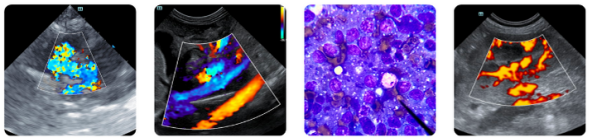


PATIENT

Hailey Groening

SPECIES

Canine

BREED

Shar Pei

SEX

Spayed female

AGE

13 years

WEIGHT

29.1 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Western New York VS

REFERRING VET

Bryce Hauschildt, DVM

INVOICE

74829

DATE

4/24/26

PRESENTING CLINICAL SIGNS

CLINICAL SIGNS: decreased appetite and significant weight loss
MEDICATIONS: Prednisone 5mg- 1/2 tablet once a day
April 15, 2026 CBC RBC 5.55 (5.65 - 8.87 M/µL) LOW HCT 34.7 (37.3 - 61.7 %) LOW HGB 12.3 (13.1 - 20.5 g/dL) LOW EOS 0.01 (0.06 - 1.23 K/µL) LOW PLT 520 (148 - 484 K/µL) HIGH PDW 5.2 (9.1 - 19.4 fL) LOW PCT 0.49 (0.14 - 0.46 %) HIGH Blood Chem: ALT 450 (10 - 125 U/L) HIGH GGT 498 (0 - 11 U/L) HIGH

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. The luminal contents are anechoic. Multiple small polypoid structures are noted protruding into the bladder lumen. The bladder neck and proximal urethra appear normal. No uroliths are identified.

The left kidney measures 5.96 × 2.91 cm, with a cortical thickness of 0.48 cm in the sagittal plane. The right kidney measures 5.30 × 3.20 cm, with a cortical thickness of 0.52 cm. Both kidneys are normal in shape and size for a dog of this size. The cortex is isoechoic relative to the liver. The corticomedullary ratio is preserved, and corticomedullary definition is maintained. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Doppler color demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.59 cm at the cranial pole and 0.60 cm at the caudal pole. The right adrenal gland measures 0.51 cm at the cranial pole and 0.57 cm at the caudal pole.

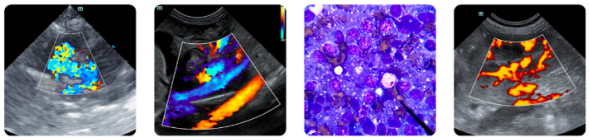
Spleen

Splenic thickness is 1.30 cm, within normal limits. A well-defined, homogeneous hypoechoic nodule measuring approximately 1.05 × 1.21 cm is identified at the cranial margin of the ventral extremity of the spleen. The remaining splenic parenchyma is unremarkable.

Liver

A large, solid hepatic mass measuring approximately 7.06 × 6.77 cm (at least ~8 cm in maximal dimension) is identified, most likely arising from the left medial liver lobe. The mass appears relatively well-defined. The remaining hepatic parenchyma is subjectively normal in size, with sharp margins and a regular contour, and shows a homogeneous echotexture. No hepatic lymphadenopathy is identified.

The gallbladder is moderately distended. The wall shows mucosal hyperplasia. The contents are predominantly anechoic with a small amount of biliary sludge. No biliary ductal dilation is identified.



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Gastrointestinal

The stomach is empty and folded, with a mural thickness of 2.03 mm and preserved wall layering (within normal limits). The pylorus measures 5.33 mm. Duodenum: 3.81 mm. Jejunum: 3.44–3.97 mm. Wall layering is preserved throughout. No ultrasonographic evidence of inflammation, ileus, or foreign material is identified. Colon wall thickness ranges from 0.84–1.18 mm, within normal limits, with formed feces present.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Large hepatic mass (~7–8 cm), likely arising from the left medial liver lobe

SECONDARY FINDINGS

- Small, well-defined hypoechoic splenic nodule
- Multiple polypoid lesions within the urinary bladder lumen
- Gallbladder mucosal hyperplasia with mild biliary sludge

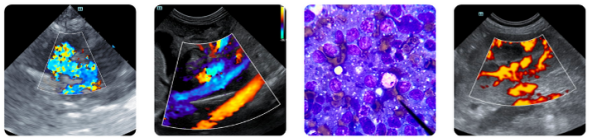
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This study identifies a large hepatic mass, which is the most clinically significant finding and likely explains the patient's weight loss, decreased appetite, and marked elevation in liver enzymes (including severe GGT elevation).
Given the size of the lesion and the associated clinical and biochemical abnormalities, a neoplastic process is strongly suspected. Differential diagnoses for a solitary large hepatic mass include primary hepatic neoplasia (hepatocellular carcinoma) and biliary carcinoma.

A small splenic nodule is also identified. In isolation, this could represent benign processes such as nodular hyperplasia or extramedullary hematopoiesis; however, metastatic disease cannot be excluded, particularly in the context of a primary hepatic mass.

The gallbladder mucosal hyperplasia and mild sludge are likely incidental or secondary findings and do not explain the clinical picture.

The polypoid bladder lesions are most consistent with polypoid cystitis, although these are considered incidental relative to the primary hepatic findings.



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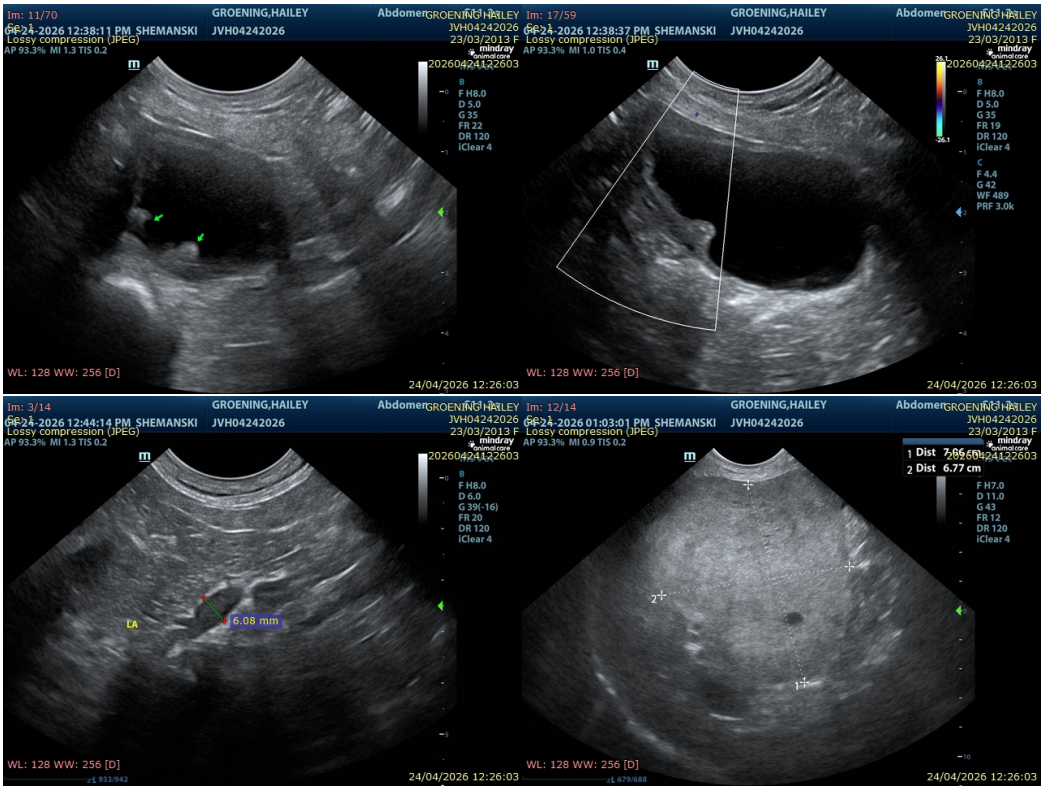
Overall, this examination supports a diagnosis of clinically significant hepatic mass lesion with high suspicion for neoplasia, with possible but unconfirmed metastatic involvement.

Recommendations

- Ultrasound-guided fine-needle aspiration of the hepatic mass has already been performed; correlation with pending cytologic results is recommended for definitive diagnosis and to guide further management.
- Cytologic evaluation of the splenic nodule may be considered, depending on clinical decision-making.
- Thoracic imaging is recommended for staging.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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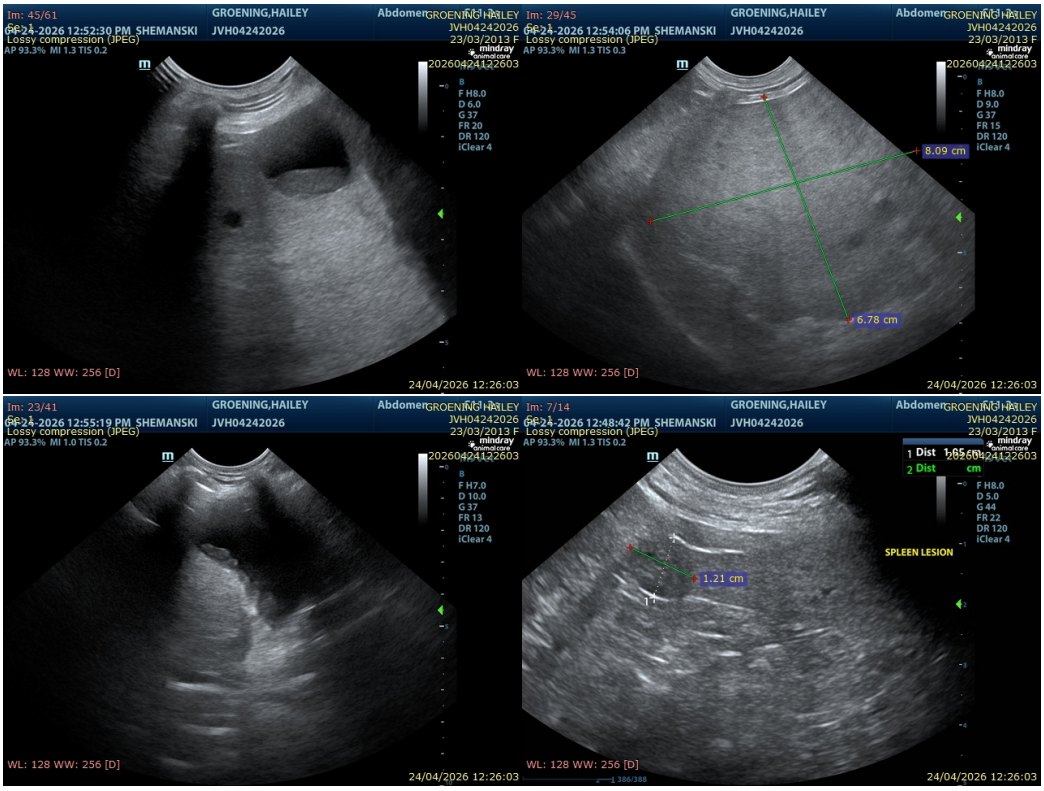

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com