



**PATIENT**

Divo Foster

**SPECIES**

Canine

**BREED**

American Eskimo

**SEX**

Neutered Male

**AGE**

16 Years

**WEIGHT**

7.3kg

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Kelly Reschny

**HOSPITAL NAME**

East Plains Animal  
 Hospital

**REFERRING VET**

Dr. Hindle

**INVOICE**

72753

**DATE**

2/5/26

**PRESENTING CLINICAL SIGNS**

Progressive history of weight loss, inappetence, GI signs (vomiting and diarrhea), suspected PUPD for the last few months. Presented initially to our clinic January 19th 2026. On examination patient was mildly underweight, loss of muscling, dehydration. Conjunctivitis OU- treated with tobramycin course. Bilaterally incipient cataracts, iris atrophy. Moderate dental disease. Grade 3/6 left apical HM. Abdomen guarded on palpation. Bloodwork performed did not reveal a clear cause for the clinical picture and abdo US was recommended but not elected. After failure to respond to medical therapy (SC fluids, cerenia, metronidazole, z/d low fat diet) owner elects to pursue ultrasound.

Abnormal PE/Chem/CBC/UA Results: Labs attached

**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 prostate is unable to be visualized in these images.

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 4.2 cm. Right kidney measured 4.05 cm.

**Adrenal Glands**

The right adrenal gland is normal in size (1.3 cm at cranial pole and 0.80 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.43 cm at cranial pole and 0.45 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

The spleen is unable to be well visualized in these images.

**Liver**

In the cranial abdomen, primarily the left cranial abdomen, appearing to originate primarily from the liver is a large, 7.8 cm x 8.0 cm, irregular, mixed but solid mass. Some normal liver parenchyma is noted cranial to the mass. The gallbladder is unable to be visualized.

**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.



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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.

**PRIMARY FINDINGS**

- The large cranial abdominal mass appears to be originating from the liver, with differentials including both benign inflammatory etiologies (hepatoma/adenoma, other), as well as more likely infiltrative neoplasia such as hepatocellular carcinoma versus round cell neoplasia versus even sarcoma versus other. The two can't be fully differentiated without tissue sampling. While the mass appears to originate from the liver, the spleen is unable to be well visualized, and while thought less likely splenic involvement can't be definitively ruled out.

**SECONDARY FINDINGS**

- Age related kidney changes.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given patient's history, a 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.

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

Ultimately, however, if a cytologic diagnosis is unable to be obtained, or the diagnosis warrants surgery and an exploratory laparotomy is planned, a pre-surgical planning abdominal CT scan is recommended for further staging/identification.



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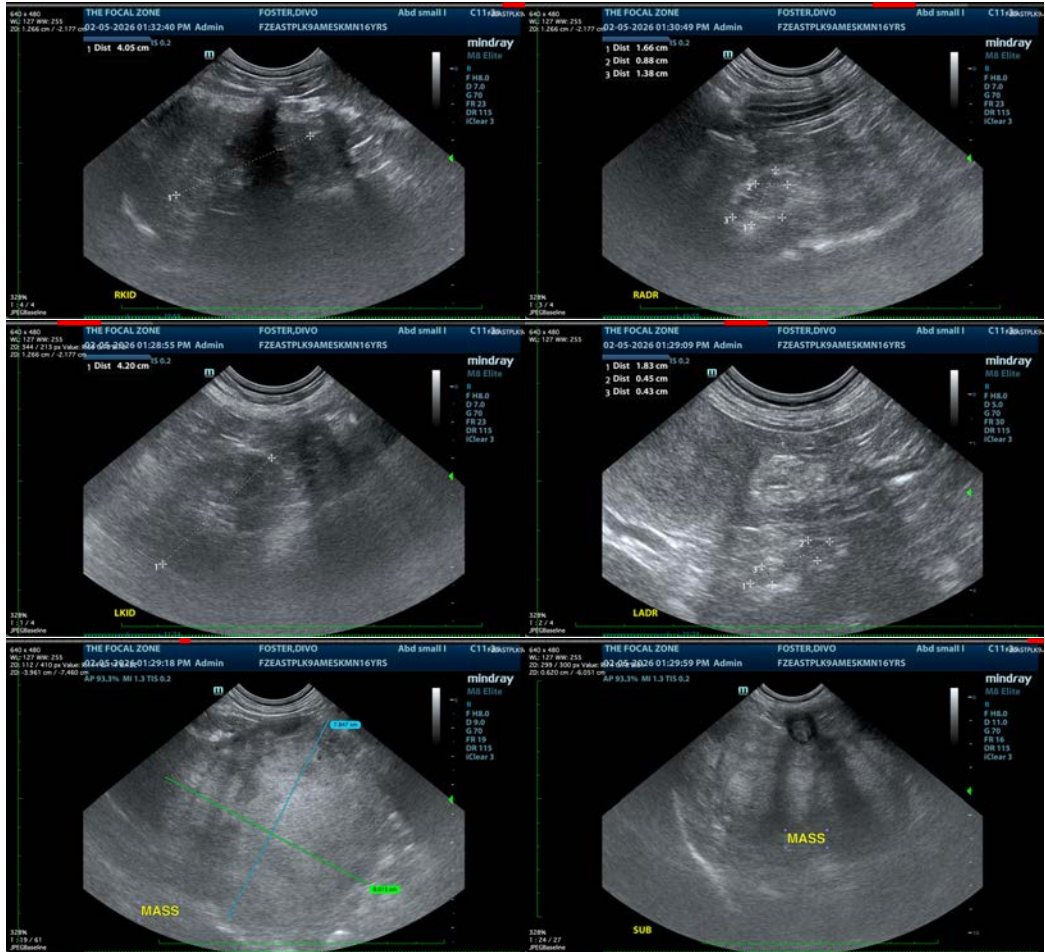
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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