



PATIENT

Cali Koontz

SPECIES

Canine

BREED

Miniature Poodle

SEX

Spayed Female

AGE

12 Years

WEIGHT

22 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Scott

HOSPITAL NAME

Wyckoff Veterinary
Hospital

REFERRING VET

Dr. Scott

INVOICE

73422

DATE

3/5/26

PRESENTING CLINICAL SIGNS

For a few months owner noticed blood around the house and realized when she wiped her vulva that's where the blood was coming from- no blood in urine. pet has been on incurin for over a year now (1mg SID) and owner thinks that's what's causing this. Great appetite, no pu/pd, no incontinence issues since being on the incurin

Abnormal PE/Chem/CBC/UA Results: PE- vulva a bit enlarged dental disease, etc- owner interested in getting dental too cbc/chem/t4 - ALP 410, ALT 126, GGT 16, chol 681, triglycerides 800, T4 1.0, UA-USG 1.022 (mid day sample), UPC 1.0, all else normal

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 in size (5.4 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 in size (4.5 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 for a small dog, especially the right. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.65 cm at the cranial pole and 0.69 cm at the caudal pole. Right measures 1.2 cm at the cranial pole and 0.80 cm at the caudal pole.

Spleen

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Additionally near the cranial aspect of the spleen, there is an approximately 1.2 cm x 0.90 cm non-capsule disrupting, mildly heterogeneous, primarily hypo- to anechoic nodule/mass. Splenic vasculature appears normal.

Liver

The liver contains an approximately 4.5 cm x 5.2 cm mixed hypoechoic mass in the mid caudal aspect of the liver as well as (I suspect) a smaller mildly heterogeneous, hypo- to anechoic nodule near the left caudal liver measuring 2.1 cm x 2.7 cm. Having said that, the 2nd lesion actually being the previously described splenic nodule adjacent to or overlying the caudal liver can't be definitively ruled out.

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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is 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.

In the caudal abdomen, dorsal to the urinary bladder, between the cystourethral junction and the colon is an approximately 3.5 cm long x 0.93 cm thick, irregular, hypoechoic tubular structure consistent with a prominent hypoechoic empty uterine body.

ULTRASONOGRAPHIC FINDINGS

- Prominent uterine body/uterine stump.
- The previously diagnosed liver mass is static in size and appearance with the same differentials present including both benign and infiltrative neoplastic disease that can't be differentiated without tissue sampling. A 2nd smaller but similar appearing liver nodule is suspected.
- The splenic nodule is also static in size and appearance, with the differentials being unchanged.
- Very mildly subjective 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.



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- 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

Further recommendations, given the liver and splenic nodules, are in part dependent on what has previously been done, the results of those diagnostics, etc., but could include:

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 aspirate of the liver nodule(s) and splenic nodule could be considered if patient's coagulation status is appropriate.

Patient's reported presenting complaint is likely related to the uterine changes described above and should be interpreted in combination with whether patient is in fact spayed and whether it was a full ovariohysterectomy. If so, further hormone testing to assess ovarian remnants or potentially other sources of estrogen such as adrenal hormone testing, etc. could be considered. Ultimately, however, infiltrative neoplasia affecting the uterine stump/body can't be ruled out. Therefore, exploratory laparotomy for planned excisional biopsies may be warranted.

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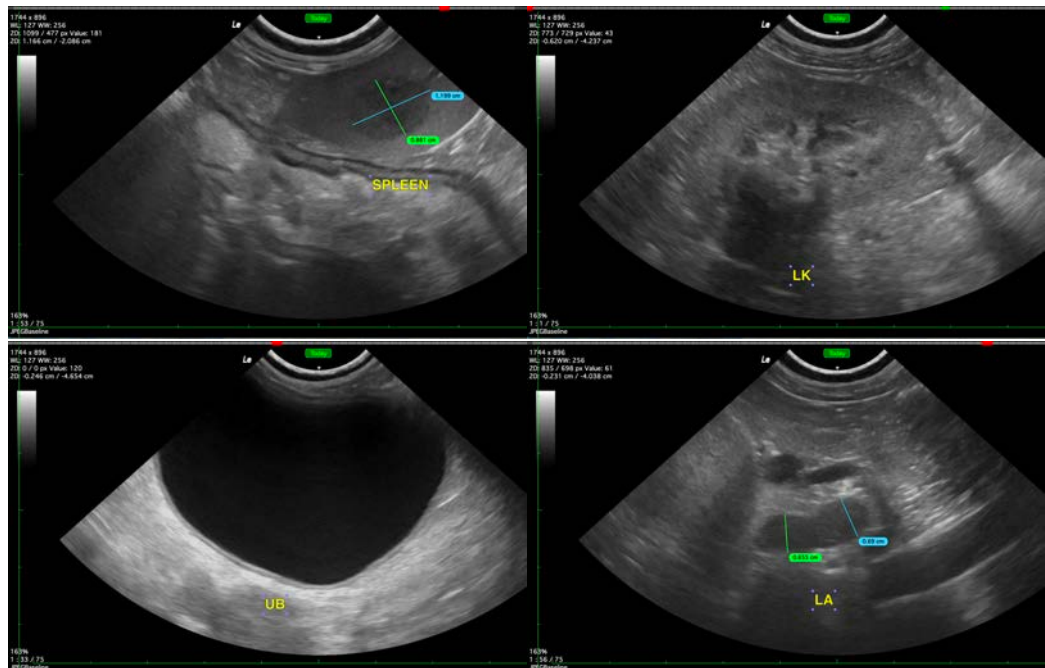
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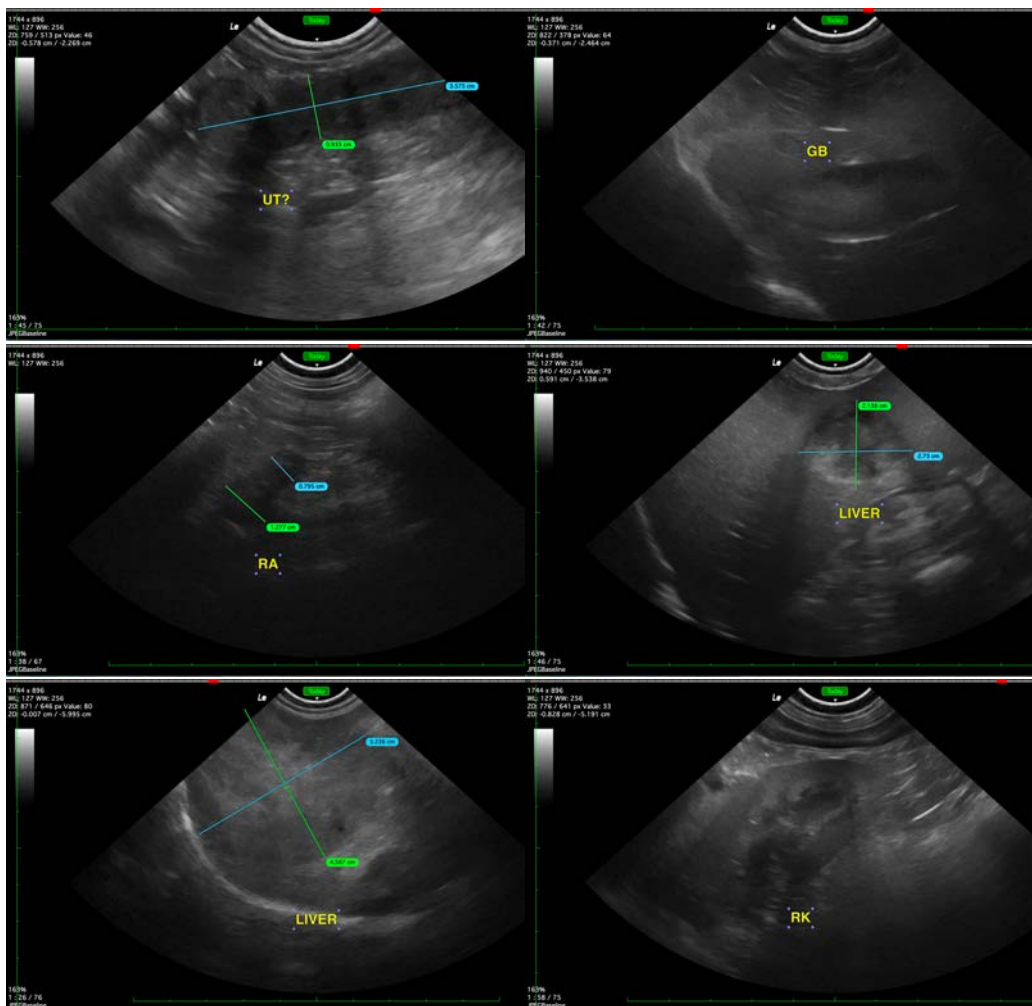
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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