



PATIENT

Marko Jolley

SPECIES

Canine

BREED

Aus Cattle Dog Mix

SEX

MN

AGE

11yr

WEIGHT

54.4lb

PRESENTING CLINICAL SIGNS

- Clinical Exam Findings:
- Staging for cancer.
- 1/16/26 - Integument: ~4cm soft fluctuant growth along L lateral elbow (near the elbow) w/ defined margins on palpation, appears adhered down to the underlying muscle, ~4cm soft fluctuant growth along L lateral mid-antebachium w/ no clear margins, ~2cm fluctuant freely-movable SC growth along L axilla, ~1.5cm slightly hairless, bluish-red in color cyst R lateral cheek - 1ml of yellow straw-colored fluid aspirated today, ~8cm SC fluctuant mass adhered down to the R inner cranial shoulder, ~1cm SC freely-movable nodule susp. lipoma along R lateral elbow.
- prev. noted 0.5 cm diameter fluid filled cyst on R lateral cheek not open or draining but gradually growing. On R lateral distal to elbow, 2cm alopecia and 1.5 cm diameter abrasion, no SC swelling or discharge. Likely lipomas - 2.5 cm on L lateral elbow, 2 cm on L lateral thorax, 1.5 cm on R flank.
- Aspirated sample from L lateral mid-antebachium growth - revealed a population of epithelioid cells on IH cytology. Sample submitted to pathologist (Dr. Rae) for further evaluation.
- ABNORMAL Labwork Values
- Cytological findings: Diagnosis: Soft tissue sarcoma, most likely hemangiopericytoma or peripheral nerve sheath tumor.
- Current Medications Trazodone 100mg - Give 2.5 tablets by mouth 2 to 3 hours prior to stimulus/veterinary visits.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

INTERPRETED BY

R. McKenzie Daniel,
 DVM, DABVP
 (Canine and Feline)

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Creekside Veterinary
 Clinic

REFERRING VET

Dr Angstrom

INVOICE

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Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.3 cm in length. The right kidney measured 6.0 cm in length.

The area of the aortic trifurcation was free of pathology.

The residual prostate appeared normal and free of pathology.

Adrenal Glands

A well-defined, hyperechoic nodule was present in the caudal left adrenal gland with mild associated symmetrical capsule expansion. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 0.52 cm in diameter. The overall left adrenal gland measured 0.65 cm width at the caudal pole. The right adrenal gland was not definitively visualized.

Spleen



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The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

Liver/Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and mild non-organized debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Mild age related renal changes
- Small caudal left adrenal nodule
- Non-enlarged mild heterogeneous spleen
- Sonographically normal liver with mild non-organized gallbladder debris (non-mucocele)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Largely a geriatric abdomen without evidence of significant visceral pathology or neoplastic / metastatic criteria. Considerations for the adrenal nodule may include favored adenoma or hyperplasia with potential emerging primary or metastatic neoplasia, i.e. pheochromocytoma thought less likely. A screening BP to assess for evidence of hypertension which may allude to a left adrenal pheochromocytoma +/- full adrenal workup if clinical signs consistent with Cushing's syndrome are present is recommended. Sonographic monitoring of the nodule for evidence of progression with initial recheck in 4-6 weeks would be ideal.



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Assuming normal clotting status, using a 25ga needle, screening splenic FNA cytology could be considered primarily to ensure probable benign changes are present if evidence of weight loss, although splenic neoplastic criteria is thought less likely.

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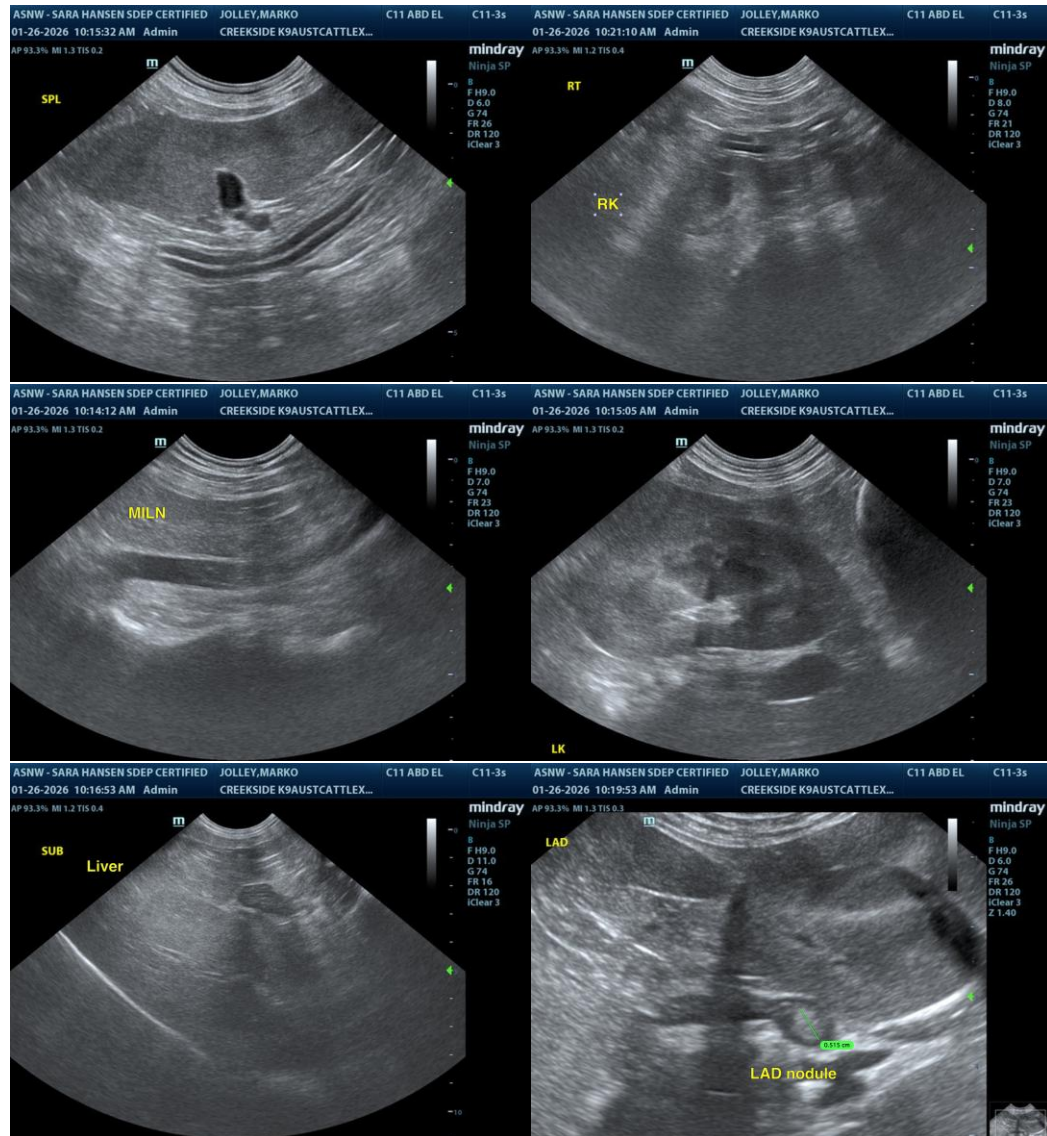
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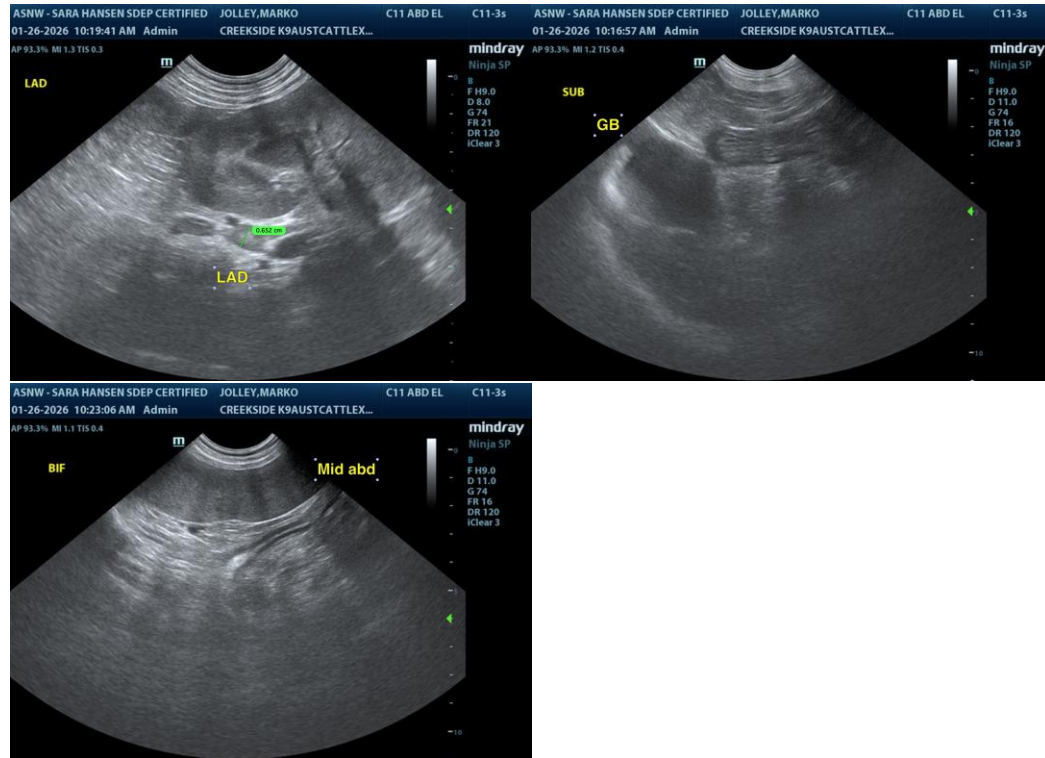
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com