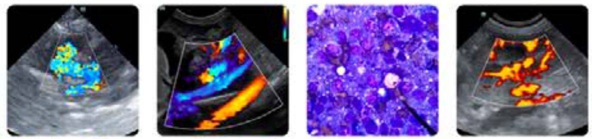


SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT
Jack Gula

SPECIES
Canine

BREED
German Shepherd x

SEX
Neutered Male

AGE
9.5

WEIGHT
45

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Christensen

HOSPITAL NAME
Tranquility Veterinary Clinic

REFERRING VET
Dr. Castellani

INVOICE
71587

DATE
11/5/25

PRESENTING CLINICAL SIGNS

Weight loss. Seems uncomfortable. PU/PD.

Abnormal PE/Chem/CBC/UA Results: Multiple abdomralitys on BW. Alk Phos= 5890 ALT= 404 GGT= 443 UPC= 4.7 Lipase= >1800 Cholesterol= 447 TP= 7.8 BUN= 40 SDMA= 19 K+= 6.1 Cl= 104 S.G.= 1.013.

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.

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

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted. Multiple non-obstructive nephroliths are noted bilaterally. Left is normal in size at 6.5 cm. Right is normal in size at 7.0 cm.

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 measures 1.0 cm at the cranial pole and 1.5 cm at the caudal pole. Right measures 1.0 cm at the cranial pole and 0.71 cm at the caudal pole.

Spleen

Spleen is subjectively normal in size 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. Multifocal mineral foci are noted. Splenic vasculature appears normal.

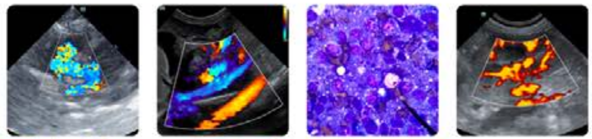
Liver

In the mid to right caudal liver is an approximately 8.0 cm x 6.5 cm mixed, heterogeneous, partially cystic, iso- to hyperechoic mass. The remaining liver surrounding the mass 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.



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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.

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

- Differentials for the liver mass including benign change such as nodular hyperplasia, steroid or vacuolar hepatopathy, extramedullary hematopoiesis, hepatoma/adenoma, or even a chronic inflammatory lesion. However, given the discrete mass-like appearance, infiltrative neoplasia such as a hepatocellular carcinoma, sarcoma, other can't be ruled out without tissue sampling.
- 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.
- Spleen mineralization – This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism.
- Bilateral chronic kidney disease changes with bilateral non-obstructive nephrolithiasis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the liver mass, recommendations 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.

Fine needle aspirates of the mass are recommended if patient's coagulation status is appropriate.

Alternatively, or if a cytologic diagnosis is unable to be obtained, pending the evaluation and workup for all of the reported abnormalities, an exploratory laparotomy for planned excisional biopsy/liver lobectomy could be considered. The mass appears focal and caudal and likely fully resectable. However, ultrasound can't guarantee full resectability, and a pre-surgical planning abdominal CT scan could be considered.

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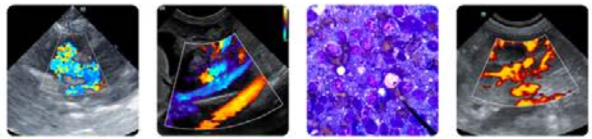
In the meantime, given the other laboratory changes, a blood pressure is recommended if not recently evaluated, as is testing for Leptospirosis.

Underlying adrenal disease such as hyperadrenocorticism can't be ruled out based on patient's reported clinical signs and the appearance of the adrenal glands. However, workup of hyperadrenocorticism typically is not recommended in the face of concurrent, potentially more serious illness. In the future and/or if patient's clinical signs warrant management to improve quality of life, etc., a low-dose Dexamethasone suppression test 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
info@sonopath.com