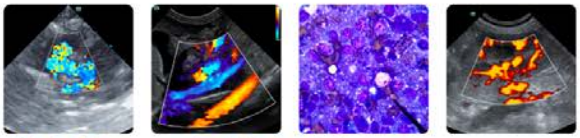




SonoPath www.animalsoundsnw.com info@animalsoundsnw.com 541.357.9423

**PATIENT**

Daisy Bliss

**SPECIES**

Canine

**BREED**

German Shorthair Pointer

**SEX**

Spayed Female

**AGE**

11 Years

**WEIGHT**

69.8 lbs

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Animal Care Center (Salem)

**REFERRING VET**

Dr. Harbord

**INVOICE**

73539

**DATE**

3/10/26

## PRESENTING CLINICAL SIGNS

Normal mentation, no respiratory effot, many SQ masses, soft palpable non painful abdomen. Grade 4/6 heart murmur. Meds:Galliprant 1 tab SID, started 3/10 Denamaring give one tab once daily.

Abnormal PE/Chem/CBC/UA Results: 9/10/25: ALT 1432, AST 300, ALP 343, GGT 19, Chol mild inc 360, and lipase inc. 885. 3/5/26 #4 cuff LF lateral: AVG 154/87 (106). 173/85 (112) 165/91 (111) 147/89 (102) 145/83 (99) 144/91 (108) HR 122, RR 32

## 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 (6.16 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 (5.83 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 (1.1 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 (0.48 cm at cranial pole and 0.61 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### *Spleen*

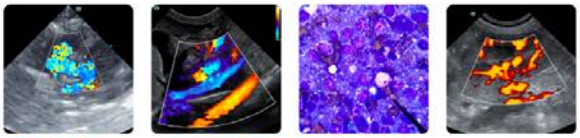
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

**There may be some very subtle accessory spleen tissue just medial to the hilus, but no significant pathology is visible to me in these images at this time.*

### *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. In the cranial mid liver there is an approximately 0.80 cm x 2.0 cm in size discrete anechoic density/suspect cyst. Visible vasculature and biliary tree appear normal without distension or congestion.

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.





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### *Gastrointestinal*

The visible stomach wall is normal in thickness and layering. The lumen is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is 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.

There is no apparent pathologic lymphadenopathy noted in these images.

## ULTRASONOGRAPHIC FINDINGS

- Suspect incidental hepatic cyst. Other differentials include hematoma, fluid-filled nodule, and even (while considered less likely), infiltrative neoplasia versus other can't be definitively ruled out.

- Otherwise, an obvious cause for the reported increased liver enzymes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia (considered unlikely), etc. cannot be definitively ruled out.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's historical liver enzyme changes, if not recently evaluated, a recheck full general metabolic health screen is recommended to include chemistry panel, electrolytes, CBC, 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.

Further recommendations include further investigation of possible underlying hepatopathy i.e., bile acids if total bilirubin is not increased, infectious disease testing, liver sampling, etc. are largely dependent on whether another underlying cause is discovered and the results of the recheck chemistry panel.

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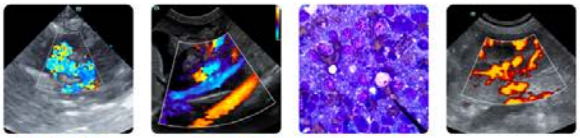

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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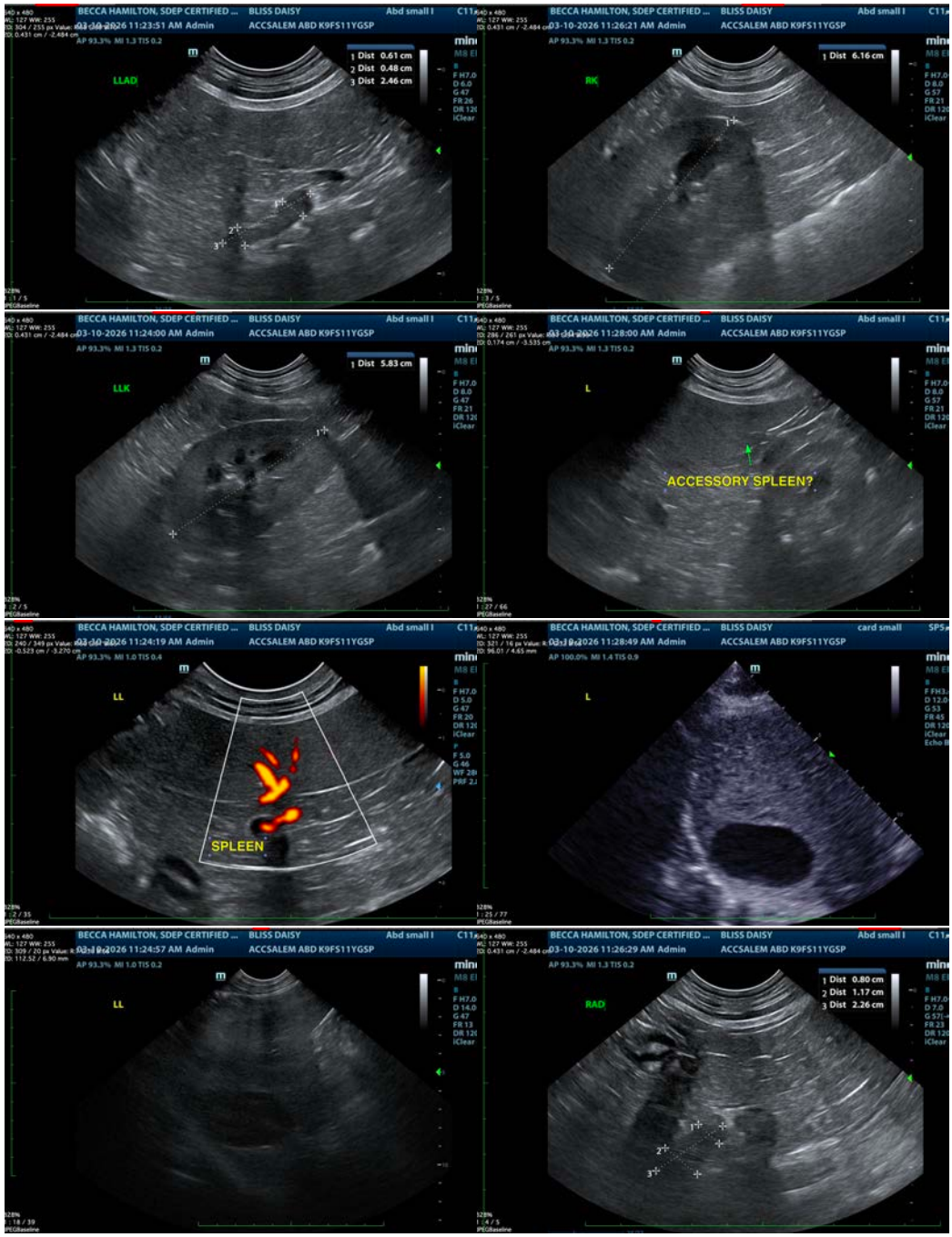

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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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