



PATIENT

Emmie Power

SPECIES

Canine

BREED

American Pitbull
Terrier Mix

SEX

FS

AGE

12 years

WEIGHT

54 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

**IMAGING
PERFORMED BY**

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

South Reno Veterinary
Hospital

REFERRING VET

Dr. Schmitt

INVOICE

11760

DATE

4/21/2026

PRESENTING CLINICAL SIGNS

Owner reports no vomiting diarrhea coughing sneezing. Eating and drinking normal. Mobility and activity normal. Owner adopted about 2 weeks ago. See previous veterinary medical records. Owner has stopped medications no exercise intolerance or coughing. Patient walks at least 1 mile per day. Heart, Lungs and pulse: Grade 2/6 left-sided systolic base heart murmur and appears to be slightly audible on the right side and lungs auscult and femoral pulses within normal limits.

Abnormal PE/Chem/CBC/UA Results: MS: 4/13/2026 at 8:24a: Chemistry screen: Slight increased ALT 142 and cholesterol. 363 Severe increase alkaline phosphatase 2842 CBC: Slight increased monocytes Heartworm test antigen: No Antigen Detected Fecal: All undetected Urinalysis: Specific gravity upper end of normal. Increased pH. Both are likely contributing to falsely increase protein A: Severe alkaline phosphatemia. Monocytosis mild. Also, bile acids test. Will reassess if patient is a candidate for general anesthesia at that point. Will require all of these tests prior to anesthesia if owner wants to proceed.

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 (6.44 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 (6.48 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

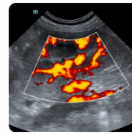
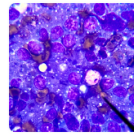
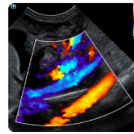
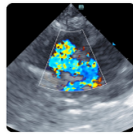
Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left adrenal measures 1.0 cm at the cranial pole and 1.1 cm at the caudal pole. Right adrenal measures 0.92 cm at the caudal pole and the cranial pole is difficult to fully visualize/isolate for measurement.

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.

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 right cranial liver, there is an approximately 6.4 cm x 8.2 cm largely homogenous, mixed echogenic mass. Visible vasculature and biliary tree appear normal without distension or congestion.



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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.

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

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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. There is no evidence of obstruction or foreign material noted.

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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.

WEIGHT

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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.

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Beth Johnson, DVM
DACVIM

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

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Loetitia Saint-Jacques,
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There is no apparent pathologic lymphadenopathy noted in these images.

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ULTRASONOGRAPHIC FINDINGS

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- The liver mass could represent a benign process such as marked nodular hyperplasia, a hepatoma/adenoma, chronic inflammatory lesion, other. Although infiltrative neoplasia including hepatocellular carcinoma, round cell neoplasia versus sarcoma versus other, can't be ruled out without tissue sampling.
- Mild 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.
- 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.

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Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.

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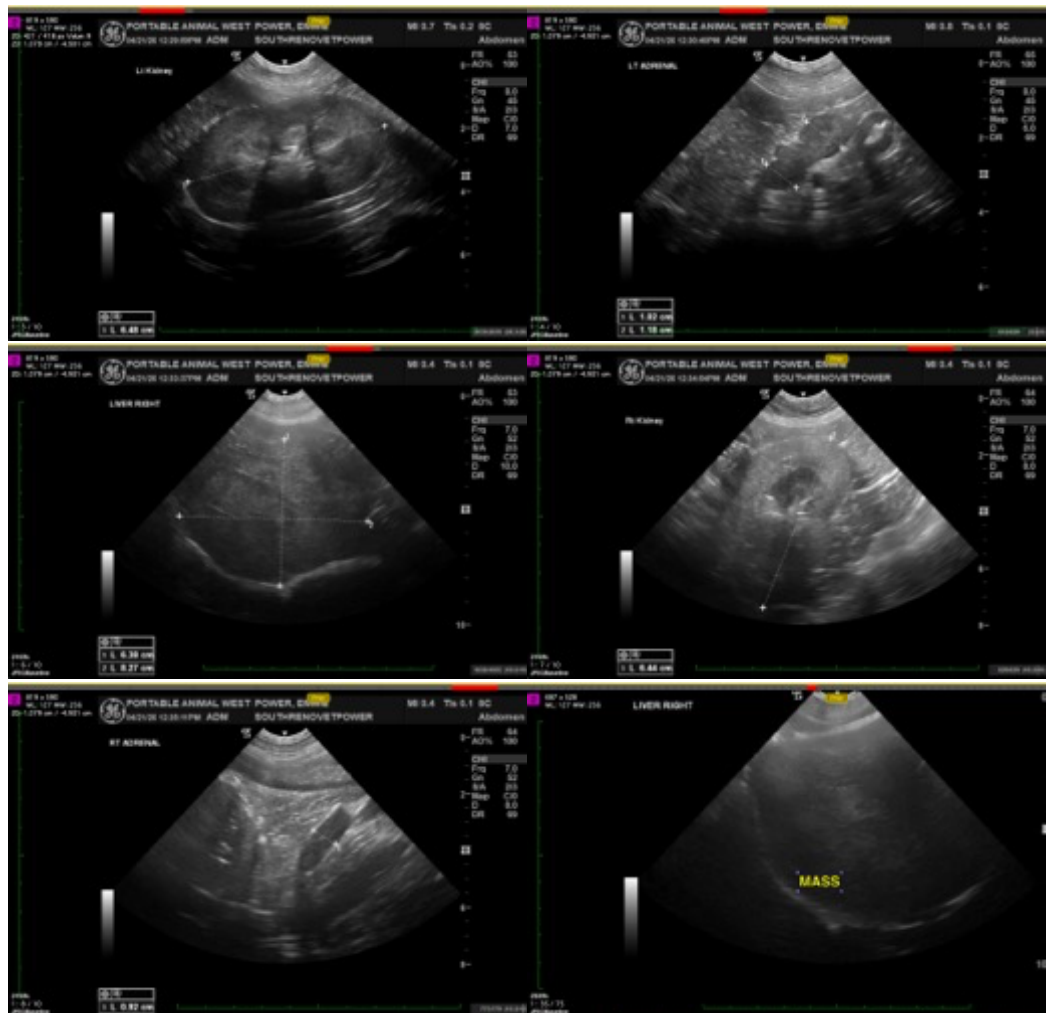
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the changes described above, there are several differentials for patient's reportedly increased alkaline phosphatase, however, the most significant finding in these images is the liver mass. Therefore, initial recommendations include:

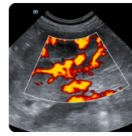
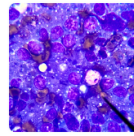
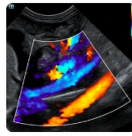
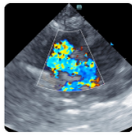
- Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.
- Fine needle aspirates of the mass are recommended if patient's coagulation status is appropriate.
- Alternatively, or if a cytology diagnosis is unable to be obtained, an exploratory laparotomy for planned excisional biopsy/liver lobectomy could be considered.



Imaging
performed by



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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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