

PATIENT

Benny Johnson

SPECIES

Canine

BREED

Pug

SEX

Neutered Male

AGE

10 Years 10 Months

WEIGHT

24 pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Johnathan Moss

HOSPITAL NAME

Harvest Hills
Veterinary Hospital

REFERRING VET

Dr. Johnathan Moss

INVOICE

15326

DATE

04/22/26

PRESENTING CLINICAL SIGNS

Pt presented for chronic cough, which was pred responsive. found abdominal mass on rads

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

Left kidney is normal in size (4.9 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 (5.1 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 (0.36 cm at cranial pole and 0.43 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.50 cm at cranial pole and 0.45 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The splenic parenchyma definitively identified as 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). Splenic vasculature appears normal. An approximately 0.40 cm by 0.60 cm anechoic non-capsule disrupting density near the cranial aspect of the spleen was present. *See Other.*

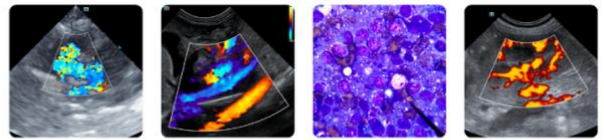
Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is (mildly, moderately or markedly) heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion. This change is most significant in the cranial liver.

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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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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 empty with no evidence of obstruction, foreign material or infiltrative disease.

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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.

Pancreas

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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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Free Abdomen

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

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There is no apparent pathologic lymphadenopathy noted in these images.

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In the cranial abdomen, there's an approximately a 4.6 cm by 5.9 cm largely homogenous, mixed echogenic, but primarily hyperechoic mass that in some views appears to originate from the spleen. Having said that, definitive etiology is difficult to determine.

ULTRASONOGRAPHIC FINDINGS

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- The cranial abdominal/suspect splenic mass could represent a benign process such as extramedullary hematopoiesis, nodular hyperplasia, chronic inflammatory lesion, even a large myelolipoma versus other, although infiltrative neoplasia, including sarcoma, round cell neoplasia, etc., can't be ruled out without tissue sampling.

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- The moderately heterogeneous, especially cranial liver, similarly could represent a benign process such as nodular hyperplasia, chronic inflammatory change, extramedullary hematopoiesis, etc., although infiltrative neoplastic or metastatic nodules while thought less likely can't be ruled out.

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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.

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- Hypo- to anechoic splenic nodule- likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions and cannot be ruled out.

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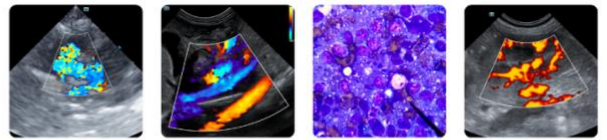
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Fine needle aspirates of the suspected splenic mass +/- liver are recommended if patient's coagulation



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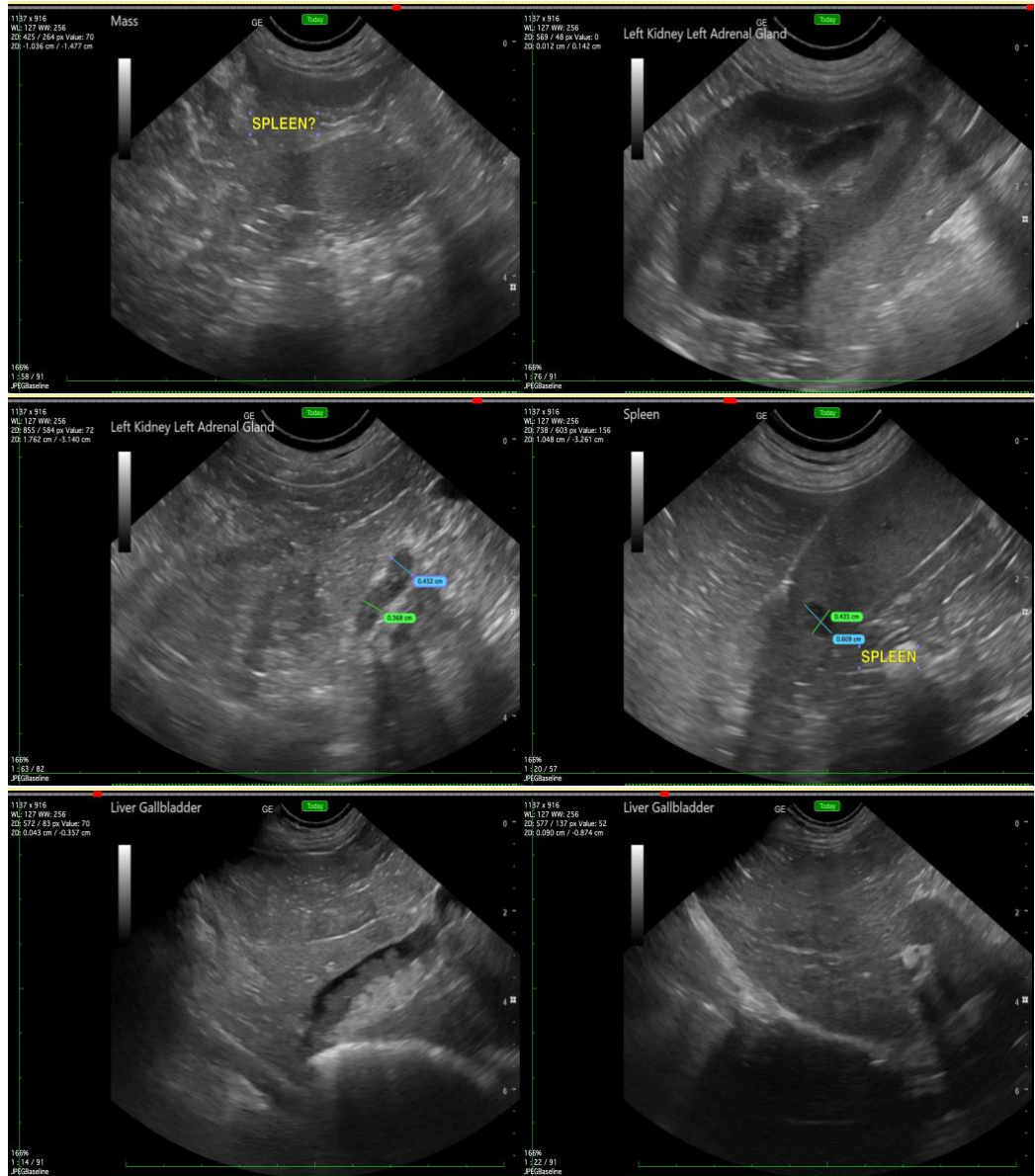
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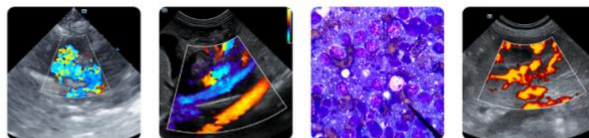
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status is appropriate.

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





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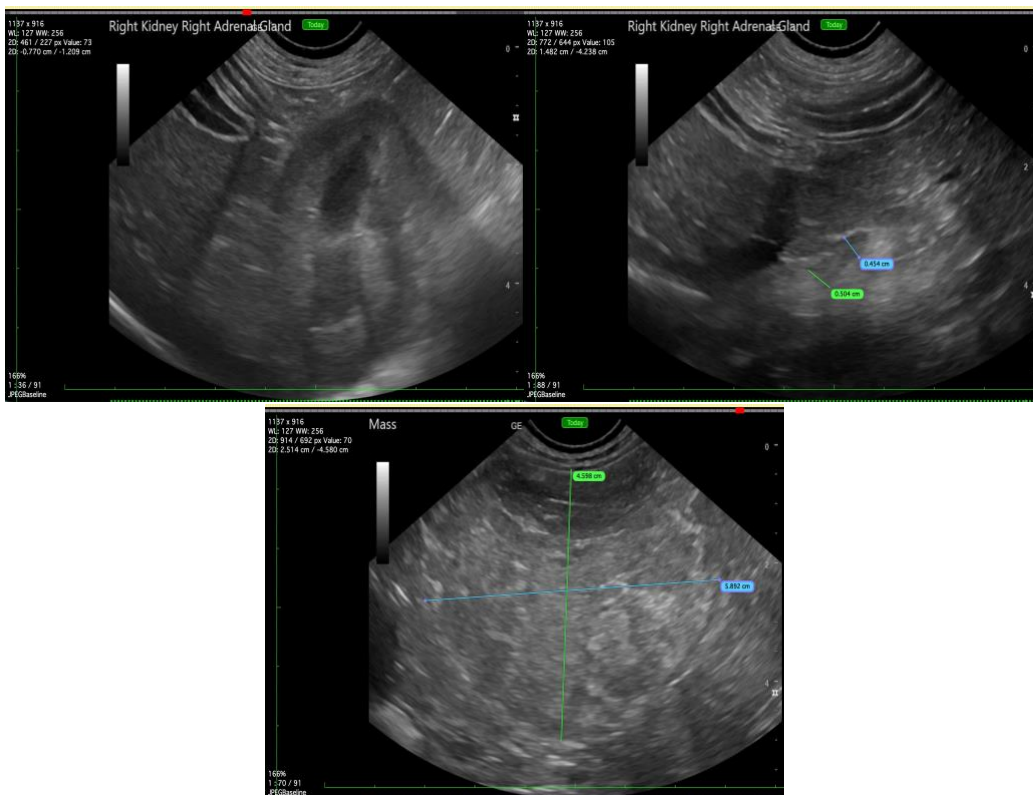
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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