



PATIENT

Honey Rescue Dogs

SPECIES

Canine

BREED

Beagle Mix

SEX

Spayed Female

AGE

11 Years

WEIGHT

16.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue Vet
Clinic

REFERRING VET

Dr. Jessie Evoniuk

INVOICE

16527

DATE

05/27/26

PRESENTING CLINICAL SIGNS

Abdominal US to evaluate for potential liver disease vs other underlying disease process, Pulled from shelter less than 1 week ago; no prior medical history available. Eating and drinking well; on weight control diet. Limping noted, primarily left front limb; able to jump on couch with some difficulty

Abnormal PE/Chem/CBC/UA Results: Eyelids do not fully close; risk for exposure keratitis, Grade 3+ dental disease, Abdomen: Right flank: soft, rounded ~1.5" diameter mass- suspected lipoma, Left front limb: pain on manipulation of shoulder (especially flexion), palpable prominence of scapular spine-muscle atrophy, lameness, Integument: Left forehead: focal, dark, 0.5 cm mass near left ear; right side: facial droop, muscle atrophy; mammary region: ~1/4cm raised skin mass- rounded, Neurologic: Right side: facial droop, head tilt, incomplete eyelid closure, muscle atrophy of temporal area 5/26/26, fasted: ALT 627 5/21/26, non-fasted: ALP 167, ALT 310, Creatinine < 0.2, Potassium 8.4, Chloride 105, Amylase 445

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** presented a moderate thickening of the cranioventral and craniodorsal mucosae with micropolypoid mucosal changes without involvement of the submucosae. The urine presented some echogenicity consistent with suspended debris and a trace amount of sand. No evidence of urethral pathology was present. This presentation is most consistent with chronic cystitis. Technically transitional cell carcinoma cannot be ruled out without histopathological review but is not overtly suspected based on this pattern. Cystocentesis and urine culture +/- pathological review of urine cytology would be warranted. No overt calculi were present at this time. Some mucosal ulcerative changes were present. Wall thickness measured up to 0.78 cm.

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. The capsules were acceptably uniform without significant irregularities. The left kidney measured 4.0 cm in length. The right kidney measured 4.8 cm in length. Slight pinpoint mineralizations were present in both kidneys.

Adrenal Glands

The **left adrenal gland** was visualized obliquely. The left adrenal gland measured 0.5 cm width.

The **right adrenal gland** revealed a moderately expansive mass measuring 2.2 cm x 1.55 cm deriving from the cranial pole. The right adrenal gland measured 0.8 cm width at the cranial pole and 0.5 cm width 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.



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Liver

The **liver** revealed slight coarse architecture and minor increased portal markings with normal size, contour and vascularity. No evidence of portosystemic shunting. The gallbladder and common bile duct were unremarkable.

Gastrointestinal

The **gastrointestinal tract** presented considerable gastric artifact due to the presence of ingesta. This did not permit thorough evaluation of portions of the gastric and upper intestinal structure. No overt abnormality was seen in the visualized tissue, however. This is consistent with a post-prandial presentation within a few hours of mealtime. If the prandial temporal interval does not fit the case history, and the patient presents a history of post-prandial vomiting, this could indicate a delayed upper gastrointestinal outflow due to primary or secondary pyloric hypertrophy, upper GI infiltrative disease, motor deficits, or a non-visualized foreign body. A prudent approach would be to rescan this patient at 24 hour NPO status to further review the non-visible regions if stomach primarily as well as assess any delayed outflow issue.

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

- Right adrenal gland mass- adenoma, adenocarcinoma, pheochromocytoma.
- Chronic cystitis bladder pattern.
- Full stomach.
- Renal mineralizations.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Full urinary workup is warranted. Serial blood pressure measurements are recommended in this patient. If hypertension is an issue metanephrine level is recommended. If the patient appears Cushingoid and urine specific gravity is less than 1.020 then work-up for adrenal dependent Cushing's is indicated. Recheck is recommended in 2-3 weeks to assess for any progression of the adrenal gland. Right adrenalectomy would be indicated. Liver biopsy could be performed at that time given the ALT elevations. Leptospirosis titers are indicated to ensure this is not an underlying issue. BRAF testing is indicated even though carcinoma is unlikely but technically possible. No evidence of caval invasion.



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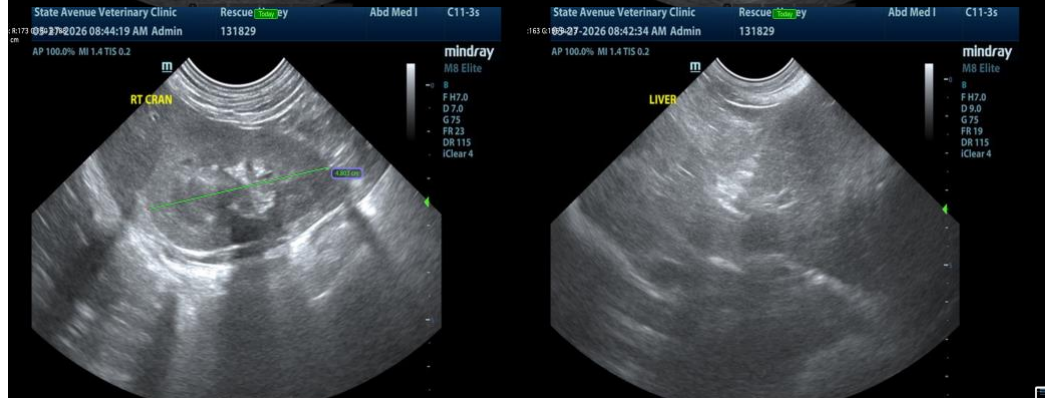
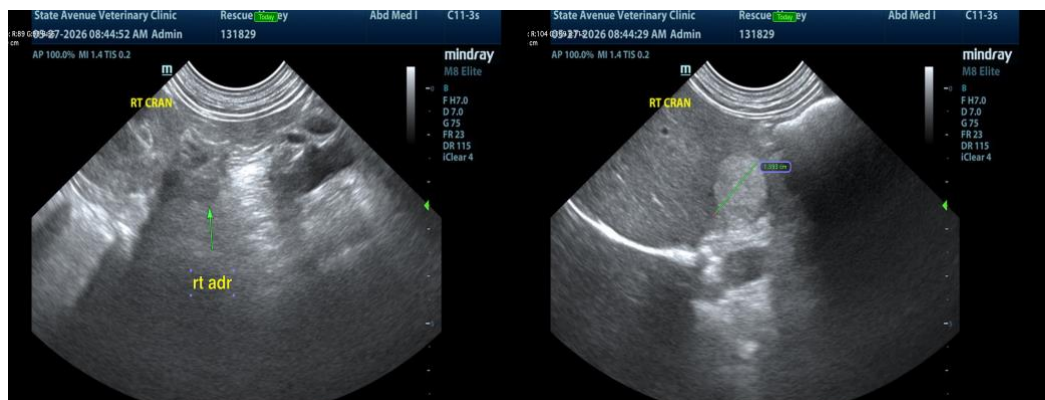
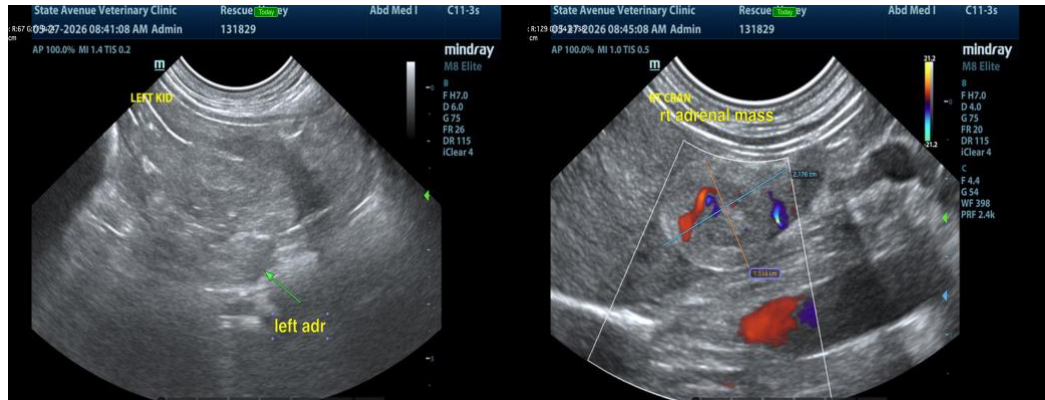
Dr. Jessie Evoniuk

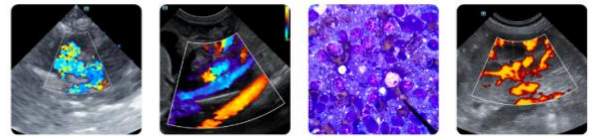
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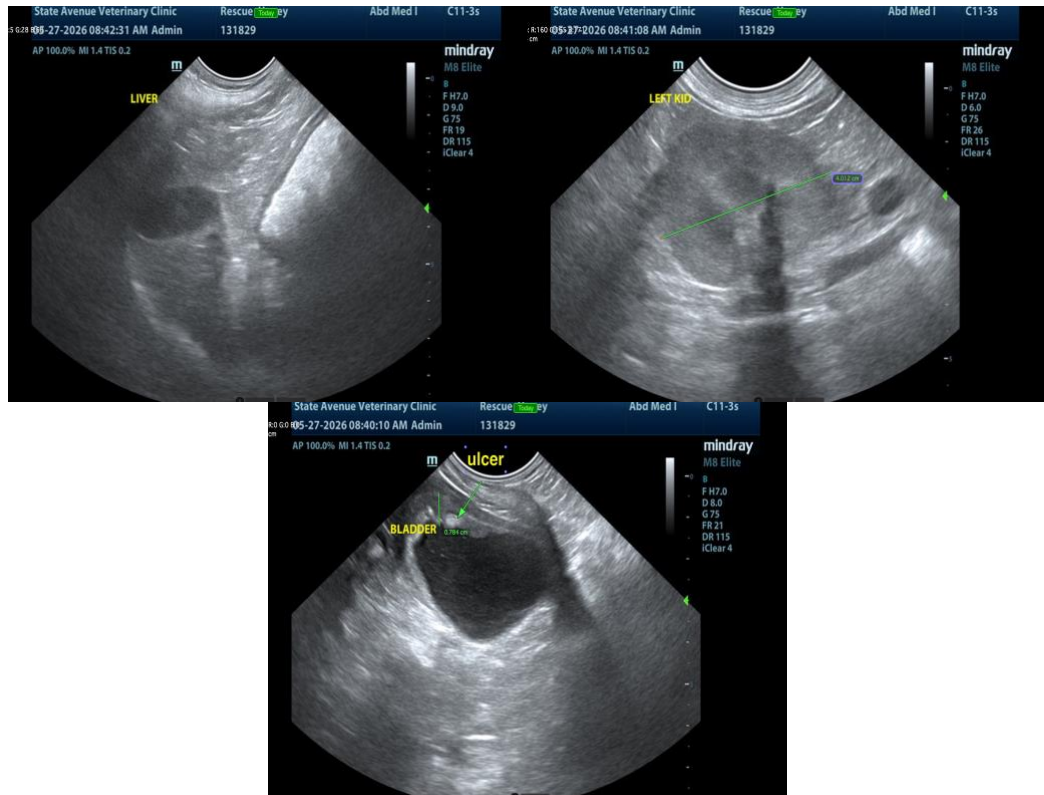
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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