



**PATIENT**

Louie Litchfield

**SPECIES**

Canine

**BREED**

Chihuahua/Dachshund  
Mix

**SEX**

Neutered Male

**AGE**

10 Years

**WEIGHT**

17.4 Pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING  
PERFORMED BY**

Kelly Vazquez

**HOSPITAL NAME**

Ridge Road AH

**REFERRING VET**

Dr. Pathak

**INVOICE**

20762

**DATE**

1/23/23

**PRESENTING CLINICAL SIGNS**

History: Possible abdominal mass palpated on 1/20/23. Anorexia x 1 week and weight loss.

Abnormal PE/Chem/CBC/UA Results: Elevated ALT/AST/ALP.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

Left kidney is normal is size (4.81 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.

Right kidney is normal is size (4.98 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**

Left adrenal gland is normal in size (1.55 cm long x 0.53 cm at cranial pole and 0.63 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.3 cm long x 1.07 cm at cranial pole and 0.47 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

The spleen is almost primarily composed of a large 7+ x 5-6+ cm in size heterogenous cavitated mass that demonstrates capsular escape and is surrounded by a scant amount of anechoic free fluid.

**Liver**

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as mild 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.

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

**Pancreas**

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The observed pancreas 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**

**SEX**

Neutered Male

A scant amount of anechoic free fluid is noted in the abdomen, around the splenic mass. There is no apparent lymphadenopathy.

**Other**

**AGE**

10 Years

A small amount of pleural effusion is noted in these images. There is no visible evidence of pericardial effusion noted in these images at this time.

**ULTRASONOGRAPHIC FINDINGS**

**WEIGHT**

17.4 Pounds

**Primary Findings**

- Cavitated splenic mass is most concerning for infiltrative neoplasia, such as sarcoma, especially given the free fluid. Other infiltrative neoplasia, including round cell neoplasia is possible. Benign lesions, such as hematoma, extramedullary hematopoiesis, etc., are possible but considered much less likely.
- Bicavitary effusion is most concerning for paraneoplastic effusion given the splenic mass. Other differentials, including underlying cardiac disease, hypoalbumenia, etc., are possible and should be ruled out.

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**Secondary Findings**

- 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. Pending results, a full echocardiogram may also be recommended.

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A fine needle aspirate of the splenic mass could be considered if patients coagulation status is appropriate, however, if the abdominal fluid is a hemoabdomen, then alternatively, an exploratory laparotomy for planned splenectomy may be the better option given the risk for progressive hemorrhage with even benign splenic lesions.



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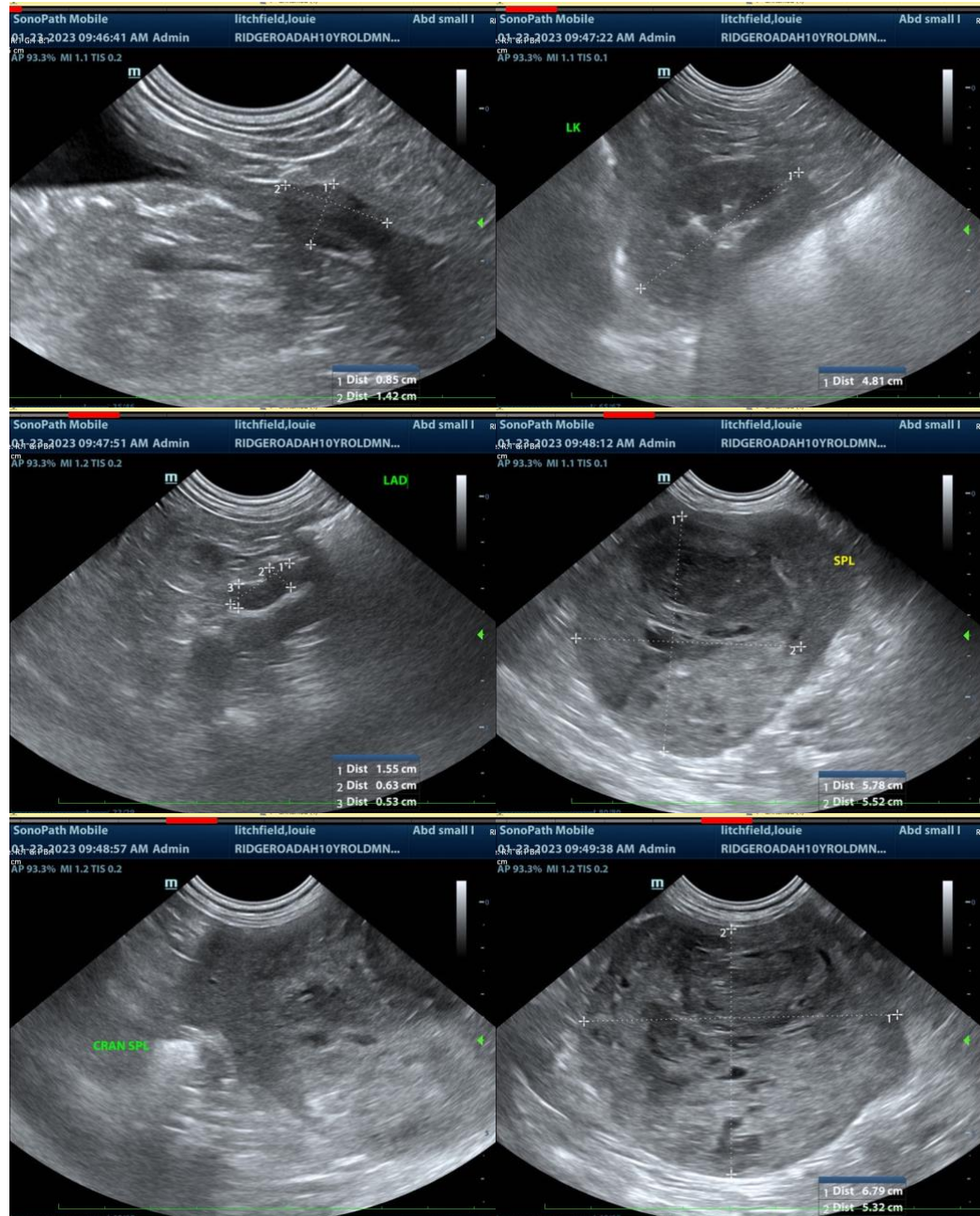
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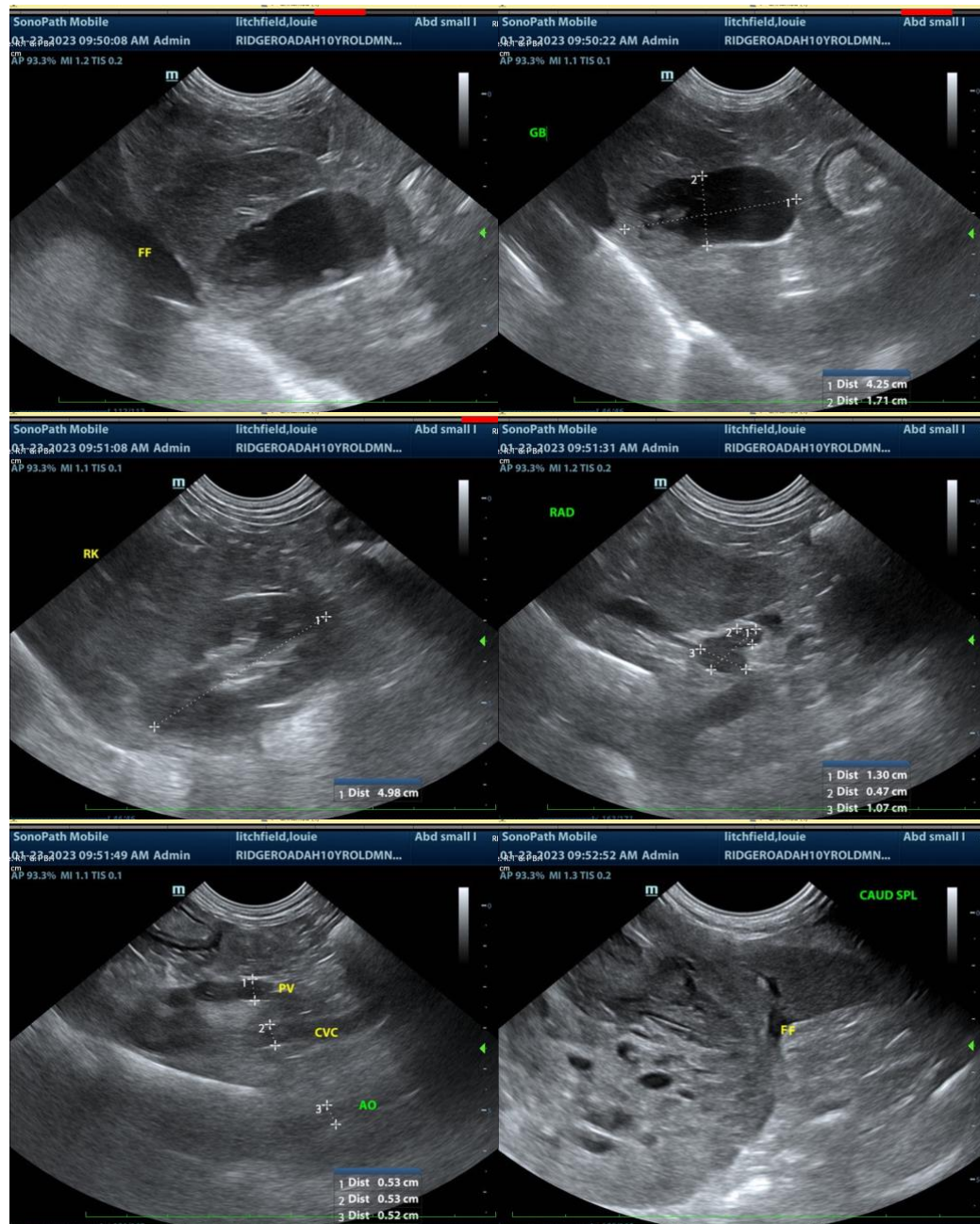
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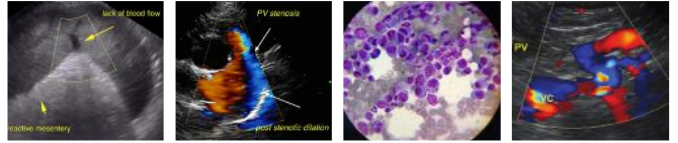


The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**

Beth.Johnson@SonoPath.com



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