



PATIENT

Moxie Oates

SPECIES

Canine

BREED

Labrador

SEX

Spayed female

AGE

13 years

WEIGHT

53 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Andrew Keller

HOSPITAL NAME

Birch Bark VC

REFERRING VET

Dr. Keller

INVOICE

75387

DATE

5/12/26

PRESENTING CLINICAL SIGNS

History: History of resistant UTI, difficult to treat currently due to inappetence
Significant CP deficits and weakness both hindlimbs
2 weeks ago had intra-articular Kenalog injection @ referral, has been inappetant and lethargic since.
Now extremely lethargic, difficulty ambulating and weakness
Abnormal PE/Chem/CBC/UA Results: Elevated Neutrophils Significant azotemia (Creatinine increased from 1.8 to 3.9 since 3/26, BUN also elevated, mild Hyperglycemia) Elevated respiratory effort, possible laryngeal paralysis History of resistant UTI Nausea/inappetence

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed minor mural thickening. The bladder wall thickness measured up to 0.43 cm with a minor amount of suspended debris. Grouping of which measured 0.9 cm.

The **kidneys** were subnormal in size with irregular contour and multi-focal cortical infarcts and mineralization. The left kidney revealed a cortical infarct and areas of mineralization. Calculus measured 0.75 cm in the left renal pelvis. The left kidney measured 5.6 cm. The right kidney revealed dystrophic changes with infarcts and mineralization. The right kidney measured 3.7 cm.

Adrenal Glands

The **adrenal glands** were not visualized.

Spleen

The **spleen** revealed a focal, expansive mass that measured 3.0 cm. There was no evidence of rupture, but capsular expansion and disrupted architecture are present.

Liver

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 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.



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Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

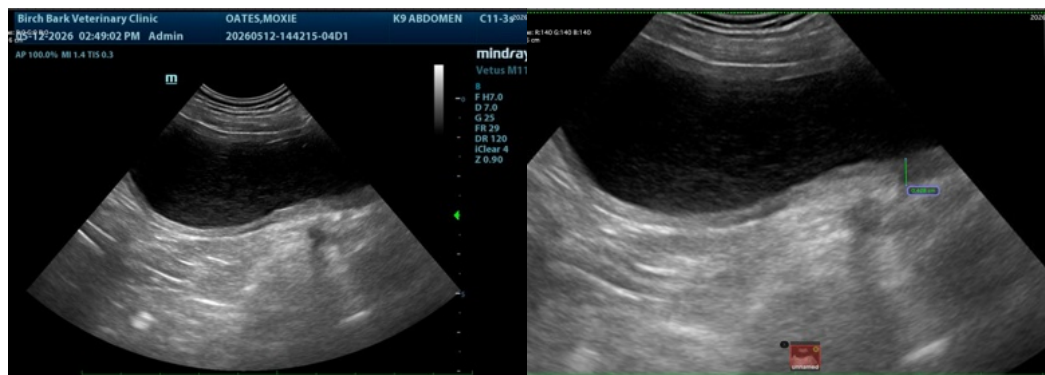
Pancreas

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.

ULTRASONOGRAPHIC FINDINGS

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ideally further imaging of the adrenal glands and deep pelvic urethra would be performed in this patient to ensure that concurrent disease is not present. Approximately 1.0 cm into the pelvic urethra was imaged. Examination of the vaginal vestibule for predisposing issues is recommended. There is concern for emerging renal failure in this patient. Urine culture and sensitivity, 4-6 week antibiotic therapy based on culture results would be ideal. IV fluid support and injectable antibiotics may be the best approach. Splenectomy is warranted after chest radiographs and rapid echocardiogram to ensure that metastatic disease is not an issue.





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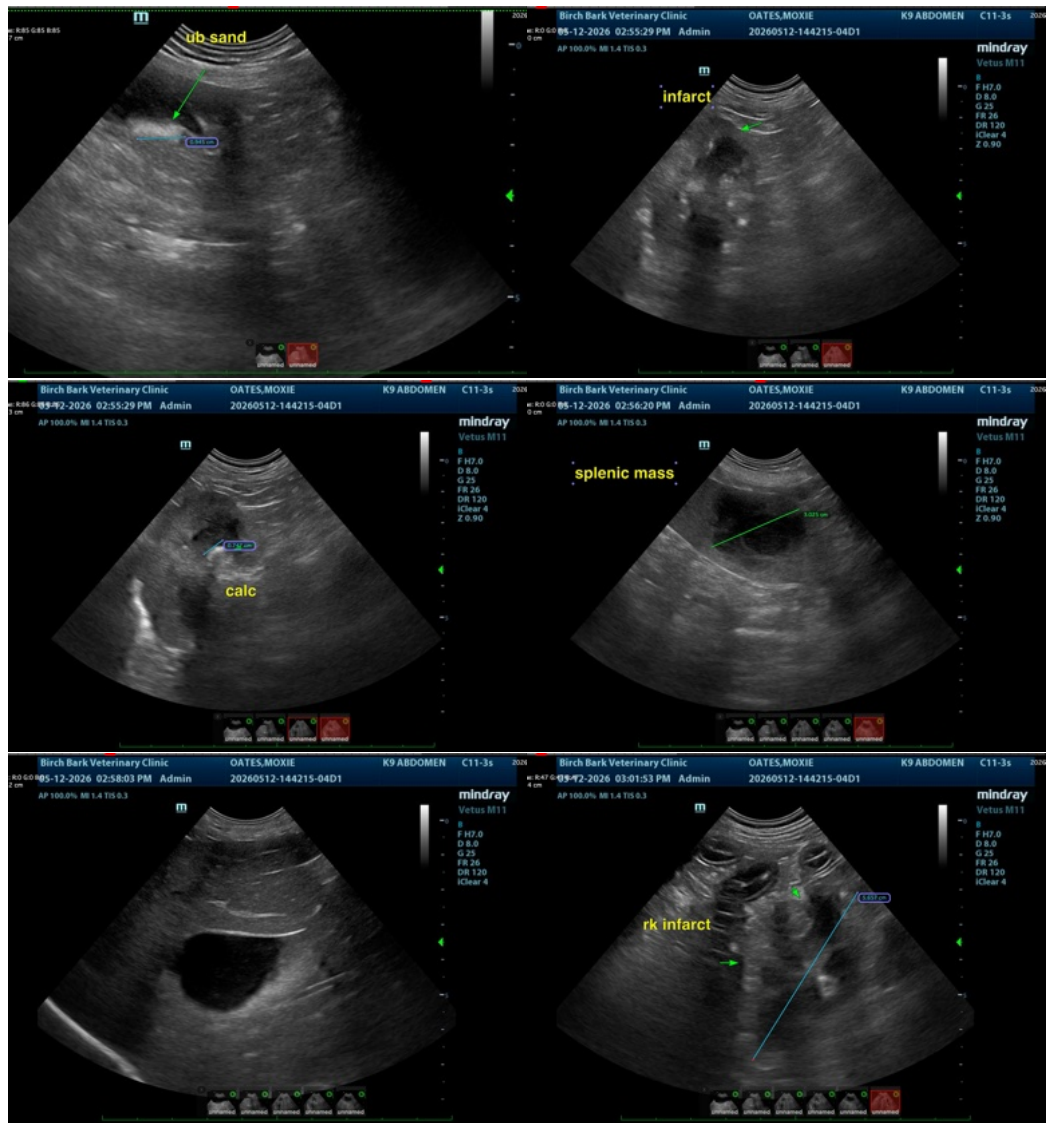
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@SonoPath.com