



## PATIENT

Zorro Szucs

## SPECIES

Canine

## BREED

American Bulldog

## SEX

Intact Male

## AGE

12.5 years

## WEIGHT

66 lbs

## INTERPRETED BY

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

## IMAGING PERFORMED BY

Dr. Christensen

## HOSPITAL NAME

Tranquility VC

## REFERRING VET

Dr. Peng

## INVOICE

78815

## DATE

6/17/26

## PRESENTING CLINICAL SIGNS

History: P presented lethargic, decreased appetite. Lethargy of 1 day's duration, decreased appetite since the morning of presentation. One episode of vomiting yesterday after panting heavily, panting subsided after being brought inside. Lives outside in a run with trees for shade and a water pool for cooling, not on F/T prevention and 3 ticks were found on him recently. No known exposure to potential toxins per owner. Enlarged R popliteal and submandibular lymph nodes, mild limp LF leg, 1 pinpoint red spot on skin cranial to prepuce found on exam, intact male. Radiographs revealed enlarged liver with rounded edges and mass effect in abdomen, subjectively increased bronchointerstitial opacity in lungs. Current medications: \_Doxycycline 200mg PO BID\_ Diagnostic abnormalities: \_Anaplasma positive on 4Dx (new per O report), mild neutrophilia (12k/uL), incr. BUN (31), decr. Na/Cl (141/105). Rest of CBC/chem wnl.

## 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. The right kidney measured 5.8 cm. The left kidney measured 5.6 cm.

The **prostate** was uniformly enlarged with lobar swelling appeared to impinge upon the urethra and mildly deviate the descending colon. The prostatic tissue was hyperechoic containing focal areas of decreased echogenicity. Microcystic and macrocystic changes were noted. The largest cyst measured 2.1 cm. I cannot rule out abscessation. These changes are suggestive of either chronic inflammatory episodes, benign cystic pathology or both. Underlying neoplasia cannot be completely ruled-out but is lower on the differential list. This presentation is most consistent with benign prostatic hyperplasia with possible active prostatitis. Neutering or off-label Finasteride (Propecia) (0.1-0.5 mg/kg Sid) treatment is indicated +/- FNA or prostatic wash cytology and culture. The prostate measured 6.8 x 4.8 cm.

The iliac lymph nodes were unremarkable.

### Adrenal Glands

Both **adrenal glands** were visualized and recognized as having largely normal shape, size, position and acceptable echogenicity for this age group and breed. Some heterogeneity was noted within the adrenal parenchyma without concerning capsular distortion. These changes are likely age related but should be monitored by sonogram should the patient be suspected of having adrenal disease. The right adrenal gland measured 2.4 x 0.95 cm at the cranial pole and 0.81 cm at the caudal pole. The left adrenal gland measured 2.25 x 0.57 cm at the cranial pole and 0.74 cm at the caudal pole.



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## *Spleen*

The **spleen** in this patient was mildly enlarged, heterogenous and was folded upon itself. Isoechoic nodular changes were visualized.

## *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.

## *Gastrointestinal*

There was some residual chyme and gas was noted in the **stomach**, yet not pathological. This is consistent with post prandial presentation. Transit of chyme into the small intestine was normal. Curvilinear patterns were maintained throughout the GI tract. No evidence of pathology. 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

Geriatric abdomen.

BPH prostate with cysts or possible abscessation.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasound-guided drainage and culture of the prostatic cysts are indicated. Neutering would be recommended in this patient with ultrasound-guided drainage of the cyst and culture. The discomfort may be linked to the underlying GI signs. Supportive care should prove effective.



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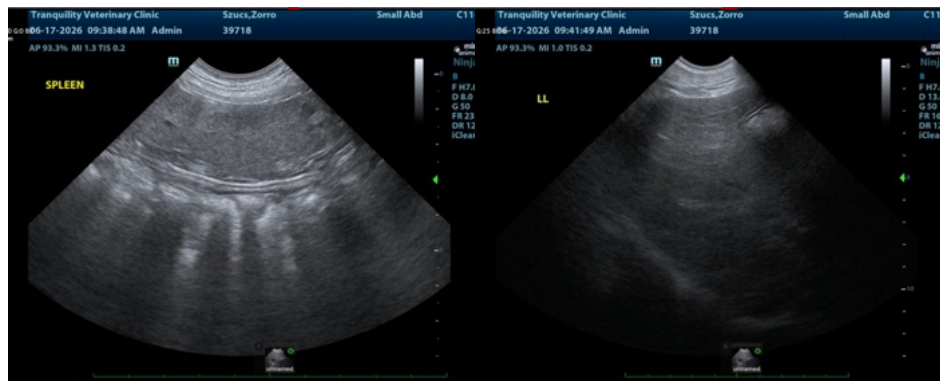
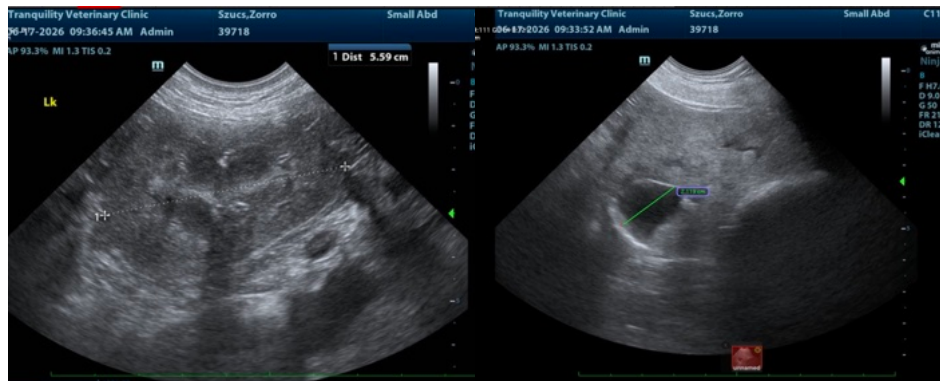
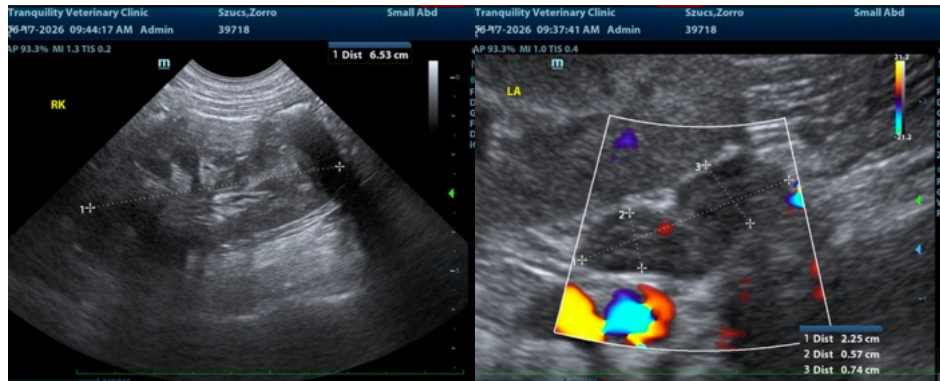
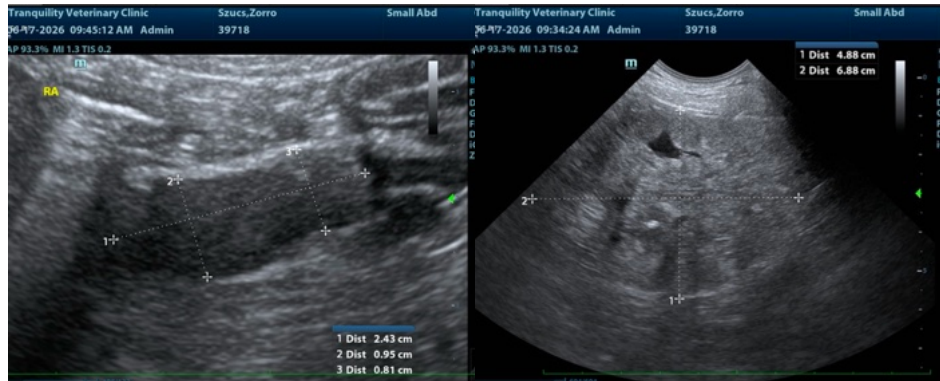
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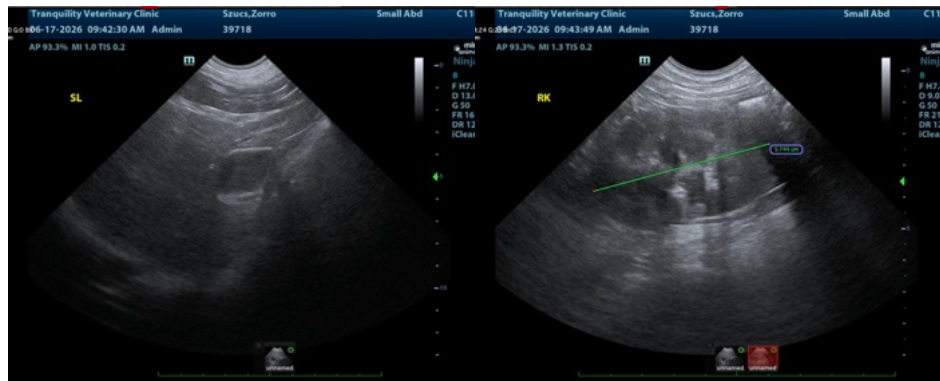
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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