



<b>PATIENT</b>	<b>PRESENTING CLINICAL SIGNS</b>
Tucker Drada	Elevated Liver enzymes- concerned w/ possible tumor. Swollen LN all over body- possible Lymphoma.
<b>SPECIES</b>	Meds: Prednisone 20 mg PI BID
Canine	Abnormal PE/Chem/CBC/UA Results: SC ALT 434, ALP 1479, GGTP 29, CBC: Neutro 82, Lymph 11, Abs Neuts 11890, T4 1.1
<b>BREED</b>	<b>ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN</b>
Mix	<b>Urinary System</b>
<b>SEX</b>	Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.46 cm). Mucosa is hyperechoic and irregular. Additionally, along the mid inner dorsal wall is an approximately 0.77 cm long x 0.56 cm thick echogenic density. No visible blood flow is noted but can't be ruled out. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.
Neutered Male	
<b>AGE</b>	Prostate is normal in size, echotexture and echogenicity for a neutered male.
12 Years 8 Months	
<b>WEIGHT</b>	Kidneys are significantly enlarged in size (left 6.58 cm, right 6.89 cm) with increased cortical echogenicity and disruption of normal corticomedullary architecture caused by multifocal heterogenous (primarily hypoechoic) nodules. A hypoechoic subcapsular rim "halo" is present. The pericapsular area is enhanced by hyperechoic fat and mesentery. No mineral is observed.
46.6 lbs	
<b>INTERPRETED BY</b>	<b>Adrenal Glands</b>
Beth Johnson, DVM DACVIM	The caudal pole of the right adrenal gland is normal in size (0.63 cm), shape and overall architecture, echogenicity and echotexture. The cranial pole is difficult to fully visualize in these images. Visible surrounding vasculature appears normal.
<b>IMAGING PERFORMED BY</b>	The left adrenal gland is normal in size (0.55 cm at cranial pole and 0.76 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.
Rebecca Hamilton	
<b>HOSPITAL NAME</b>	<b>Spleen</b>
Animal Care Center of North Jersey	Spleen is subjectively large in size with a swollen and scalloped/undulating capsular contour. Multifocal coalescing nodules are noted throughout the parenchyma. Additionally near the cranial aspect of the spleen is an approximately 2.8 cm in diameter heterogeneous, largely hyperechoic nodule/mass. Splenic vasculature appears normal. Enhanced hyperechoic surrounding fat is noted.
<b>REFERRING VET</b>	<b>Liver</b>
Dr. Andalaft	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.
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<b>DATE</b>	Gallbladder is moderately distended with anechoic bile as well as 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.
2/18/26	



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***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.

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.

Diffusely, lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

**PRIMARY FINDINGS**

- The appearance of the nodular kidneys is suggestive of infiltrative neoplasia such as round cell neoplasia i.e., renal lymphoma. Other malignant primary renal or metastatic neoplasia can't be ruled out. Similarly, severe nephritis, pyelonephritis with cysts, hematomas, benign inflammatory granulomatous nodules, etc., while thought much less likely can't be ruled out, especially given the concurrent pathology.
- Honeycomb Spleen – This finding is strongly suggestive of infiltrative disease such as round cell neoplasia. Benign disease cannot be ruled out but is considered less likely. The hyperechoic mass near the cranial aspect of the spleen may represent the same underlying pathology or concurrent benign disease such as fibrosis or calcification of an old hematoma or infarct, myelolipomas, etc.
- Diffusely aggressive lymph nodes – concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes. The focal dorsal wall change could represent a pile of dependent debris versus tissue. If it is tissue, both a benign inflammatory change or early /emerging infiltrative neoplasia are differentials.



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**SECONDARY FINDINGS**

- Moderate 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.

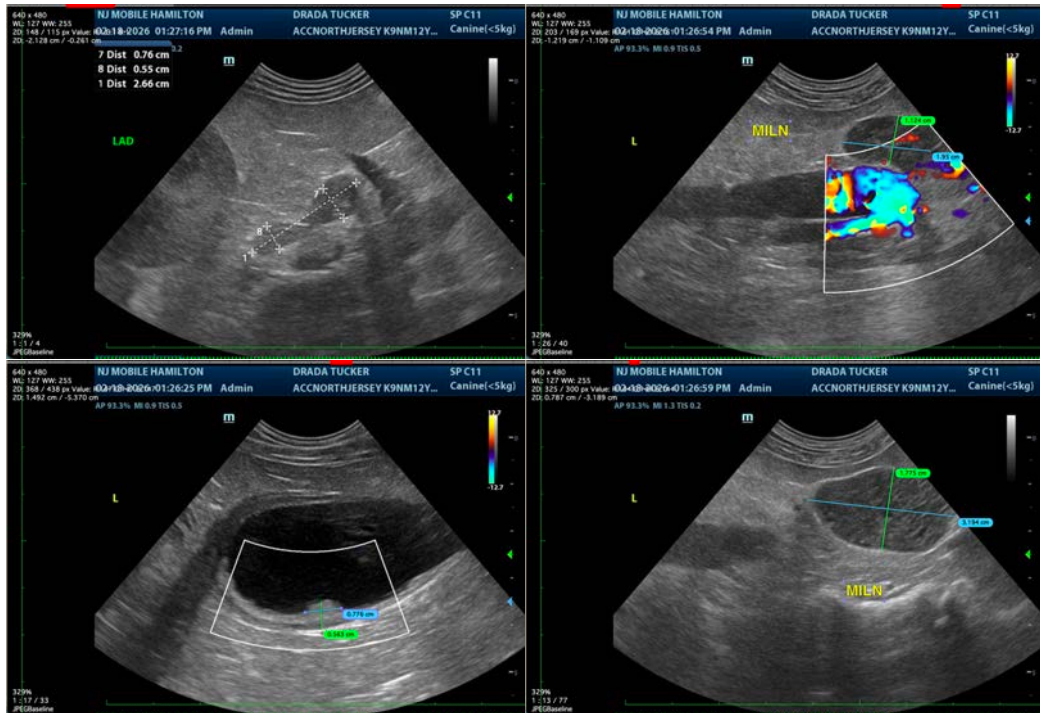
**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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.

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended. Additionally, submission of urine to look for BRAF gene mutation, which is associated with uroepithelial neoplasia, could be considered.

Tissue sampling is recommended. If a diagnosis is not obtained from sampling of the reportedly enlarged peripheral lymph nodes, and/or if additional staging is elected, fine needle aspirates of the kidneys, the spleen +/- the enlarged intraabdominal lymph nodes could be considered if patient's coagulation status is appropriate.

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





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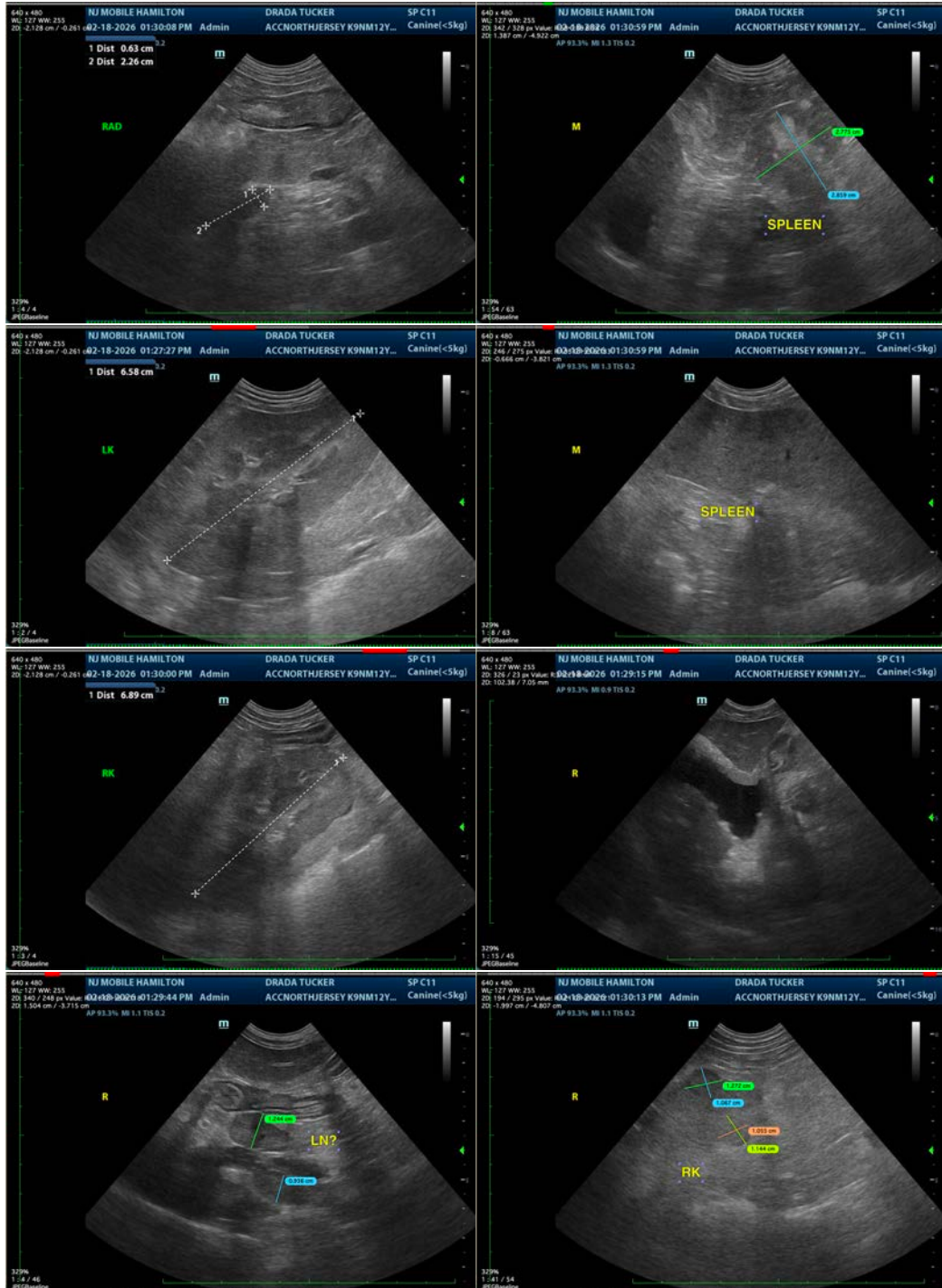
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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