



## PATIENT

Roxy Sherman

## SPECIES

Canine

## BREED

Jack Russell Mix

## SEX

Female

## AGE

15

## WEIGHT

5.5

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Dr. Laura de Cordon

## HOSPITAL NAME

Lakeview AH

## REFERRING VET

Dr. Laura de Cordon

## INVOICE

36603

## DATE

4/14/26

## PRESENTING CLINICAL SIGNS

History: Vomiting and diarrhea for the last week, Anorexia, History of kidney disease  
Abnormal PE/Chem/CBC/UA Results: BW: increased PL

## 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.

The kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. No mineral is observed. Moderate to severe left kidney pyelectasia is present, measuring 0.67 cm sagittal view. Mild pyelectasia is present in the right kidney. The left kidney is small/normal measuring 3.58 cm. The right kidney is small/normal, measuring 3.4 cm.

### *Adrenal Glands*

The adrenal glands are unable to be visualized in these images.

### *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). No 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. Focally, in the mid to caudal liver is an approximately 2.4 cm x 1.7 cm in size, homogenous, hypoechoic mass. Visible vasculature and biliary tree appear normal without distension or congestion.

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.

### *Gastrointestinal*

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. 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.



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## *Pancreas*

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

## *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 process such as nodular hyperplasia, hepatoma/adenoma, chronic inflammatory change, other, although infiltrative neoplasia such as a hepatocellular carcinoma, round cell neoplasia, etc., can't be ruled out without tissue sampling.
- 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.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Moderate bilateral chronic kidney disease changes with bilateral pyelectasia, most significant in the left kidney.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Additionally, if not recently evaluated, a full general metabolic health screen is recommended to also include CBC chemistry panel and electrolytes.

A routine fecal/Giardia exam is recommended if not recently evaluated.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Given the liver changes, three view thoracic radiographs are recommended for further assessment of



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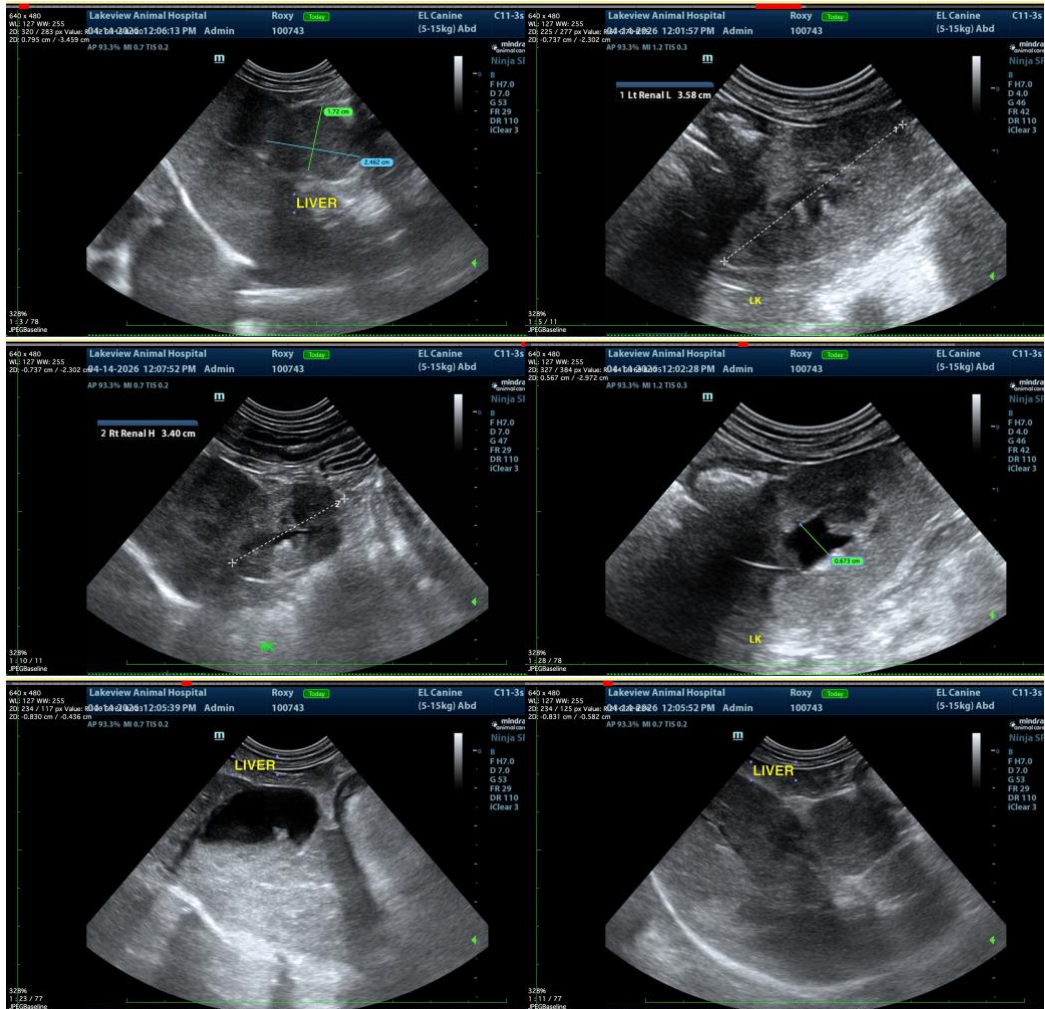
**DATE**

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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.

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



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



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