



PATIENT

Pippa Robash

SPECIES

Canine

BREED

Jack Russel Terrier

SEX

Spayed female

AGE

13 years

WEIGHT

14.9 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Kimberly Morgan

HOSPITAL NAME

Seven Fields VH

REFERRING VET

Dr. Morgan

INVOICE

69487

DATE

12/10/25

PRESENTING CLINICAL SIGNS

History: Decreased appetite for few weeks, chemistry is normal
Abnormal PE/Chem/CBC/UA Results: Mid abdominal pain

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the proximal urethra and vesicoureteral junction. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.85 × 2.60 cm, and the thickness of the cortex is 0.41 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. The right kidney is normal in shape and size: 4.28 × 2.36 cm, and the thickness of the cortex is 0.40 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

Adrenal Glands

The left adrenal gland measures 0.45 cm at the cranial pole and 0.47 cm at the caudal pole. The right adrenal gland was not as clearly visualized as the left; only a small portion measuring 0.50 cm was seen.

Spleen

Splenic thickness is 1.36 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture except for a few small incidental hyperechoic foci (3 mm) that appear to represent myelolipomas or Bates bodies. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and is isoechoic compared to the falciform fat, with a normal echotexture. It contains several hypoechoic and hyperechoic foci, the largest measuring 1.3 x 1.6 cm. In the region of the hepatic hilus, between the liver and the pylorus, there is a 3.7 x 2.7 cm mass, markedly hypoechoic, irregular, without defined margins, and containing several small anechoic areas suggestive of necrosis. It is unclear whether this represents a hepatic lymph node or a mass directly connected to the hepatic parenchyma (more likely).

The gallbladder lumen is normally distended. The wall is thin, and the contents are primarily anechoic. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded, with mural thickness (2.16 mm) and preserved wall layering. The pylorus measures 3.77 mm. The duodenum measures 3.44 mm. The jejunum measures 2.63 mm. Arising from one of the jejunal segments, there is a large mass extending at least 3×4 cm, with markedly irregular borders and a highly invasive appearance. It is markedly hypoechoic and causes complete destruction of the wall and invasion of adjacent tissues. No signs of intestinal obstruction are identified.

The colon: transverse 0.97 mm, fairly empty. Descending colon 1.02 cm with few fecal material.

Pancreas

No definitive images of the pancreas were obtained; however, given the affected region of the liver - between the liver and the pylorus- pancreatic origin cannot be entirely excluded. No free fluid or peripancreatic fat reaction is seen.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes are not visualized. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Large infiltrative jejunal mass with complete loss of wall layering and extension into surrounding tissues.
- Large irregular hypoechoic mass in the hepatic hilus with central necrotic areas and ill-defined margins.
- Several hepatic nodules.

SECONDARY FINDINGS

- Small splenic hyperechoic foci consistent with incidental myelolipomas/Bates bodies.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

In the jejunum, a large highly invasive heterogeneous mass replaces the normal intestinal wall architecture. Layering is completely lost, the margins are irregular, and the mass appears to extend beyond the serosa into surrounding tissues. These features are hallmarks of an aggressive intestinal neoplasm. Of the potential differentials, intestinal adenocarcinoma remains the leading consideration, given its typically infiltrative nature and high metastatic rate. High-grade lymphoma, GIST, or other sarcomas remain possible but less likely based on the ultrasonographic appearance. No overt intestinal obstruction is seen, which is expected in masses that invade rather than occlude the lumen.



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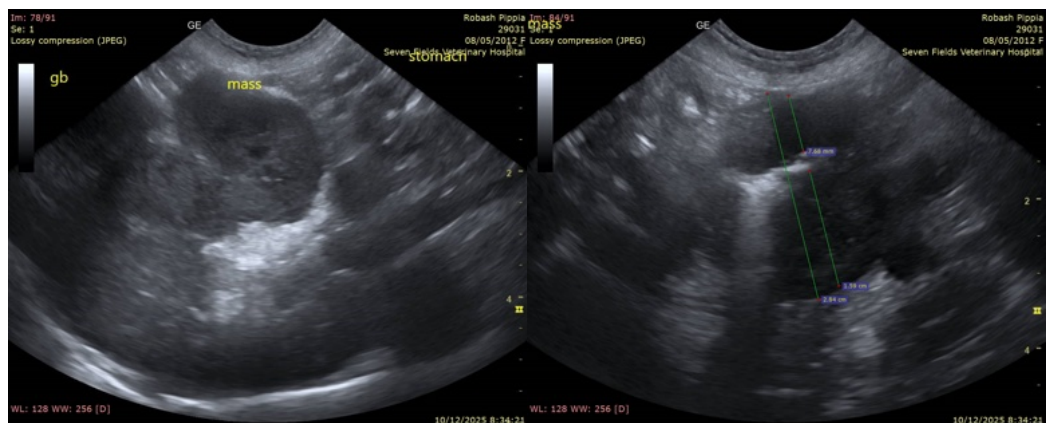
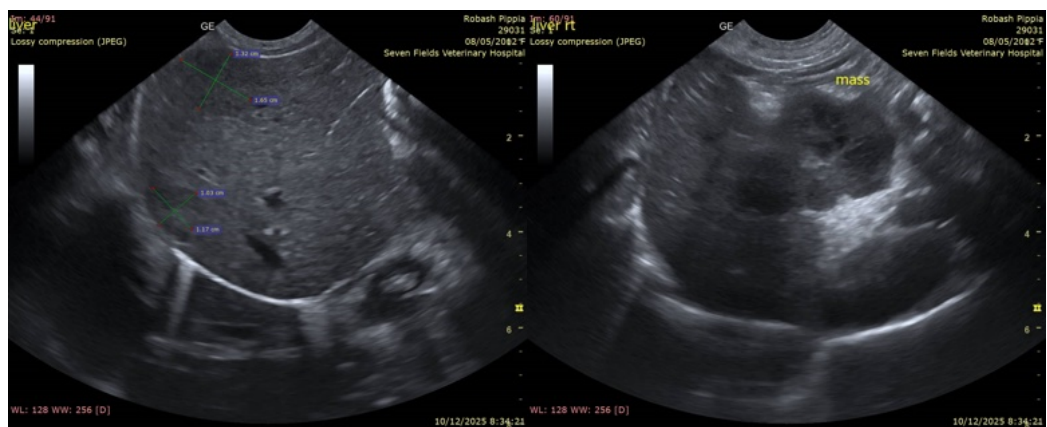
A large, irregular, markedly hypoechoic mass with central necrotic areas is present in the region of the hepatic hilus between the liver and the pylorus. This lesion appears infiltrative and inseparable from adjacent structures. While the exact organ of origin cannot be confirmed ultrasonographically, its behavior is most consistent with secondary extension from an intestinal primary tumor (intestinal adenocarcinoma or high-grade lymphoma). The coexistence of discrete hepatic nodules raises significant concern for metastatic disease. The absence of abdominal effusion does not reduce suspicion for malignancy, as many carcinomas and lymphomas do not generate fluid until later stages.

The liver contains several nodules. Although they do not display a classic 'target' or appearance, the concurrent presence of multiple abdominal masses raise concern for hepatic metastases.

The spleen contains only small, incidental hyperechoic foci consistent with myelolipomas or Bate's bodies.

Recommendations

- Fine-needle aspiration or core biopsy of the jejunal mass, a hepatic nodule, and the hilar mass (if safely accessible), to achieve a definitive diagnosis and determine tumor origin.
- Thoracic radiographs or CT to assess for pulmonary metastasis and help with staging.
- Abdominal CT with contrast (if available) for surgical planning, evaluation of organ of origin, and assessment of the full extent of invasion.





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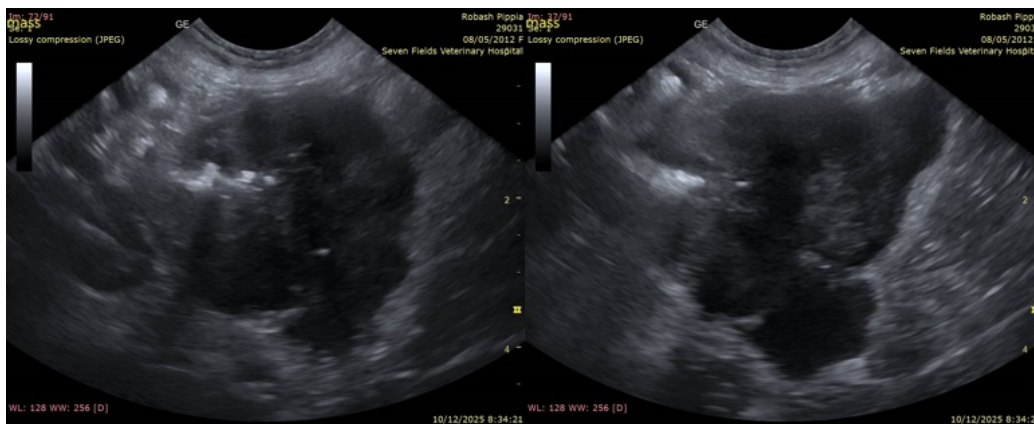
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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