



## PATIENT

Mayzie Jones

## SPECIES

Canine

## BREED

Boxer

## SEX

Female Spayed

## AGE

12y

## WEIGHT

26.6 kgs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Patti Mayfield, DVM

## HOSPITAL NAME

Ridegview VC

## REFERRING VET

Caelli Edmonds, DVM

## INVOICE

13292

## DATE

3/17/26

## PRESENTING CLINICAL SIGNS

History:

- Persistent proteinuria (UPC 1.1 on 2 occasions)
- Isosthenuria (USG ~1.006–1.009)
- History of systemic hypertension (currently controlled)
- Recent mast cell tumor removal (low grade, clean margins)
- Clinically stable with no systemic illness
- No known recent tick exposure (prior screen negative)
- Medications / treatments: Benazepril (for hypertension and proteinuria), Carprofe (Rimadyl), Adequan injections, DES (for urinary incontinence), Supplements (omega-3s, musculoskeletal support, Zypan)
- Recent perioperative meds: gabapentin, trazodone, Cerenia
- Blood pressure monitoring (well controlled)
- Histopathology of MCT (low grade, complete margins)

Abnormal PE/Chem/CBC/UA Results: Physical exam: - Generally bright, alert, stable; Overweight (BCS ~6/9) - Chronic findings: Right stifle osteoarthritis (crepitus, enlargement); Gingival hyperplasia; Multiple cutaneous masses (recent MCT removed); No abdominal pain or palpable masses Urinalysis / UPC: - UPC: 1.1 (persistent, abnormal) - Protein: 1+ - USG: 1.006–1.009 (isosthenuric) - Inactive sediment (no WBC, RBC, bacteria) Bloodwork: - Albumin: mildly low (2.6 g/dL) - ALP: elevated (540 U/L) - ALT: normal - BUN, creatinine, SDMA: within normal limits - Electrolytes: within normal limits - CBC: unremarkable Other diagnostics: - Blood pressure: previously hypertensive, now controlled on benazepril Histopathology: - Low-grade mast cell tumor, clean margins - Prior fecal/tick screening: negative Echo: NSF

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was 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 7.0 cm in length. The right kidney measured 7.3 cm in length.

### Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.54 cm width at the caudal pole. The right adrenal gland exhibited asymmetrical non-homogeneous mass measuring 5.4 cm x 4.1 cm. No overt evidence of mass mineralization. Potential for vascular invasion not definitively excluded.



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## Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Solitary, small, well-defined, symmetrical, hyperechoic nodule mid spleen were present measuring 0.65 cm in diameter. 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. Acute to chronic inflammatory or neoplastic changes were not noted. The hyperechoic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

## Liver

The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild, non-organized, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

## 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 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 overt lymphadenopathy or peritoneal effusion was present.

## PRIMARY FINDINGS

- Right adrenal mass
- Normal left adrenal gland
- Nonspecific mild chronic renal changes
- Hepatopathy
- Mild gallbladder debris (non-mucocele)

## SECONDARY FINDINGS

- Small, hyperechoic splenic nodule – most consistent with benign criteria, i.e. myelolipoma



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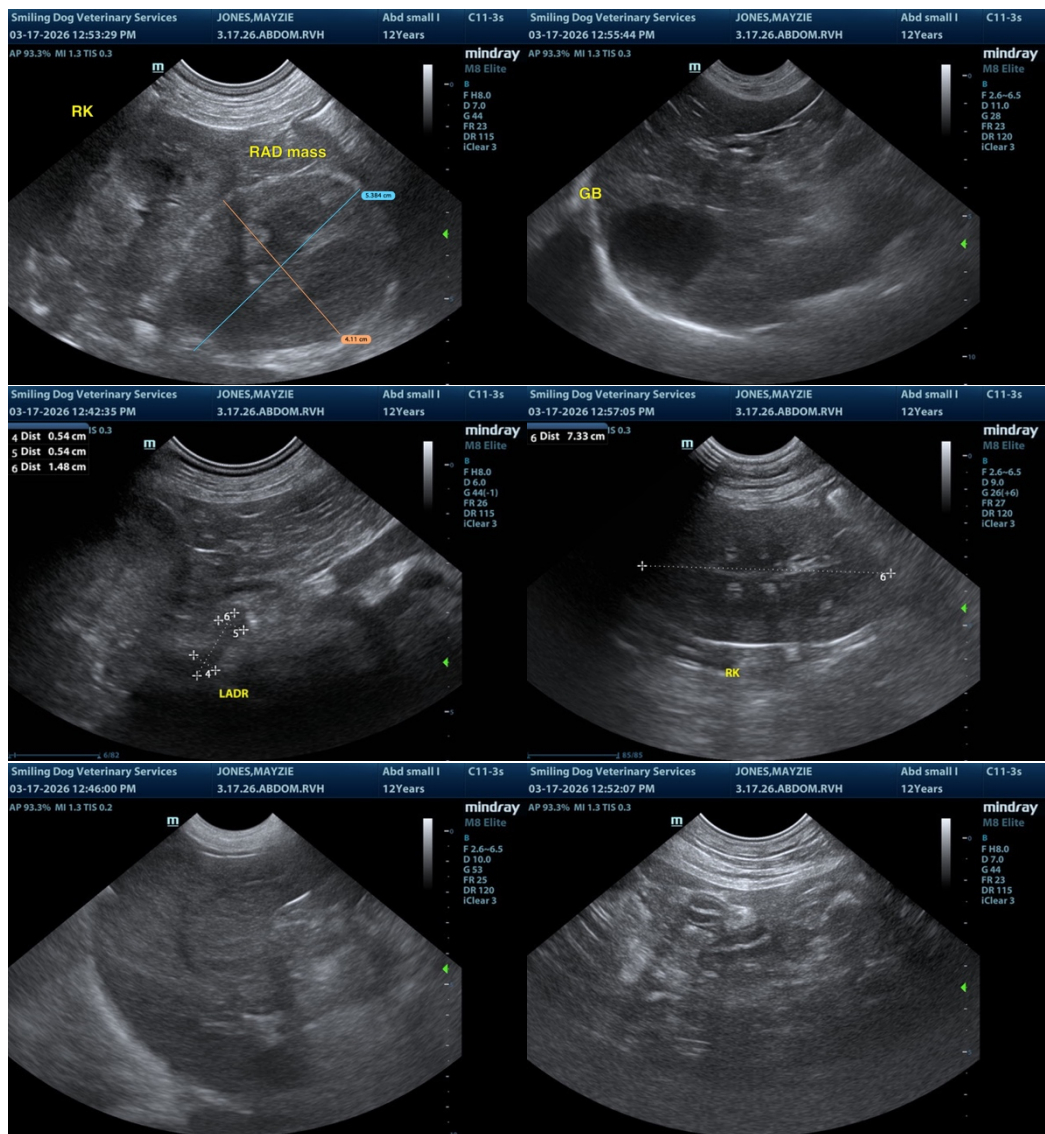
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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The right adrenal mass is certainly consistent with neoplastic criteria, i.e. carcinoma, pheochromocytoma or other. Pheochromocytoma favored given historical hypertension. Correlation with urine metanephrine level is recommended. Adrenal workup with LDDST warranted if clinical signs consistent with Cushing's Syndrome. Abdominal CT would be ideal for further assessment and surgical planning if surgery is a potential. Serial monitoring of UPC level is recommended. Hepato-supportive medications may be beneficial.





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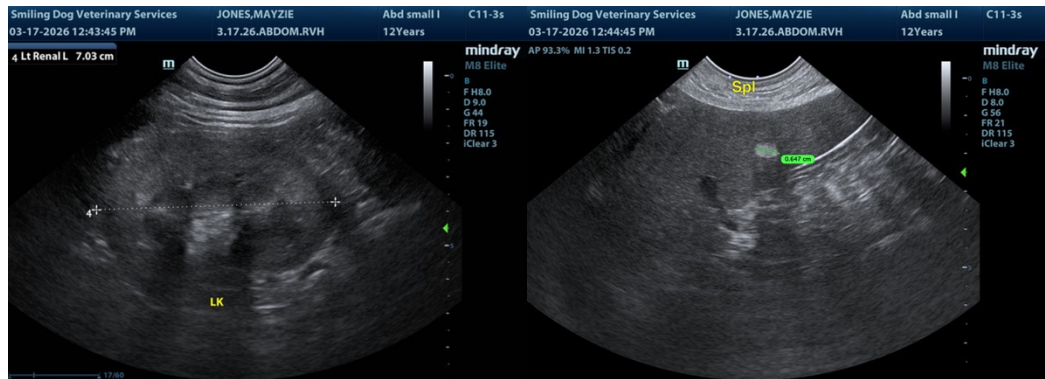
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@sonopath.com)