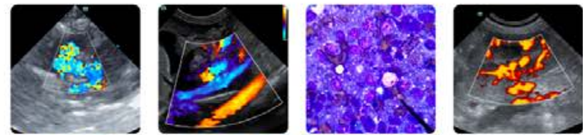


PATIENT
Bear Lamanna

SPECIES
Canine

BREED
Maltese x

SEX
Neutered Male

AGE
14 Years

WEIGHT
8.6 kg

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Amanda Stewart

HOSPITAL NAME
Erin Folk Animal Hospital

REFERRING VET
Dr. Silwanes

INVOICE
73298

DATE
2/26/26

PRESENTING CLINICAL SIGNS

Clinically seems normal (no OU/Pd, vomiting, diarrhea), uncomfortable on abdo palpation, was seen as follow up bloodwork Feb 21.

Current Medications: Hepato support since nov 2025

Abnormal PE/Chem/CBC/UA Results: Increased ALP from ~800 to 1150 since nov 2025 ; ALT increased from normal values (~359) Radiographic Findings n/a Primary Question to Be Answered in This Exam liver? reason for enzyme elevation

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 overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 5.04 cm. A cortical cyst was noted in the medial aspect of the left kidney. Right kidney measured 5.67 cm. A similar appearing cortical cyst is visible in the right kidney.

Adrenal Glands

The right adrenal gland is normal in size (0.58 cm at cranial pole and 0.52 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.63 cm at cranial pole and 0.68 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

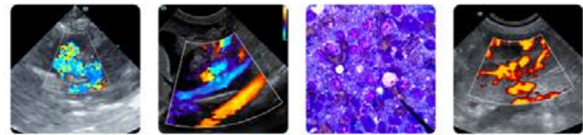
Spleen

The 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), except for an approximately 0.50 cm in diameter non-capsule disrupting hypo- to anechoic nodule in the mid spleen. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion. *See other.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. Additionally, there is an approximately 1.1 cm x 1.3 cm discrete, round, echogenic density that could represent debris, mucus, sludge, even a non-shadowing cholecystolith, although in some views it appears to be vascular, consistent with tissue i.e., benign polyp, or infiltrative neoplastic



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mass can't be ruled out. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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.

*See other.

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.

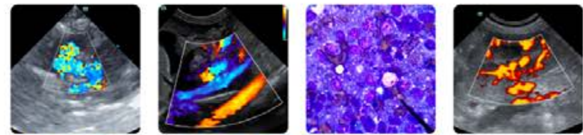
In the mid to right cranial abdomen there is an approximately 4.85 cm x 6.68 cm markedly heterogeneous, mixed, partially cavitated mass that in some views appears to originate from the mid to right caudal liver and sits just medial to the right kidney, although in some views, especially towards the end of the study, the mass appears to originate potentially from a right cranial bowel loop.

PRIMARY FINDINGS

- The mid to right cranial abdominal mass is concerning for infiltrative neoplasia, although a benign inflammatory lesion, abscess, hematoma, other can't be ruled out without tissue sampling. As described above, top two differentials for origin are liver and/or possibly bowel. It is difficult to definitively determine whether the mass originates from bowel or whether a bowel loop is just running directly adjacent to it, potentially even adhered to it.

- The gallbladder density described above could represent debris, although the vascularity suspicion indicates tissue, with both benign polyp or infiltrative neoplasia being possible.

- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.



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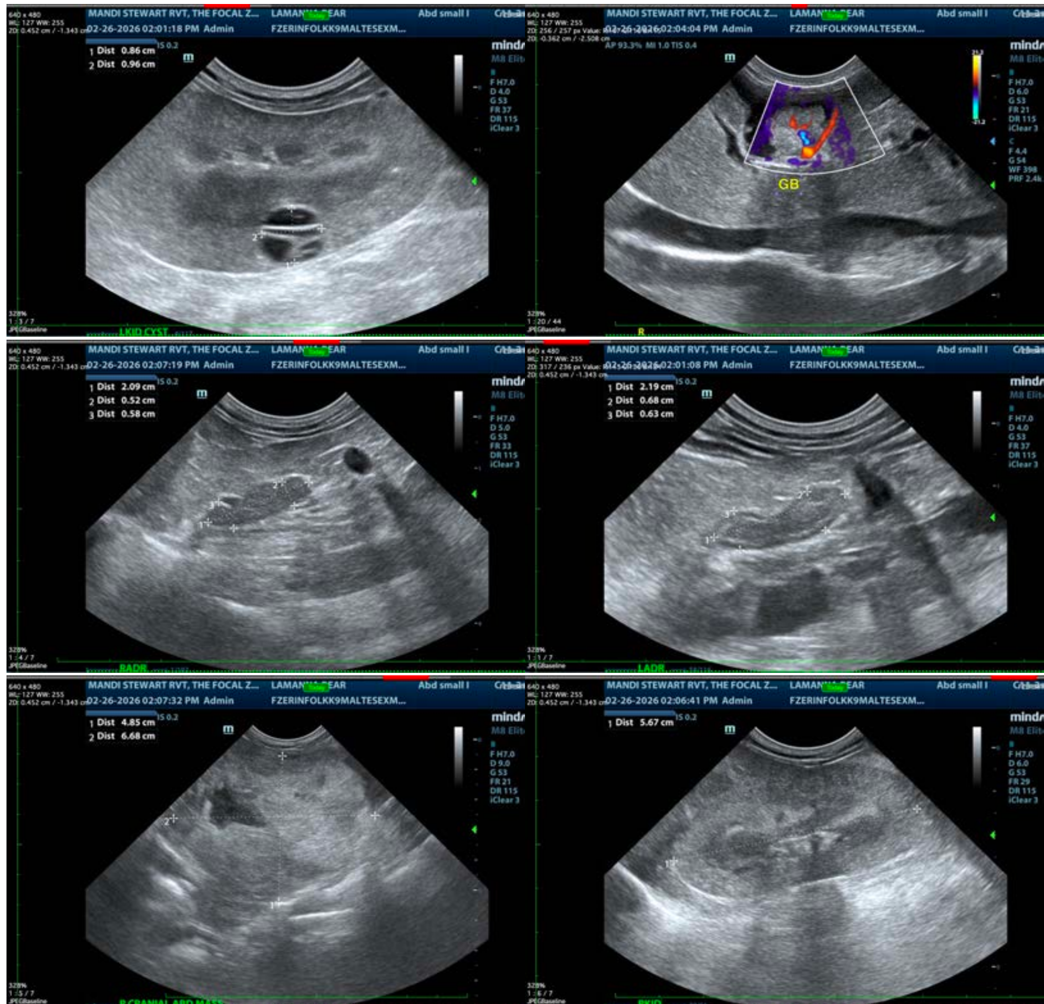
SECONDARY FINDINGS

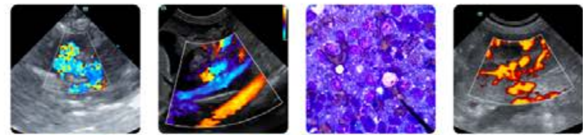
- Age related kidney changes with bilateral cortical cysts.

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 cranial abdominal mass +/- the gallbladder density could be considered if patient's coagulation status is appropriate. Alternatively, or if a cytologic diagnosis is unable to be obtained, an exploratory laparotomy for planned excisional biopsies could be considered. If surgery is elected, given the inability to definitively localize the mass combined with the gallbladder changes, a pre-surgical planning abdominal CT scan may be helpful.





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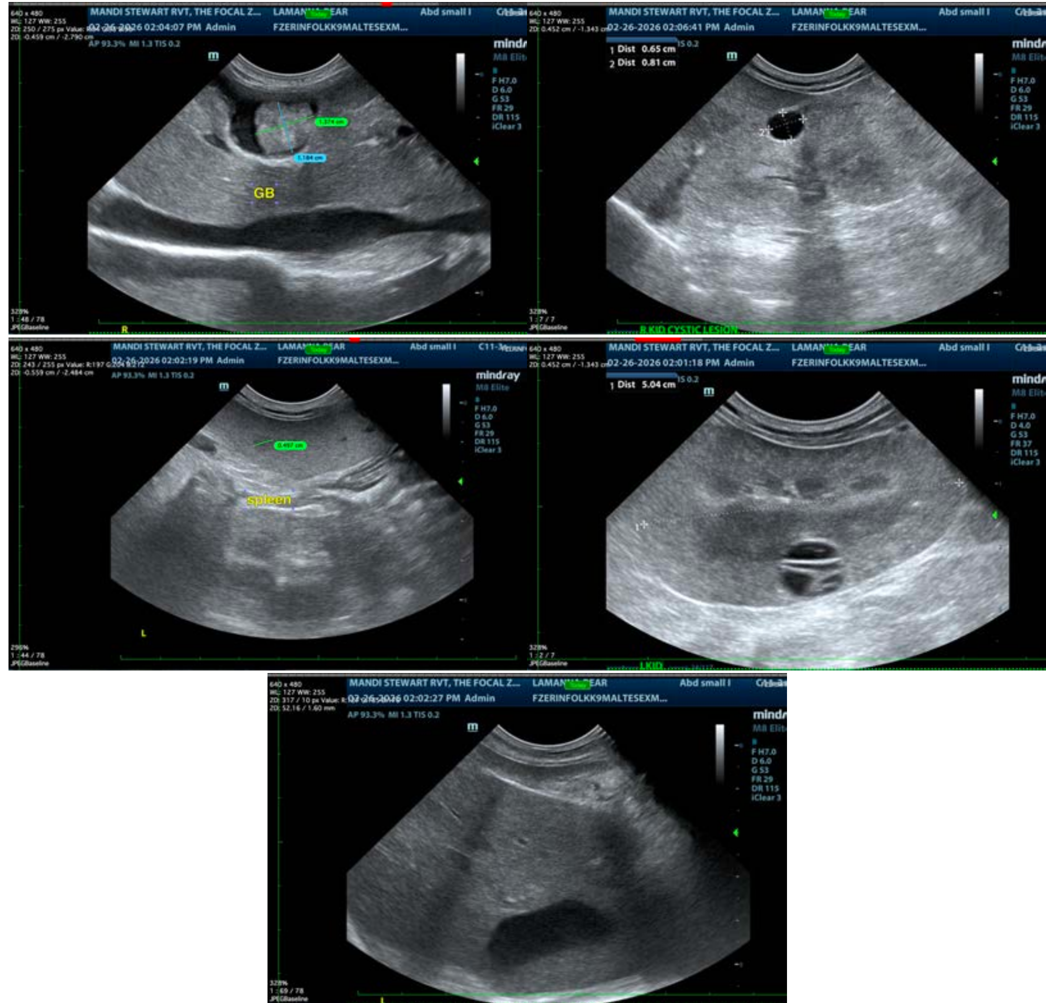

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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