



PATIENT	PRESENTING CLINICAL SIGNS
Baylor Lawson	Clinical Exam Findings: Presented July 25, 2025 for mass: ~7cm soft, adhered to body wall, subcutaneous mass R lateral thorax; cytology declined at that time Re-presented October 15th for cytology on mass, mass ~14cm Cytology Interpretation: Most consistent with mixed (chronic) inflammation, neoplasia cannot be r/o Pt presented for surgery October 27th, mass grown in size again (not measured) Pre-anesthetic bloodwork showed regenerative anemia, surgery not performed
SPECIES	
Canine	
BREED	ABNORMAL Labwork Values CBC: baso 0.13, lym 1.01, retic 469, hgb 7.3, hct 22.6%, rbc 3.15, mpv 14.8 Chem 10 WNL UA 2+ protein, 3+ blood, 2+ bilirubin, 75-100 wbc/hpf, marked rods Fecal negative Current Medications Amoxicillin
Labrador Retriever	
SEX	ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
Spayed Female	Urinary System
AGE	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.
11 Years	
WEIGHT	The right kidney is normal is size (7.0 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.
66.3 lbs	
INTERPRETED BY	The left kidney is normal is size (5.5 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.
Beth Johnson, DVM DACVIM	Adrenal Glands
IMAGING PERFORMED BY	The area of the right adrenal gland is examined without evident adrenal gland pathology. However, the gland is difficult to visualize/isolate for measurement.
Sara Hansen	The left adrenal gland is plump/swollen in size, measuring 1.1 cm at the cranial pole and 0.59 cm at the caudal pole. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.
HOSPITAL NAME	Spleen
Santa Clara Animal Hospital	The spleen is subjectively normal in size (1.5 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.
REFERRING VET	Liver
Dr. Pappas	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. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.
INVOICE	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.
71595	
DATE	
11/5/25	



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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.

ULTRASONOGRAPHIC FINDINGS

- Mild left adrenomegaly – This could be normal patient variant, stress, or suggestive of emerging adrenal disease, and should be interpreted in combination with clinical history, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's reported urinalysis results, a urine culture is recommended if not already pending.

Causes for regenerative anemia include hemorrhage or hemolysis. There is not a definitive ultrasonographically visible intraabdominal explanation for either. Having said that, infectious disease, neoplastic disease, autoimmune disease, other can't be ruled out despite a largely unremarkable ultrasound. Given patient's history, I wonder if the reported mass has a slow chronic bleed that could be contributing. Further diagnostic recommendations to consider include:

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, comprehensive infectious disease evaluation, and ultimately biopsy and/or removal of the mass.



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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