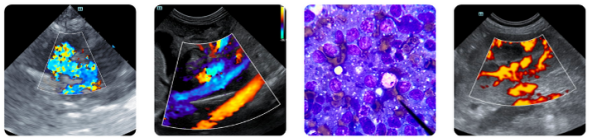


PATIENT

Nova Campbell

SPECIES

Canine

BREED

Ret Mix

SEX

FS

AGE

9 years

WEIGHT

68.9 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Mehaffey

INVOICE

11247

DATE

2/4/2026

PRESENTING CLINICAL SIGNS

- Patient sedated with Butorphanol. Elevated ALP found on screening bloodwork
- Patient was treated with a course of amoxi/metro/liver protectants with no improvement. O noted a slight increase in thirst/urination. Patient has a hx of bilateral CCL tears and OA.
- Uses carprofen and gabapentin only as needed, not daily, no current medications.
- Diagnostics: 11/22/26: HCT 45% (41-60%), Platelets 787 (120-412 k/ul), Globulins 4.4 (2.4 -4.0), ALP 2,040 (5-160), GGT 14 (0-13), Chol 474 (131-345). T4 normal. 4dx: Chronically anaplasma+. Fecal NOS. UA - USG 1.027 3+ protein, quiet sediment. 12/29/26: ALP 1,891 (23-212)

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 (7.32 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.

The left kidney is normal is size (7.02 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

Adrenal glands are mildly plump in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left adrenal measures 0.84 cm at the cranial pole and 0.74 cm at the caudal pole. Right adrenal measures 0.91 cm at the cranial pole and 0.92 cm.

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). No focal nodules or masses are observed. Splenic vasculature appears normal.

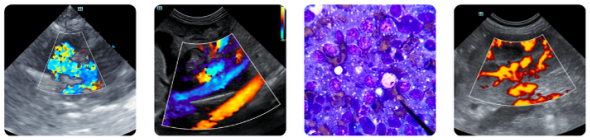
Liver

The liver contains an approximately 9.9 cm x 10.4 cm solid, but very mildly heterogenous, iso- to slightly hypoechoic mass in the mid caudal liver.

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

- The focal liver mass could represent a benign change such as nodular hyperplasia, extramedullary hematopoiesis, a hepatoma/adenoma, other. Although infiltrative neoplasia such as primary hepatocellular carcinoma, round cell neoplasia, other can't be ruled out without tissue sampling.
- Mildly 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the possible mild PU/PD and the very mild bilateral adrenomegaly, early or emerging adrenal disease/hyperadrenocorticism, contributing to patient's reportedly increased Alkaline Phosphatase can't be ruled out. However, the liver mass is the primary recommended workup starting point.

Therefore, 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 liver mass are recommended if patient's coagulation status is appropriate.

While hormone testing typically is not recommended in the face of concurrent illness due to the risk of false positives, etc., a blood pressure is recommended if not recently evaluated, as is 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 ration is recommended.

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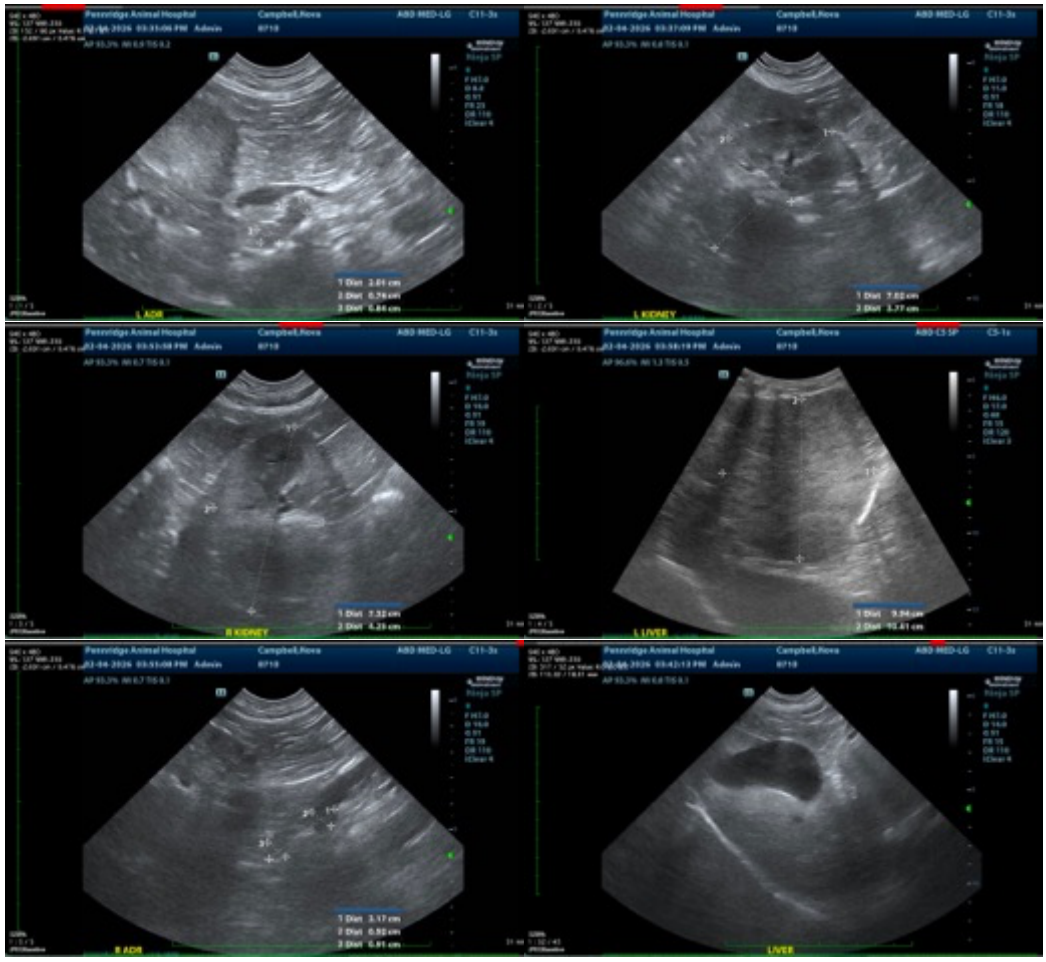

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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