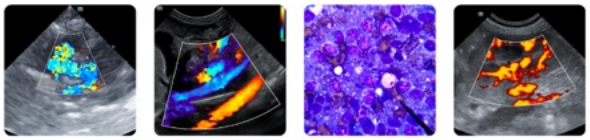


PATIENT

Ziva Alexis Stricker

SPECIES

Canine

BREED

Boxer

SEX

Spayed female

AGE

13 years

WEIGHT

67 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Christina Wagneer

HOSPITAL NAME

Angeles Clinic for Animals

REFERRING VET

Dr. Zuber

INVOICE

69900

DATE

1/6/26

PRESENTING CLINICAL SIGNS

History: Suspected soft tissue sarcoma right front leg. Screening ultrasound prior to referral for surgery. Owner reports increased thirst; recent weight loss (4 lbs over 5 months)
Abnormal PE/Chem/CBC/UA Results: Hematology: - L WBC 5.3 (5.8-16.2, prev 6.7) - L/N Lymphocytes 0.938 (0.98-4.2, prev 0.73) - Otherwise NSF Chemistry: - H K+ 5.5 (4.0-5.4, prev 5.3) - H ALP 725 (5-160, prev 414) Normal T4 1.2

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is very distended. The bladder wall appears thin and smooth. The urine is mildly turbid with scant suspended echoes. Normal appearance of the bladder neck and proximal urethra. There is no evidence of urolithiasis, cystitis, or intraluminal mass.

Left kidney: Normal size and shape (5.67×3.05 cm). Cortical thickness 0.48 cm. The cortex is isoechoic relative to the liver. Normal corticomedullary ratio and definition. No pyelectasia, nephroliths, or hydronephrosis. Normal Doppler flow pattern.

Right kidney: Normal size and shape (5.83×3.24 cm). Cortical thickness 0.55 cm. The cortex is isoechoic relative to the liver. Normal corticomedullary ratio and definition. No pyelectasia, nephroliths, or hydronephrosis. Normal Doppler flow pattern.

Adrenal Glands

Both adrenal glands have normal shape and echogenicity. Left adrenal gland: 0.70 cm (cranial pole) × 0.72 cm (caudal pole). Right adrenal gland: not fully measured in the provided images.

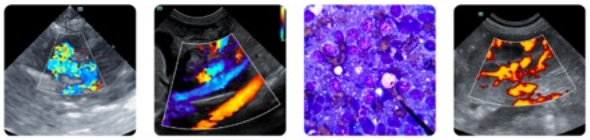
Spleen

Splenic thickness measures 2.75 cm. The spleen has mildly rounded margins and a diffusely coarse echotexture without discrete nodules or mass lesions. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. Hepatic parenchyma is homogeneous and isoechoic relative to falciform fat. No focal hepatic lesions or hepatic lymphadenopathy are identified.

The gallbladder is normally distended. The wall is thin. A small amount of biliary sludge is present, along with a small, more mineralized and organized focus (approximately 0.60×0.97 cm), compatible with an evolving cholelith. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded, with normal mural thickness (2.97 mm) and preserved wall layering.

Duodenum: 2.68 mm. Jejunum: 4.43 mm. Normal wall layering is preserved throughout. No evidence of gastrointestinal inflamation, ileus, or focal inflammatory changes is identified.

Colon measures 0.70 mm and contains formed feces.

Pancreas

The pancreas was not clearly visualized. The regions evaluated do not demonstrate sonographic evidence of pancreatitis.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Abdominal lymph nodes are not visualized, and surrounding regions appear unremarkable. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Mild diffuse splenomegaly with mildly rounded margins and diffusely coarse echotexture, without discrete nodules or mass lesions.
- Mild biliary sludge with a small, organized, partially mineralized intraluminal focus consistent with an early or developing cholelith, without evidence of biliary obstruction.

SECONDARY FINDINGS

- Mildly turbid urine with scant suspended echoes, without sonographic evidence of cystitis, urolithiasis, or intraluminal mass.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography does not identify evidence of metastatic abdominal disease in this patient with a suspected soft tissue sarcoma of the right forelimb.

The mild splenic enlargement with rounded margins and coarse echotexture, in the absence of discrete nodules or masses, is most consistent with benign diffuse splenic processes such as reactive splenic hyperplasia, age-related change, or extramedullary hematopoiesis. While these findings are not typical of metastatic disease and are unlikely related to the suspected peripheral soft tissue sarcoma, diffuse infiltrative splenic disease cannot be completely excluded on the basis of ultrasonography alone, as sonographic patterns may overlap.

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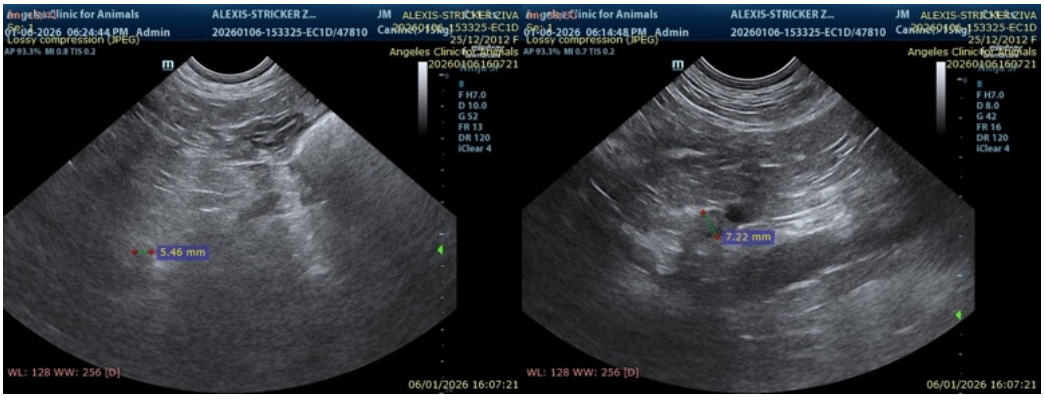
The gallbladder contains a small amount of biliary sludge and a focal, mineralized intraluminal structure consistent with an early cholelith or organized biliary sediment. There is no gallbladder wall thickening, no biliary ductal dilation, and no sonographic evidence of extrahepatic biliary obstruction. The marked elevation in ALP, in the absence of sonographic hepatobiliary disease, is most consistent with enzyme induction (steroid-induced, stress-related, or age-related isoenzyme expression) rather than primary hepatic pathology, though early or functional hepatic disease cannot be excluded by ultrasound alone.

Overall, the abdominal ultrasound findings do not explain the patient's weight loss or polydipsia and do not reveal a contraindication to proceeding with surgical management of the suspected peripheral soft tissue sarcoma.

Recommendations

- Thoracic radiographs are recommended as part of routine metastatic screening prior to surgical management of the suspected soft tissue sarcoma, as pulmonary metastasis cannot be assessed via abdominal ultrasound.
- Proceed with planned surgical management of the limb mass, as no abdominal metastatic disease or surgical contraindications are identified on ultrasound.
- Correlation with endocrine testing may be considered if clinically indicated, given the history of polydipsia, weight loss, and markedly elevated ALP (screening for hyperadrenocorticism), at the discretion of the attending clinician.
- Routine monitoring of hepatobiliary enzymes is recommended. If ALP continues to rise or additional liver enzyme abnormalities develop, further diagnostics (bile acids testing or repeat imaging) may be considered.



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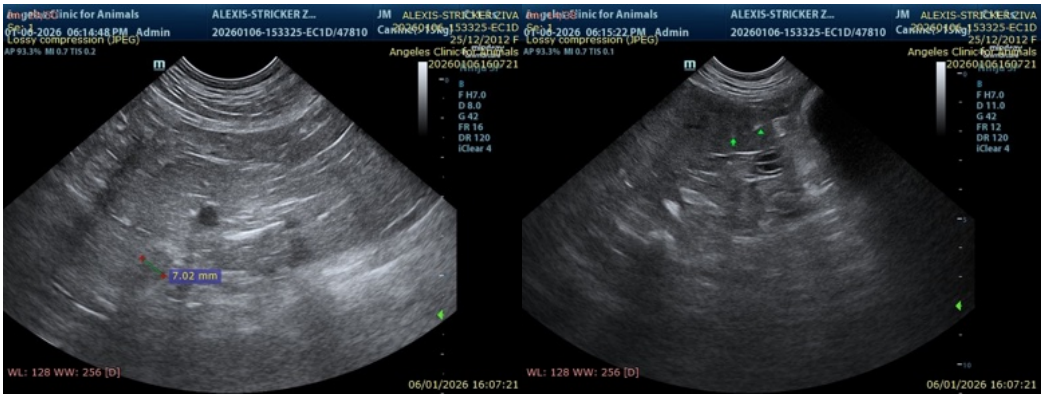

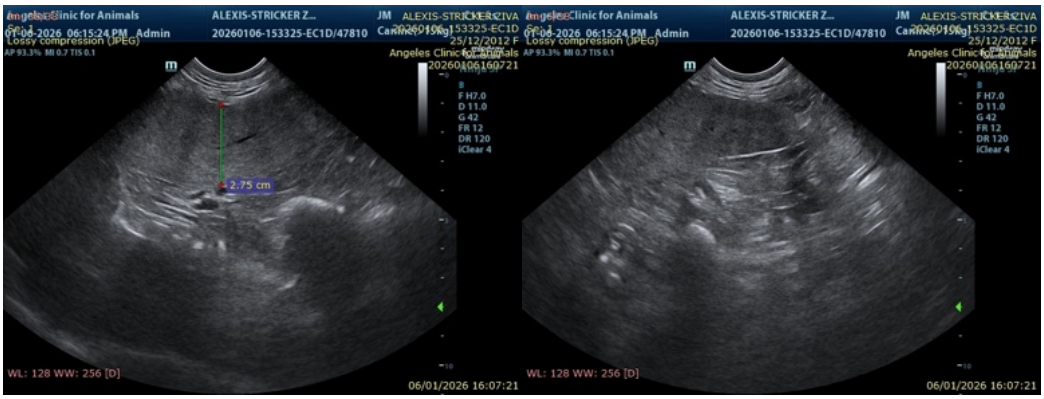

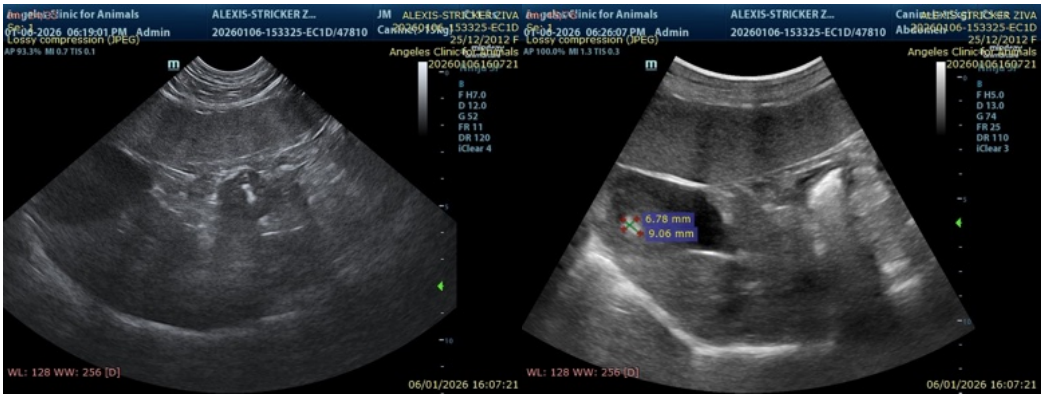

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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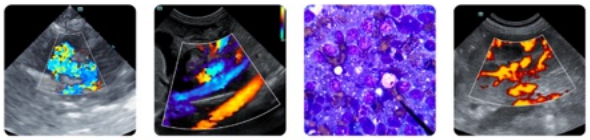

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