortical changes and trace pyelectasia were noted in the left kidney.

Adrenal Glands

The **left adrenal gland** was 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 0.51 cm.

The region of the **right adrenal gland** was unremarkable.

Spleen



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The **spleen** in this patient was uniform, yet volume contracted. Hydration status should be assessed.

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Liver

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The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. 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 minor excessive debris. Multifocal hypoechoic nodular changes were noted in the liver, nondisruptive.

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Gastrointestinal

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The upper **gastrointestinal tract/stomach** was unremarkable. The mid to distal small intestine revealed a regional mucosal and luminal thickening with hyperperistalsis and loss of mural detail. Partial obstructive pattern was noted in the distal small intestine with echogenic luminal ingesta or potential proliferative mucosal neoplasia. It is difficult to ascertain one versus the other, however, the material appears to be shadowing. The colon was unremarkable.

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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.

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ULTRASONOGRAPHIC FINDINGS

- Partial obstructive pattern in the distal small intestine- potential underlying epithelial tumor, or some shadowing luminal material that's obstructive in the distal small intestine. The upper GI tract was unremarkable.
- Nodular hyperplasia liver pattern
- Volume contracted spleen
- Age-related renal changes with slight microcystic cortical changes and trace pyelectasia in the left kidney.
- Age-related abdominal changes otherwise

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend exploratory surgery with expectations towards resection and anastomosis or enterotomy, depending upon the findings. Inspection and/or biopsy of the liver is indicated at the time of surgery. Chest radiographs are warranted prior to intervention.

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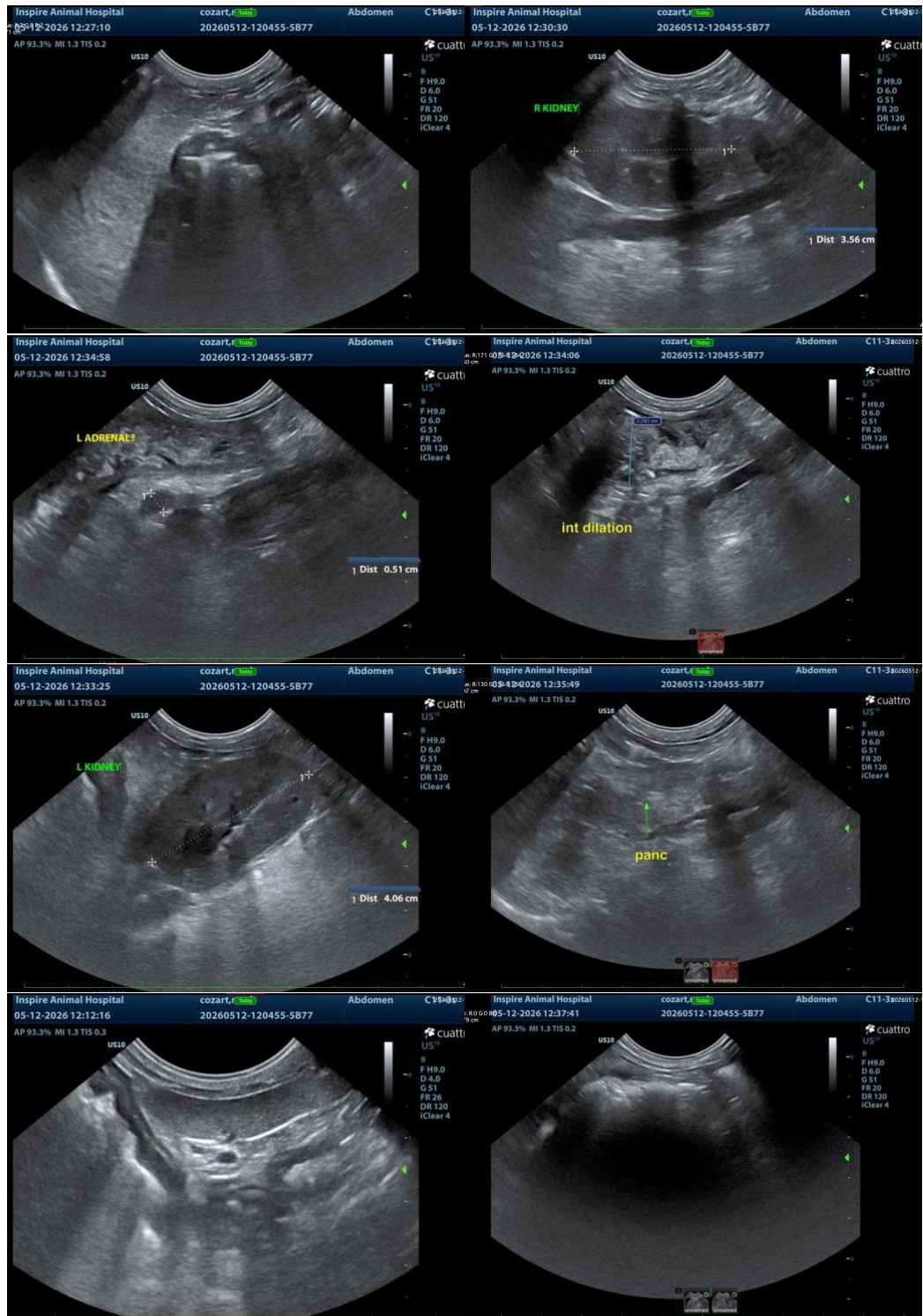
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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