

**PATIENT**

Addy Rogacki

**SPECIES**

Canine

**BREED**

Beagle

**SEX**

Spayed Female

**AGE**

11 Years

**WEIGHT**

24.4 lbs

**INTERPRETED BY**Beth Johnson, DVM  
DACVIM**IMAGING  
PERFORMED BY**

Brandi Kurzowski

**HOSPITAL NAME**

Corfu Veterinary Clinic

**REFERRING VET**

Dr. Marissa Weaver

**INVOICE**

72314

**DATE**

1/21/26

**PRESENTING CLINICAL SIGNS**

P presented 1/19/26 for lameness/lethargy. P has hx anemia that has been monitored after splenectomy. CBC shows mild anemia, had previously gotten up to 40% in July '25. Could be anemia of chronic disease/chronic inflammation, or could be related to P's hx of lymphoma (according to histopath from splenectomy). Abdominal US to screen for signs of masses/metastasis.

Abnormal PE/Chem/CBC/UA Results: 1/19/26 CBC- RBC 5.07 M/uL, HCT 33.5%, Hgb 11.9 g/dL  
Chem/lytes- K+ 3.4 mmol/L 4DX- neg 1/21/26 CBC- HCT 31.6 %, RBC 4.77 M/uL, HGB 11 g/dL

**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.

The right kidney is normal is size (4.47 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (4.45 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

**Adrenal Glands**

The areas of the adrenal glands are examined without evident adrenal gland pathology.

**Spleen**

The spleen has been previously removed.

**Liver**

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

**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.

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.



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**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.

**ULTRASONOGRAPHIC FINDINGS**

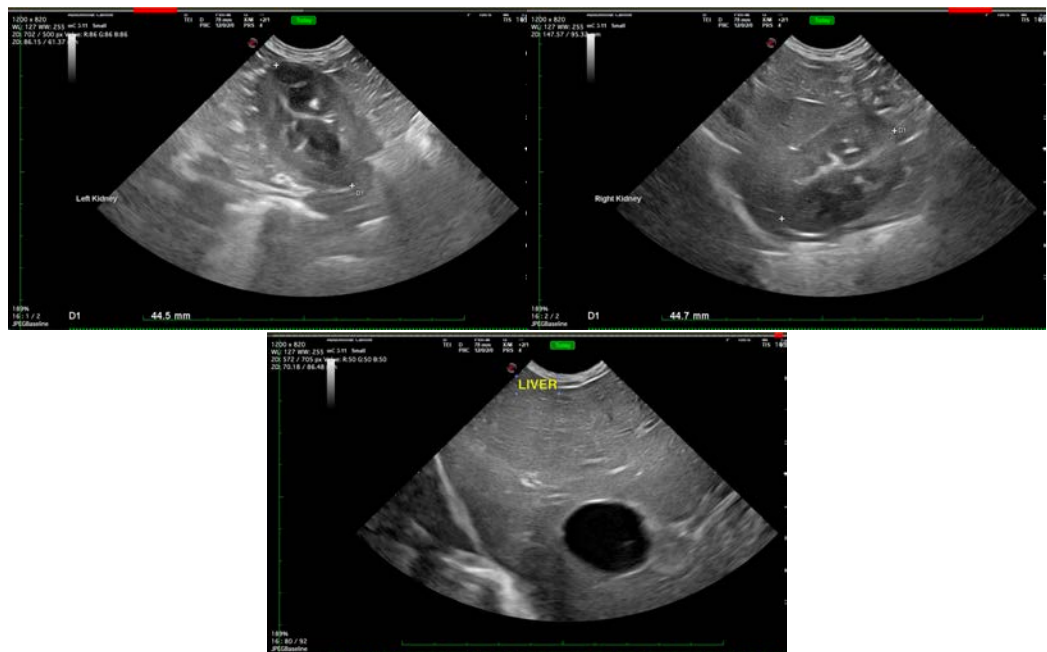
- Mildly heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Patient’s spleen has reportedly previously been removed.

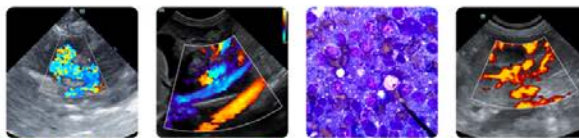
**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given patient’s history, while the appearance of the liver trends in appearance toward benign, fine needle aspirates could be considered if patient’s coagulation status is appropriate.

Otherwise, there is no definitive ultrasonographically visible intraabdominal explanation for patient’s reported clinical history.

Consultation with a veterinary oncologist could 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.

**Beth Johnson, DVM, DACVIM**  
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