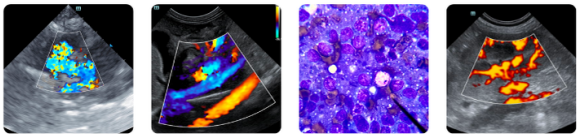


SonoPath FOSTERING THE ART OF VETERINARY MEDICINE™ www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Jordyn Dyer

SPECIES

Canine

BREED

Golden Retriever

SEX

Spayed Female

AGE

11 years

WEIGHT

19.4 kgs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Beatties PH Stoney Creek

REFERRING VET

Dr. Song/Salib

INVOICE

10761

DATE

11/19/2025

PRESENTING CLINICAL SIGNS

Inappetence since Friday Nov 14, ongoing significant weight loss and soft watery stools. P was seen in July for same issues and has continued to lose 4 more KG since then. Has been on Mirtazapine, Sulcrate, Omeprazole and Cerenia Injection.

Abnormal PE/Chem/CBC/UA Results: Bloodwork unremarkable other than Monocytes 1.22. No u/a or rads.

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 (6.1 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 (5.2 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 right adrenal gland is normal in size (1.4 cm at cranial pole and 0.6 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.65 cm at cranial pole and 0.56 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

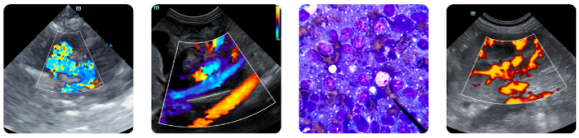
The spleen is subjectively normal in size (1.96 cm thick at the hilus) with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal. *See Free Abdomen*

Liver

The 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 except for in the mid to right caudal liver, where there is an approximately 6.5 cm x 7.5 cm homogenous, hypoechoic mass. Visible vasculature and biliary tree appear normal without distension or congestion. *See Free Abdomen*

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



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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 no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

In the left cranial abdomen, between the cranial aspect of the spleen and the caudal left liver, is an approximately 2.3 cm x 1.8 cm in size, mildly heterogenous, partially cystic, hypoechoic density that could represent a second caudal liver mass. Although, the cranial aspect of the spleen can't be ruled out. An adjacent lymph node not adhered to either organ is also a possibility.

ULTRASONOGRAPHIC FINDINGS

- Differentials for the liver mass include both a benign inflammatory or reactive change, hepatoma/adenoma, or infiltrative neoplasia such as hepatocellular carcinoma, sarcoma, round cell neoplasia, metastatic disease, etc., and can't be differentiated without tissue sampling.
- The left cranial abdominal lesion, as described above, could represent a second liver mass with the same differentials as listed above versus a splenic nodule that could represent either benign or malignant disease, lymph node versus other, and is difficult to fully differentiate in these images.

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 as well as the additional left cranial abdominal mass are recommended if patient's coagulation status is appropriate.

Having said that, the changes found in the ultrasound or have unknown if any relation to patient's reported gastrointestinal signs, therefore additional gastrointestinal evaluation may be warranted beginning with a routine fecal/giardia exam if not recently evaluated.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI

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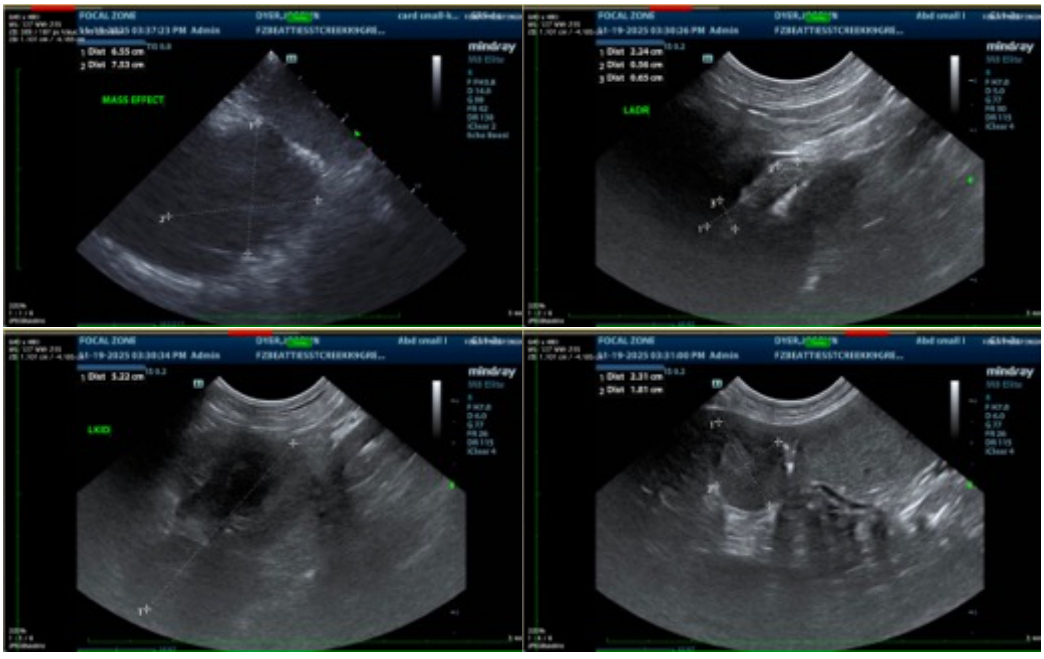
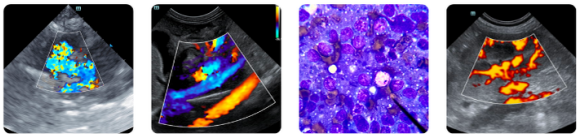
Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

In the meantime:

- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.
- Additionally, empirical deworming with a 5-day course of Panacur is recommended.
- A full course of empirical Helicobacter triple therapy could be considered.
- A probiotic, such a visbiome or proviable, may be helpful.
- Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.





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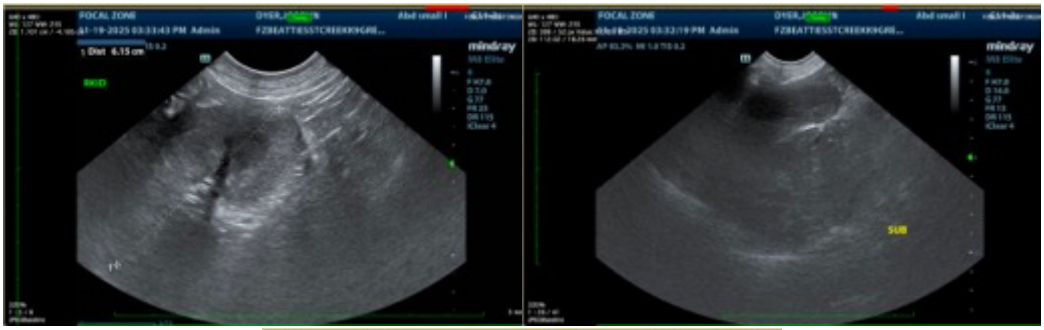

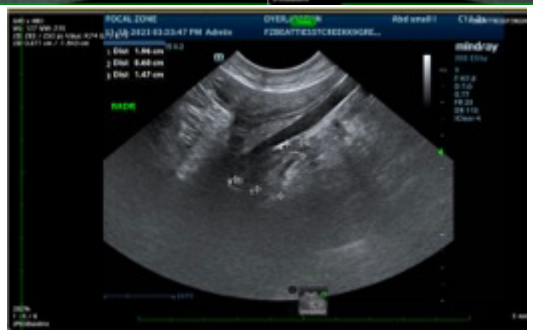

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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