



PATIENT

Mika Crosson

SPECIES

Canine

BREED

Australian Cattle Mix

SEX

Spayed female

AGE

11 years

WEIGHT

40.2 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Dana Kraeutler, CVT

HOSPITAL NAME

Pocono Peak VC

REFERRING VET

Dr. Santore

INVOICE

70360

DATE

1/21/26

PRESENTING CLINICAL SIGNS

History of increasing hepatic values, pt clinically doing well per owner.

1/13/26: ALT: 363, ALP:1678, GGT:23, BIL (conjugated): 0.1, CHOL:370, PLT:583

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is poorly distended. The bladder wall appears thickened and mildly irregular, most notably at the cranial aspect; however, due to underdistension, wall thickness may be overestimated and cannot be reliably assessed. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no definitive ultrasonographic evidence of inflammatory or neoplastic changes.

Left kidney: Normal in shape and size, measuring 6.20×3.11 cm, with cortical thickness of 0.59 cm in the sagittal plane. Renal cortical echogenicity is normal. A small cortical cyst measuring 4.20×4.28 mm is present. The corticomedullary ratio and definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are identified. Color Doppler evaluation demonstrates a normal perfusion pattern.

Right kidney: Normal in shape and size, measuring 6.71×3.54 cm, with cortical thickness of 0.65 cm in the sagittal plane. The renal cortex is isoechogenic relative to the liver. The corticomedullary ratio and definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are identified. Color Doppler evaluation demonstrates a normal perfusion pattern.

Adrenal Glands

Both adrenal glands are normal in shape and echogenicity. The left adrenal gland measures 0.75 cm at the cranial pole and 0.80 cm at the caudal pole. The right adrenal gland measures 0.73 cm at the cranial pole and 0.79 cm at the caudal pole.

Spleen

Splenic thickness measures 1.90 cm. The splenic parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The majority of the liver is subjectively normal in size, with sharp margins and a regular contour, and the hepatic parenchyma appears uniform and isoechoic relative to the falciform fat.

However, a very large heterogeneous hepatic mass, measuring at least 11×6.6 cm, is identified. The mass has irregular, invasive margins and demonstrates exophytic caudoventral growth, with parenchymal and vascular continuity with the liver, suggesting hepatic origin. The exact lobe of origin cannot be confidently determined due to the size of the lesion and associated mass effect, although involvement of the caudate lobe is suspected. The mass is in close association with the portal vein and



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caudal vena cava, which appear mildly displaced. The lesion shows multifocal anechoic areas likely representing necrosis and is internally vascularized. It extends toward the left abdomen, displacing intestinal loops caudally, and cranially contacts the distal esophagus and the cranial aspect of the right pancreatic lobe.

The gallbladder is normally distended. The wall is thin, and the contents are primarily anechoic with a very small amount of biliary sludge. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal

Stomach: Empty and folded, with mural thickness of 4.02 mm and preserved wall layering.

Duodenum: Wall thickness 4.34 mm, with a mildly corrugated appearance and fluid-filled lumen.

Jejunum: Wall thickness ranges from 2.79–3.37 mm, with preserved wall layering.

No ultrasonographic evidence of obstruction, ileus, or active inflammation is identified.

Colon: Transverse colon wall thickness 1.90 mm, with formed feces in the descending colon.

Pancreas

The pancreas appears subjectively normal. The right pancreatic lobe is in contact with the hepatic mass at one point, though this appears to represent contact rather than direct invasion.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed. No definitively abnormal abdominal lymph nodes are identified; however, lymphadenopathy cannot be entirely excluded given the size of the hepatic mass and regional distortion. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Large hepatic mass with irregular, invasive margins and exophytic caudoventral growth.

SECONDARY FINDINGS

- Small left renal cortical cyst (incidental).
- Poorly distended urinary bladder limiting wall assessment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This abdominal ultrasound identifies a very large, invasive hepatic mass with exophytic growth, vascular continuity with the liver, and significant mass effect on adjacent structures, including the portal vein, caudal vena cava, gastrointestinal tract, and pancreas. These features are highly suggestive of a primary hepatic neoplasm.



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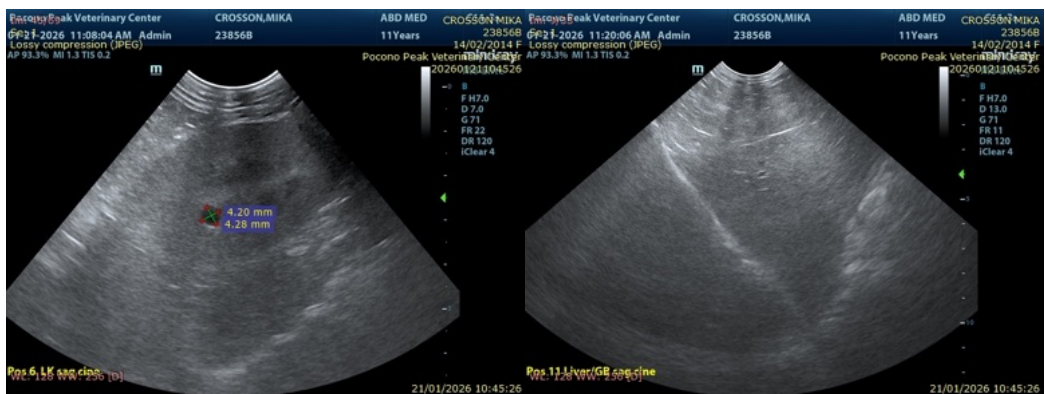
Given the patient's markedly elevated cholestatic enzymes with normal bilirubin, and the absence of ultrasonographic evidence of biliary obstruction, this lesion most likely represents a primary hepatic tumor causing functional cholestasis and enzyme induction, rather than obstructive cholestasis. Differential diagnoses include hepatocellular carcinoma, cholangiocarcinoma, and less likely other primary hepatic malignancies.

Despite the extensive size of the lesion, the patient is reportedly clinically well, which is not uncommon in dogs with slowly progressive primary hepatic tumors.

The remainder of the liver appears ultrasonographically unremarkable, highlighting the known limitation of imaging in detecting microscopic hepatic infiltration or diffuse parenchymal disease.

Recommendations

- Await results of the pending hepatic cytology.
- If surgical intervention is being considered, contrast-enhanced CT is recommended for staging and assessment of vascular involvement and surgical feasibility.
- Thoracic imaging is advised to complete staging and assist in therapeutic decision-making.





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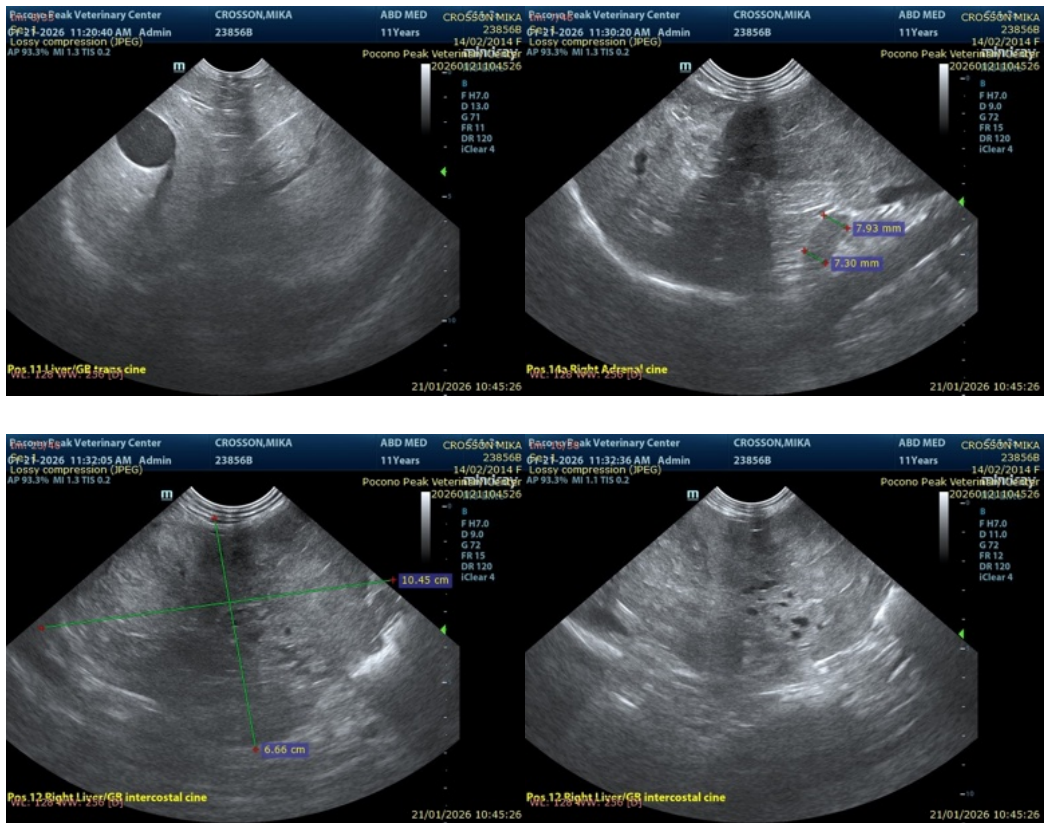
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

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