



## PATIENT

Tara Fasick

## SPECIES

Canine

## BREED

Doodle

## SEX

Spayed Female

## AGE

11 Years

## WEIGHT

30.2 kg

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Melissa Randolph

## HOSPITAL NAME

Shores VEC

## REFERRING VET

Dr. Julia Kerr

## INVOICE

36513

## DATE

4/10/26

## PRESENTING CLINICAL SIGNS

History: \*4/6 P did not eat her morning meal and had 0% interest in anything. P continued hyporexia. P was noted as lethargic. 4/7 P was offered chicken and rice and ate 100%. P continued to become more lethargic. P vomited 1 time. Owners noted P had a urinary accident in the house. P also noted to be leaking urine. 4/8 P seen at RDVM. diagnostics sent out. Worsening lethargy. P started having formed stools with mucous. P diet is Hill's Z/D dry. P history of allergies. rdvm concern for elevated liver values. P admitted for supportive care. Foley urinary catheter was placed. \*concern for r/o liver cancer vs liver insult of infectious vs auto immune vs inflammatory vs toxin vs other; bladder mass vs hormonal vs neurologic.

Abnormal PE/Chem/CBC/UA Results: PE: subtle pain 1/4; pale icteric MM; sclera icteric; urine golden yellow color rdvm 4/9 U/A: USG 1.020, pH 7, protein 30, Urobilinogen 12, bilirubin 6, blood 250; CBC: PLT 93k; T4 wnl ; chem AST 265, ALT 1,489, ALP 333, T bili 5.6 lepto (witness test): negative coag: PT 18.3 H, aPTT 111.5 normal.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

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. There is a foley urinary catheter in place.

Left kidney is normal in size (6.99 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.

Right kidney is normal in size (6.93 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*

Left adrenal gland is normal in size (0.46 cm at cranial pole and 0.41 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is unable to be well visualized in these images.

### *Spleen*

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal.

### *Liver*

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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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 mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. 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 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.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

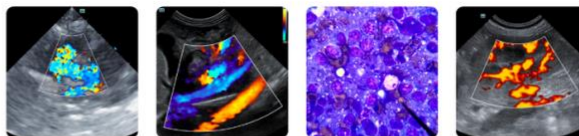
- Coarse splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis and lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- An obvious cause for the subtle liver changes 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, etc. cannot be definitively ruled out.

### Secondary Findings

- Foley urinary catheter in place

## 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.



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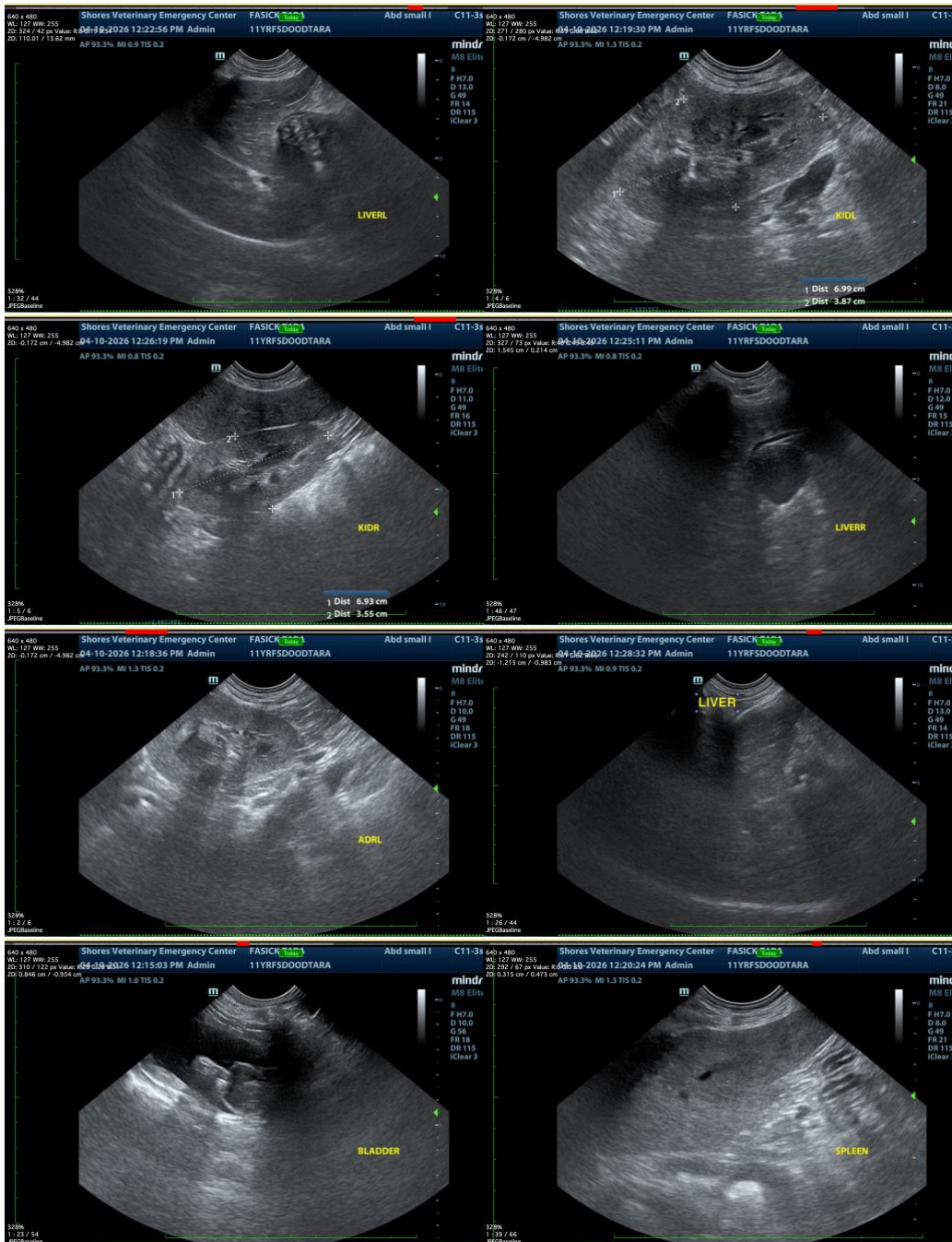
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Fine needle aspirates of the spleen +/- liver are recommended if patient's coagulation status is appropriate.

Pending results of sampling, comprehensive infectious disease evaluation could be considered.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.





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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