



PATIENT

Cinder Roberts

SPECIES

Canine

BREED

GSD

SEX

Spayed Female

AGE

6 Years

WEIGHT

31.8 kg

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Lindsay Powell CVT

HOSPITAL NAME

Hershey Animal
Emergency Center

REFERRING VET

Dr. Brittany Lang

INVOICE

16104

DATE

05/12/26

PRESENTING CLINICAL SIGNS

Cinder presented to HAEC on 5/12/26 at 2am for an acute collapse episode. On physical examination, she was tense on cranial abdominal palpation, and no obvious fluid wave/distension was appreciated. PE: Oral Cavity: Mucous membranes pale pink/tacky. Cardiovascular: mild tachycardia. Abdominal: tense on cranial abdominal palpation, unable to palpate deep, no fluid wave/distension appreciated. Integument: small dermal growth dorsal head, approximately 0.5cm, alopecic. Musculoskeletal: bilateral vestigial hind dewclaws

CBC: HCT 36.6 (L), WBC 20.26 (H), Neutrophils 17.05 (H), Monocytes 1.92 (H), Eosinophils 0.02 (L), Platelets 83 (L), MPV 13.4 (H), Platelet crit 0.11 (L) Invue: Platelets 50-100k (moderately decreased) Chem: TP 5.1 (L), Albumin 2.2 (L), ALT 132 (H), Cholesterol 97 (L) EPOC: pCO2 25.7, TCO2 16.8, BE - 6.5 Rads - Decreased peritoneal contrast consistent with a moderate amount of peritoneal effusion of uncertain origin. Differentials for the effusion include hemoabdomen secondary to a ruptured hepatic or splenic mass (benign or malignant), transudate due to underlying nephropathy, chronic enteropathy, or portal hypertension, or uroperitoneum secondary to urinary bladder rupture. - The small cardiac silhouette and caudal vena cava may indicate dehydration or hypovolemia.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with a mild amount of suspended echogenic mobile debris. The bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure, with appropriate corticomedullary definition and cortex to medulla ratio. The cortices are uniform in texture with normal echogenic relationship to liver and spleen. The medullary structure differed distinctly from the cortex and no evidence of pyelectasis is present. The capsules are uniform without significant irregularities noted. The left kidney measures 6.69 cm. The right kidney measures 6.87 cm.

Adrenal Glands

The left adrenal gland is visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measures 0.7 cm x 2.0 cm.

The right adrenal gland is not definitively visualized. In the right hepatorenal quadrant, there's no overt evidence of an adrenal mass effect or concern for vascular invasion identified.

Spleen

The spleen is subjectively enlarged with a diffusely heterogeneous parenchyma. There are scattered, ill-defined, hypoechoic to minimally cavitated regions throughout the parenchyma, the largest of which measures approximately 1.6 cm x 1.4 cm. The capsule is slightly swollen and rounded with no overt distortion by an identifiable mass effect. The vasculature is normal with no evidence of congestion, spontaneous contrast, or thrombosis. The spleen measures 2.0 cm at the hilus.

Liver



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The liver is similarly affected as the spleen with ill-defined, hypoechoic to partially cavitated mass lesions throughout the parenchyma. It is subjectively mildly enlarged with slightly rounded contour, and the parenchyma is diffusely heterogeneous. The vasculature is normal with no evidence of congestion.

The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

Gastrointestinal

The stomach and intestines are free of stasis and peristaltic activity, with no significant dilation noted. There is normal wall thickness and acceptable curvilinear mural detail. The pyloric-duodenal junction and ileocecolic junction are patent, and the colon contains normal shadowing feces. There is no evidence of shadowing obstructive material or overt infiltrative disease noted. No associated abnormal lymphatic activity is documented.

Pancreas

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

Free Abdomen

There is no significant lymphadenopathy. There's a moderate volume of anechoic to mildly echogenic free peritoneal effusion noted.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.
- The changes within the liver and spleen are concerning for potential metastatic neoplastic disease. There's no overt definitive mass lesion or source of the intraabdominal hemorrhage, however, given the appearance of both organs, either the liver or spleen or both is considered the most likely source of the hemorrhage.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection. Fine needle aspirates of the spleen and liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

If the hemorrhage is suspected to be active or continually progressing, an exploratory laparotomy with splenectomy and hepatic biopsies may be required. However, given the location and multicentric nature of the lesions, complete resection is considered less likely to be achievable.

Additionally, given the location of the lesions within the liver, if this is a source of hemorrhage, hemostasis may be challenging as resection may not be feasible.



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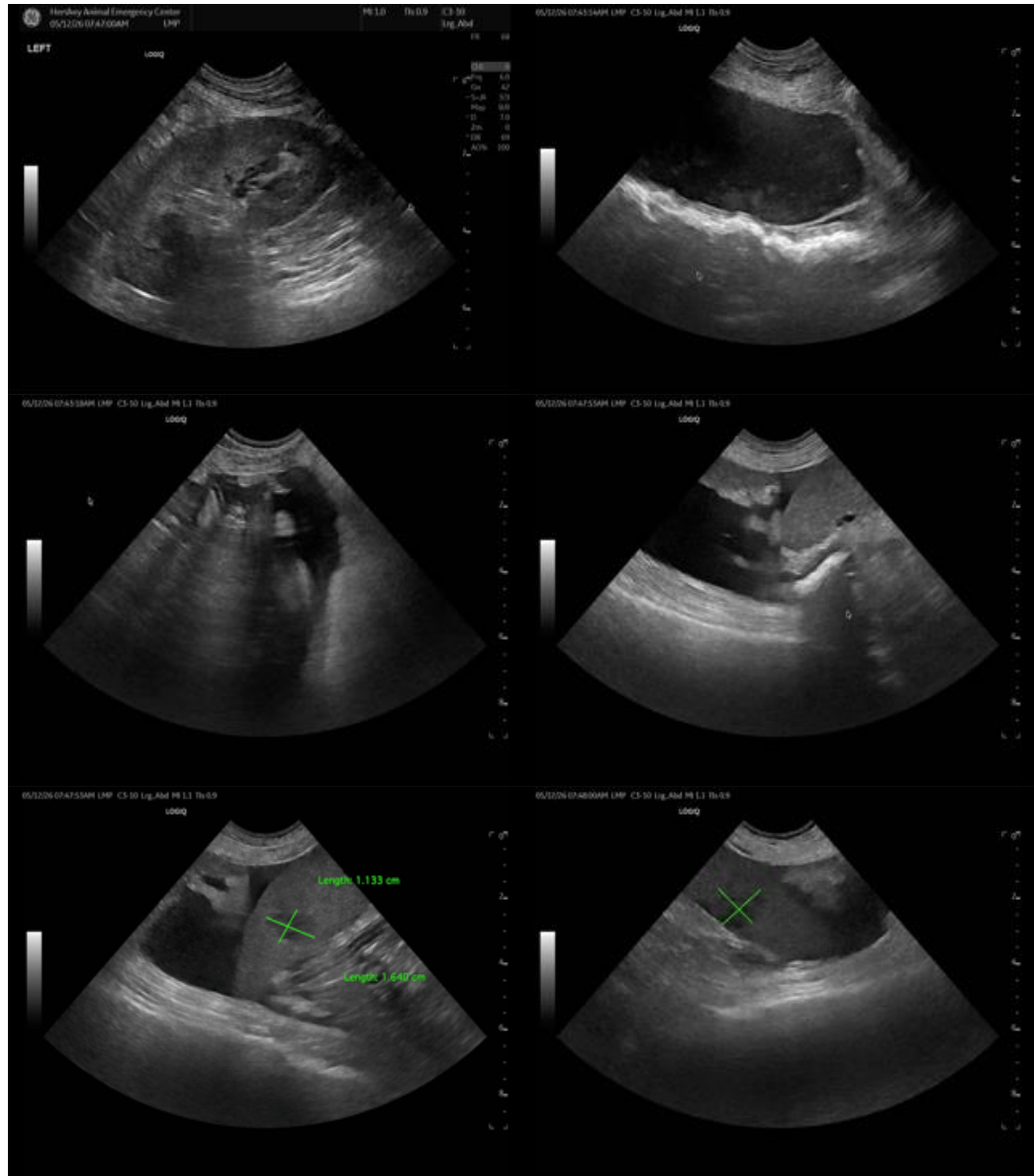
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Alternatively, an abdominal CT with angiography may be beneficial to further evaluate these lesions and assist with surgical planning.





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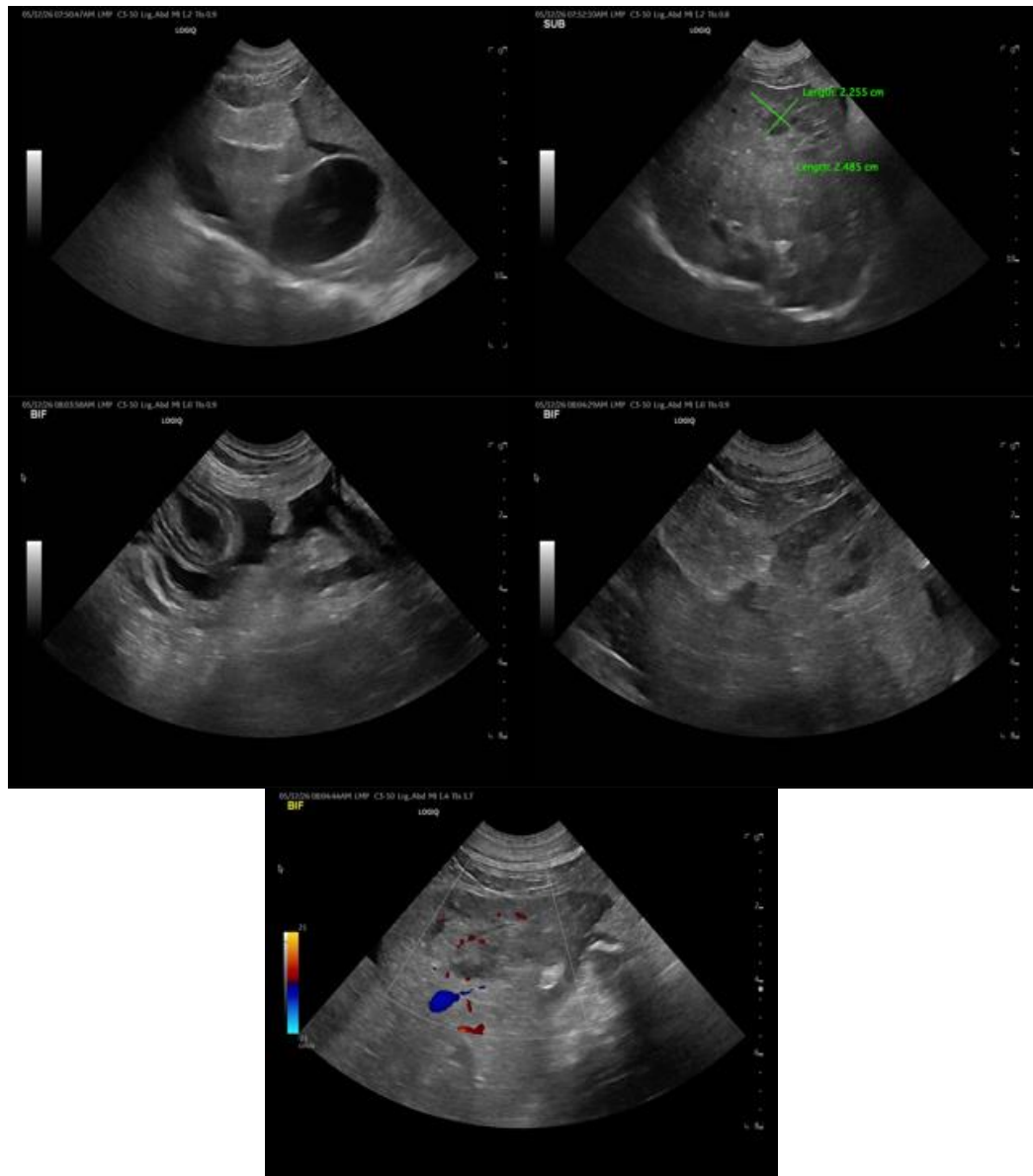
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com