PATIENT

Gretchen Ruell

SPECIES

Canine

BREED

Shetland Sheepdog

SEX

FS

AGE

12 years

WEIGHT

25 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Wareham Animal Hospital

REFERRING VET

Dr. Alberto Fernandez

INVOICE

11333

DATE

2/18/2026

PRESENTING CLINICAL SIGNS

- Presented for hyporexia and vomiting. Began as diarrhea and vomiting - bilious material. Today ate some yogurt and vomited 20 minutes later.
- CBC: HCT 24.2, HGB 8.4, RBC 4.33, WBC 23.41, neu 19.0, m ono 3.21, Plt 596.
- Chem 17/lytes: Glob 4.7, ALP 612, Amylase 1627.

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 (5.06 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 (4.95 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 (0.62 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 (0.49 cm at cranial pole and 0.4 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

In the area of the spleen, in images labeled “spleen” is an irregular, ill-defined, coarse, hypoechoic, scalloped mass measuring approximately 5.7 cm x 6.2 cm in size.

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. Severel discrete homogenous, hyperechoic densities/nodules are noted throughout the parenchyma with a representative nodule measuring approximately 1.8 cm x 2.5 cm in size. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

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. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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

- The splenic mass is concerning for infiltrative neoplasia such as round cell neoplasia versus sarcoma versus other. A benign process including extramedullary hematopoiesis, chronic inflammatory disease, etc. while thought less likely, can't be ruled out without tissue sampling.
- Liver nodules – Differentials for a discrete hyperechoic liver nodules include primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, myelolipomas, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.
- Emerging mucocele – 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.
- Subtle/mild mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.

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 splenic mass +/- the liver, are recommended if patient's coagulation status is appropriate.

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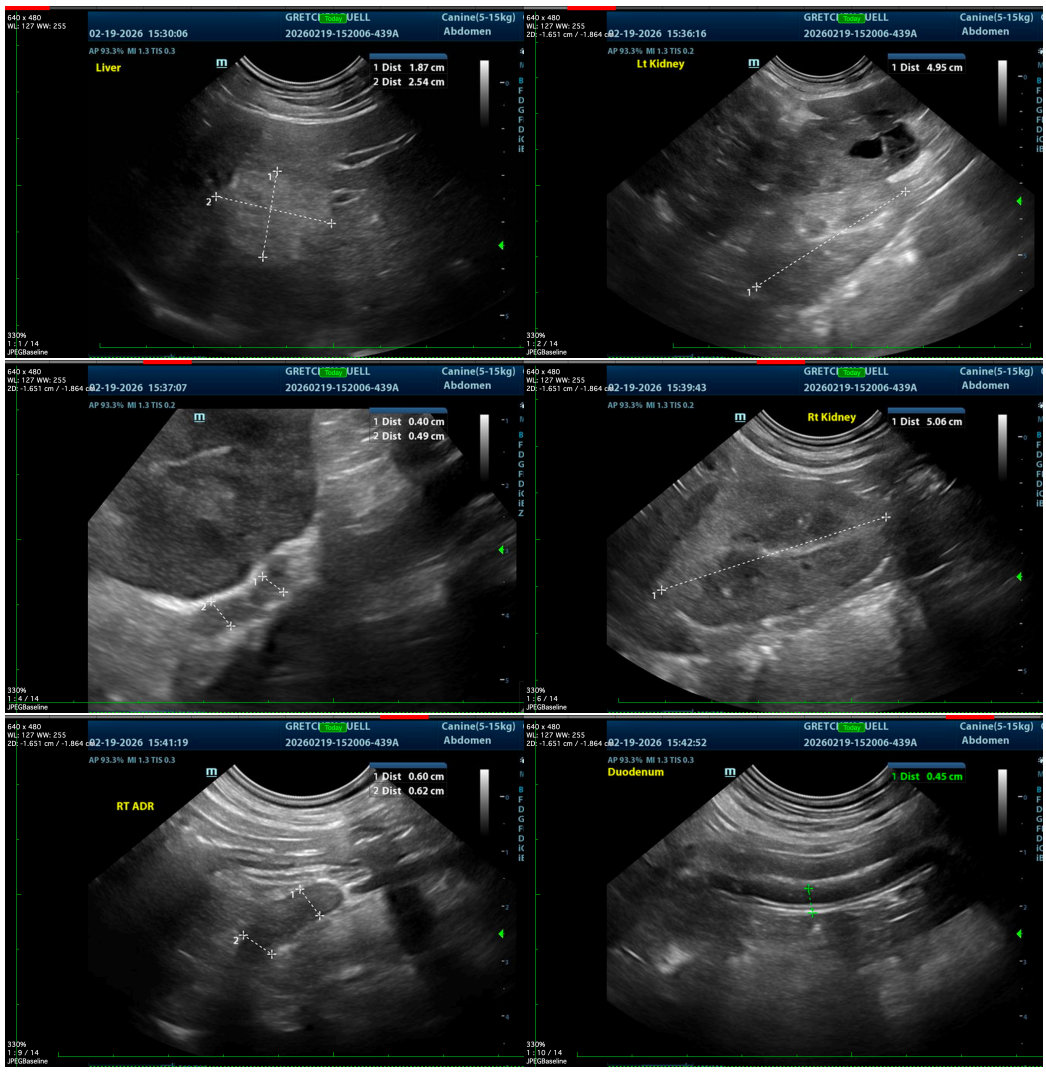
If a cytologic diagnosis is unable to be obtained, and/or the cytologic diagnosis warrants an exploratory laparotomy for planned splenectomy, liver biopsy, etc., especially given patient breed, a prophylactic cholecystectomy could be considered at the same time.

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



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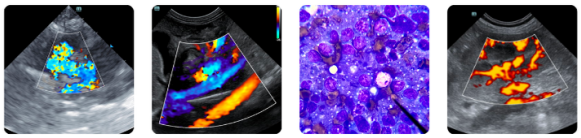

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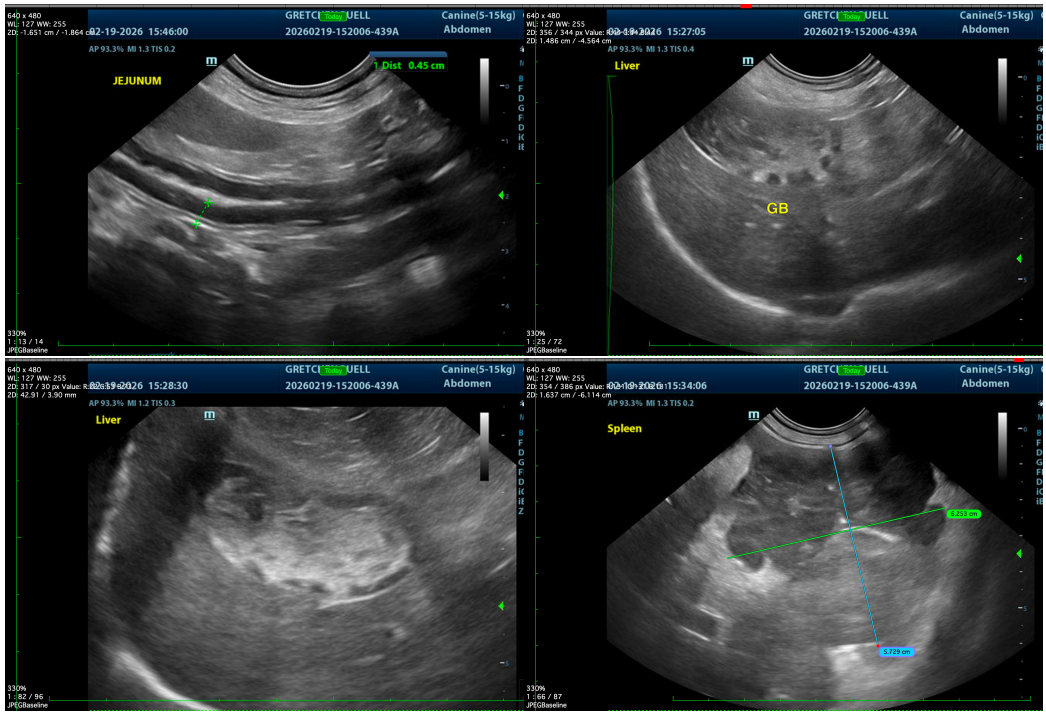

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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