PATIENT

Nike Gaffney

SPECIES

Canine

BREED

Labrador Retriever

SEX

FS

AGE

15 years

WEIGHT

58 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Pamela Harrigan, RDCS, Certified Veterinary Sonographer

HOSPITAL NAME

Falmouth Animal Hospital

REFERRING VET

Dt. Jennifer Switzer

INVOICE

11180

DATE

1/21/2026

PRESENTING CLINICAL SIGNS

- Presented for senior exam. 5 lb weight loss x 2 months. History of mild liver enzyme elevations. Suspect firm cranial abdominal mass on palpation. Progressive ALT elevation, now 222. On Gabapentin 300 mg TID

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 (6.9 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 trace pyelectasia noted. There is no evidence of mineral or infarcts observed.

The left kidney is normal is size (6.78 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

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left adrenal measures 1.3 cm at the cranial pole and 0.76 cm at the caudal pole. Right adrenal measures 1.2 cm at the cranial pole and 0.9 cm at the caudal pole. The adrenomegaly is as a result of hyperechoic nodules is noted in the cranial pole of the left adrenal gland and extending almost throughout the entirety of the right adrenal gland.

Spleen

Spleen is generally normal in size (1.9 cm thick at the hilus) and shape with a smooth capsular contour. Parenchyma is diffusely nodular in appearance characterized by small discrete hypoechoic nodules. Splenic vasculature appears normal.

Liver

Focally, in the mid to caudal liver there's a subtly slightly more discrete, homogenous, hypoechoic rounded density/possible emerging mass measuring 2.2 cm x 3.5 cm in size. The remaining liver is 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 of the gallbladder appears as a thin hyperechoic/calcified rim casting a distinct distal acoustic shadow. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

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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.

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 a scant amount of anechoic free fluid noted primarily between liver lobes.

Medial iliac and mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- The focal emerging mass like lesion within the liver could represent a benign process such as a hepatoma/adenoma, marked nodular hyperplasia, stereo vacuolar hepatopathy, chronic inflammatory disease, other. Although infiltrative neoplasia such as a well differentiated hepatocellular carcinoma, round cell neoplasia, other can't be ruled out without tissue sampling.
- Diffusely moderately 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.
- 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. With porcelain gallbladder wall – Porcelain (calcified) gallbladder is an uncommon finding in companion animals and has been observed as both an incidental finding and associated with biliary neoplasia. In humans, porcelain gallbladder can be a manifestation of chronic gallbladder disease, chronic cholecystitis, intramural hemorrhage with subsequent calcification, imbalances in calcium metabolism, and even giardiasis. This finding should be interpretated in combination with any clinical signs and/or laboratory changes suggestive of biliary disease and/or calcium dysregulation, etc.

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- Trace Free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- Mildly reactive mesenteric and medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.
- Bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease. With bilateral hyperechoic adrenal nodules – Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.

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, both the focal mass as well as the diffuse changes +/- spleen are recommended if patient's coagulation status is appropriate.

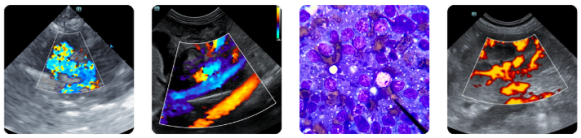
Pending results of above, given patient's reported weight loss, especially if weight loss is in the face of a normal or even increased daily caloric intake, further evaluation of digestion and absorption is recommended. Beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Also, pending results of above, bile acids could be considered if patient's total bilirubin is not increased.

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

While adrenal disease can contribute to liver enzyme increases, typically not just an ALT and underlying adrenal disease typically does not result in weight loss. Therefore, the bilateral nodules should be interpreted in combination with any clinical history of adrenal disease as they're likely normal patient variants. Having said that, a blood pressure is recommended if not recently evaluated.

NAVIX DIAGNOSTIX ANIMAL SERVICES



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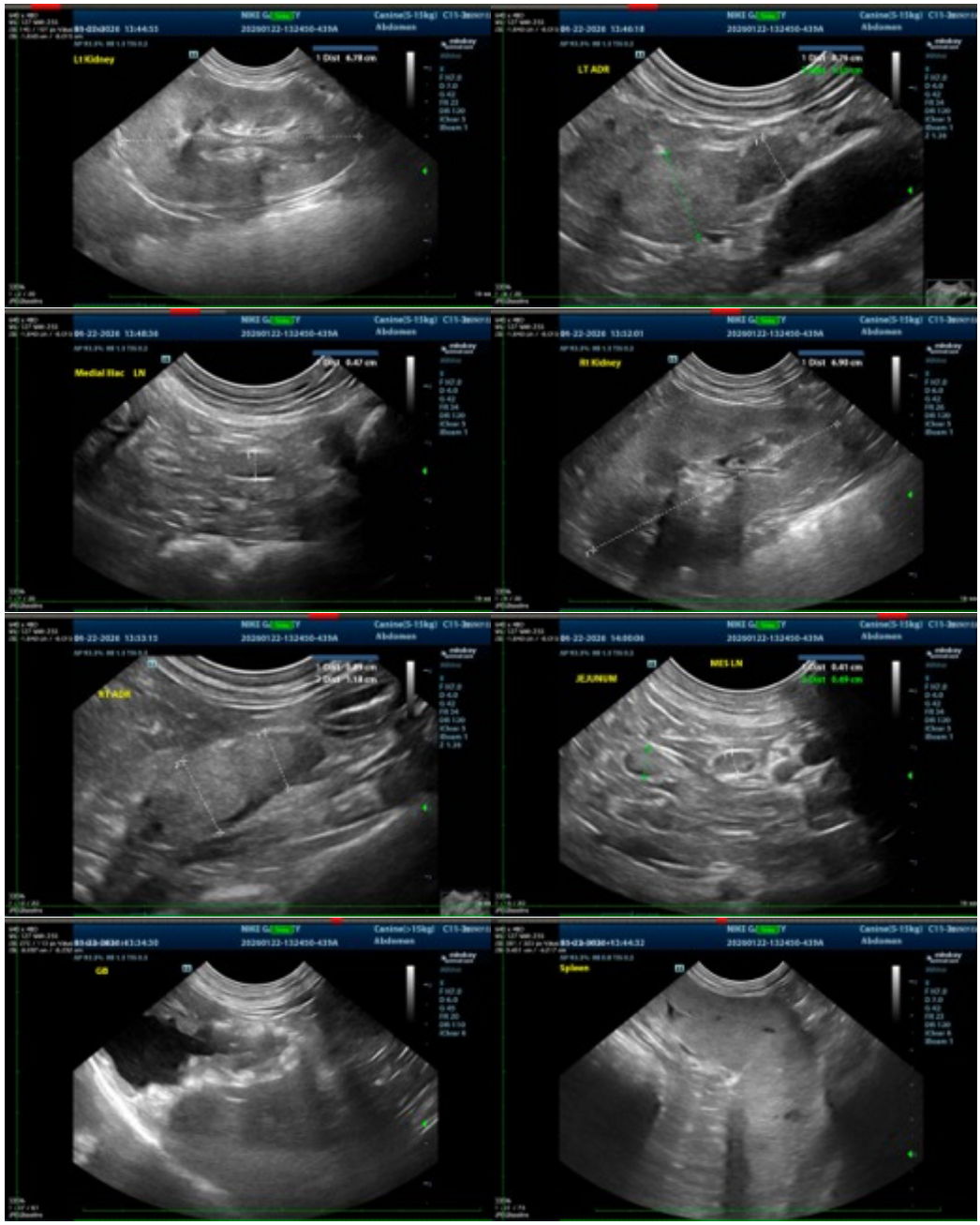

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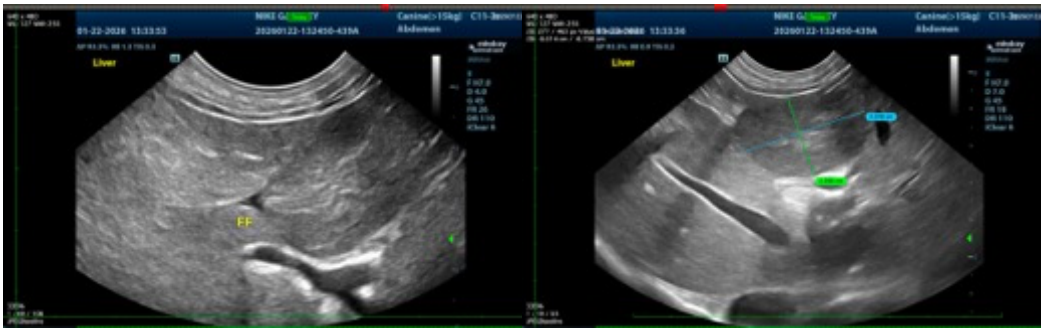

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com