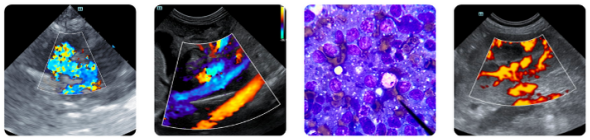


PATIENT

Allie Giannella

SPECIES

Canine

BREED

Hound Mix

SEX

FS

AGE

13 years

WEIGHT

37 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Henry

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Dr. Kristen Henry

INVOICE

11093

DATE

1/13/2026

PRESENTING CLINICAL SIGNS

Recent episode of nausea resulted in bloodwork with hypercalcemia, hepatopathy, azotemia, and pancreatic enzyme elevations. AUS recommended to further investigate.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 5.6 cm and contains several small cortical cysts. The right kidney measures 6.47 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.81 cm at cranial pole and 1.1 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.77 cm at cranial pole and 0.79 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal. Additionally, there is a small 0.4 cm x 0.6 cm hypo- to anechoic, non-capsular disrupting nodular near the caudal aspect of the spleen.

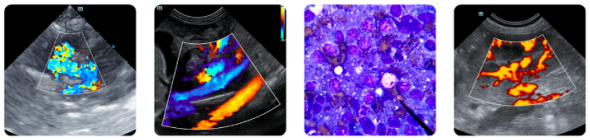
Liver

The liver contains an approximately 6.3 cm x 7.1 cm irregular, mildly heterogenous, largely hyperechoic, almost nodular appearing mass in the mid to left very caudal aspect with an almost pedunculated appearance in some views. The remaining liver is diffusely moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

Upon complete evaluation of this study, I feel relatively certain that the mass imaged in all different views is the one liver mass described above. Having said that, in some views, it appears to have a more cranial appearance almost adjacent to the gallbladder, and in one view it appears in the mid abdomen without a direct association to the liver. Therefore, while thought much less likely, a second or even third lesion can't be definitively ruled out.

PRIMARY FINDINGS

- The liver mass could represent a benign process such as nodular hyperplasia, a chronic inflammatory lesion, hepatoma/adenoma versus other. Although, infiltrative neoplasia such as round cell neoplasia i.e. lymphoma, hepatocellular carcinoma, other, can't be ruled out without tissue sampling. Especially in the face of hypercalcemia, if the hypercalcemia is a hypercalcemia of malignancy.

SECONDARY FINDINGS

- Age related kidney changes.
- Mild gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the liver mass are recommended if patient's coagulation status is appropriate.

A malignancy panel (PTH, PTHrP, iCa) to Michigan State College of Veterinary Medicine is

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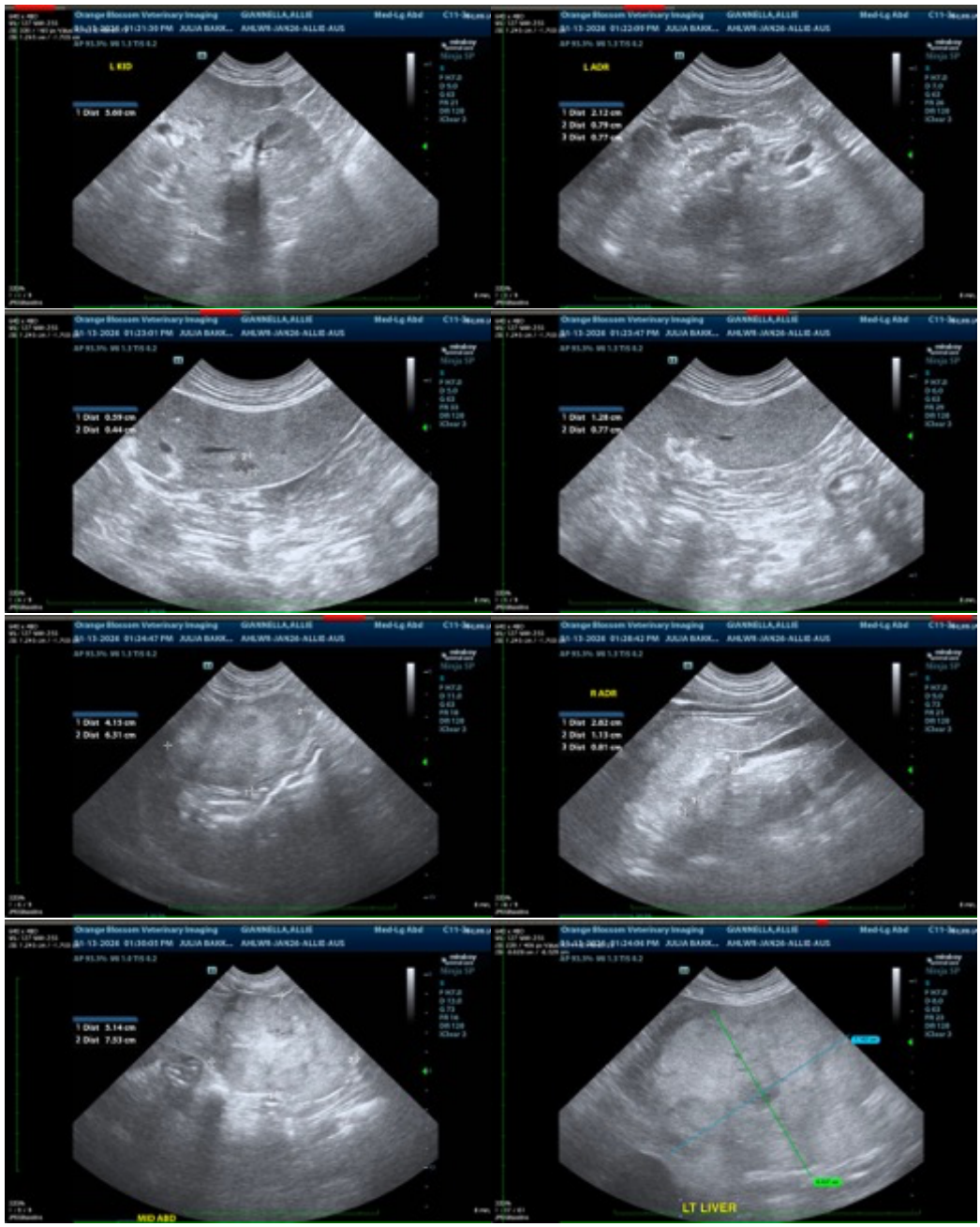
recommended for further investigation of the reported hypercalcemia.

Additionally, given the reported azotemia, if not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic treatment recommendations are largely dependent on results of the above.



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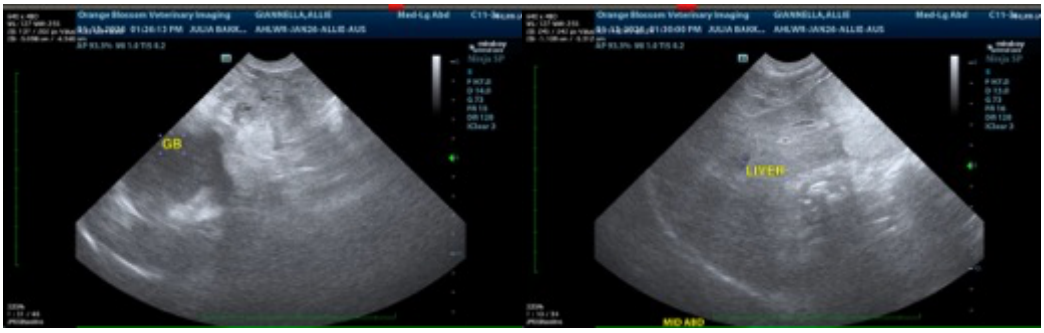

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com