PATIENT

Gracie Tassinari

SPECIES

Canine

BREED

Goldendoodle

SEX

FS

AGE

12 years

WEIGHT

58 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Chase Veterinary CLinic

REFERRING VET

Dr. Hallie Lipinski

INVOICE

11832

DATE

4/29/2026

PRESENTING CLINICAL SIGNS

Patient presented ADR/vomiting/anorexia. 103.9 temp on initial exam. Painful on abdominal palpation. 6 lb weight loss from previous exam. BUN 8, Alb 2.6, ALT 683, AST 138, ALP 1493, GGT 43, Tbili 0.5, Lipase 1435. Abdominal radiographs: peritoneal effusion, diffuse hepatomegaly, irregular marginated spleen, ill-defined soft tissue ventral to caudal lumbar vertebra *There was also a large pleural effusion noted with focused imaging (cardiac structure and function 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 is size (6.3 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Pinpoint non-obstructive mineral densities are noted bilaterally. There is no evidence of pyelectasia or infarcts observed.

The left kidney is normal is size (6.0 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Pinpoint non-obstructive mineral densities are noted bilaterally. There is no evidence of pyelectasia or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.5 cm at cranial pole and 0.6 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.6 cm at cranial pole and 0.6 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.8 cm thick at the hilus) with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. Additionally, near the mid to caudal aspect of the spleen is an approximately 1.7 cm in diameter, mildly heterogenous, expansive hypoechoic mass. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mottled by multifocal discrete hypoechoic nodules of varying sizes “moth-eaten”. 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

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Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is also mildly diffusely thick measuring 0.37 cm thick with intact layering, and is empty with no evidence of obstruction or foreign material.

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

A mild to moderate amount of free fluid is noted in these images, with some concurrent pleural effusion suspected.

In the mid left abdomen, just caudal to the spleen, is an approximately 2.3 cm x 3.4 cm mixed, largely hyperechoic density/mass of unknown origin. No other definitive pathologic lymphadenopathy is visible in these images.

PRIMARY FINDINGS

- The coarse nodular appearance of the liver and spleen is concerning for infiltrative neoplasia such as round cell neoplasia versus metastatic neoplasia versus other. Having said that, benign process, either the same or different processes affecting both organs can't be ruled out without tissue sampling.
- Gastritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.
- Mild inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- The mildly thick colon represents the same differentials as the remaining GI tract.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Mild to moderate free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

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- The mid abdominal mass of unknown origin could represent a benign inflammatory process, potentially a granuloma, reactive lymph node, lipoma, other. Although, especially given the remaining pathology, infiltrative neoplasia, potentially a metastatic lesion, or mesenteric pathology as is seen with something like carcinomatosis versus other can't be ruled out.

SECONDARY FINDINGS

- Bilateral pinpoint non-obstructive mineral densities in the kidneys.
- 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

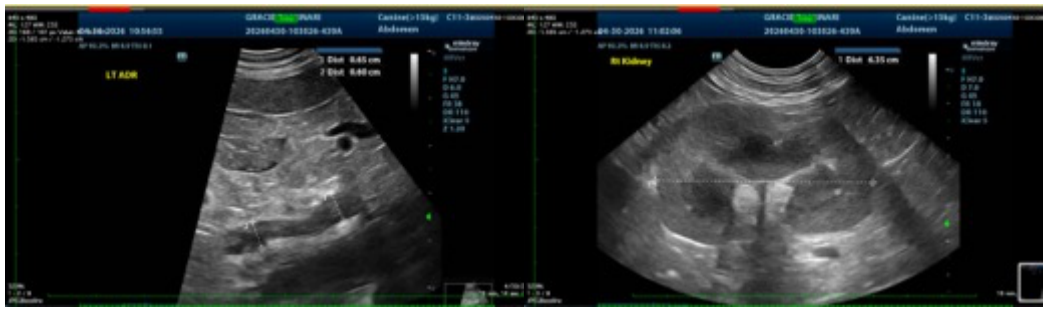
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Ultimately, looking for/trying to rule out diffuse infiltrative neoplasia is recommended; therefore, tissue sampling is recommended.

Fine needle aspirates of the splenic mass, the liver, the mass in the mid abdomen caudal to the spleen, potentially sampling of the free fluid, etc. for analysis and cytology could be considered if patient's coagulation status is appropriate.

Additionally, and/or alternatively, advanced imaging such as a thoracic and abdominal contrast CT scan could be considered.

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



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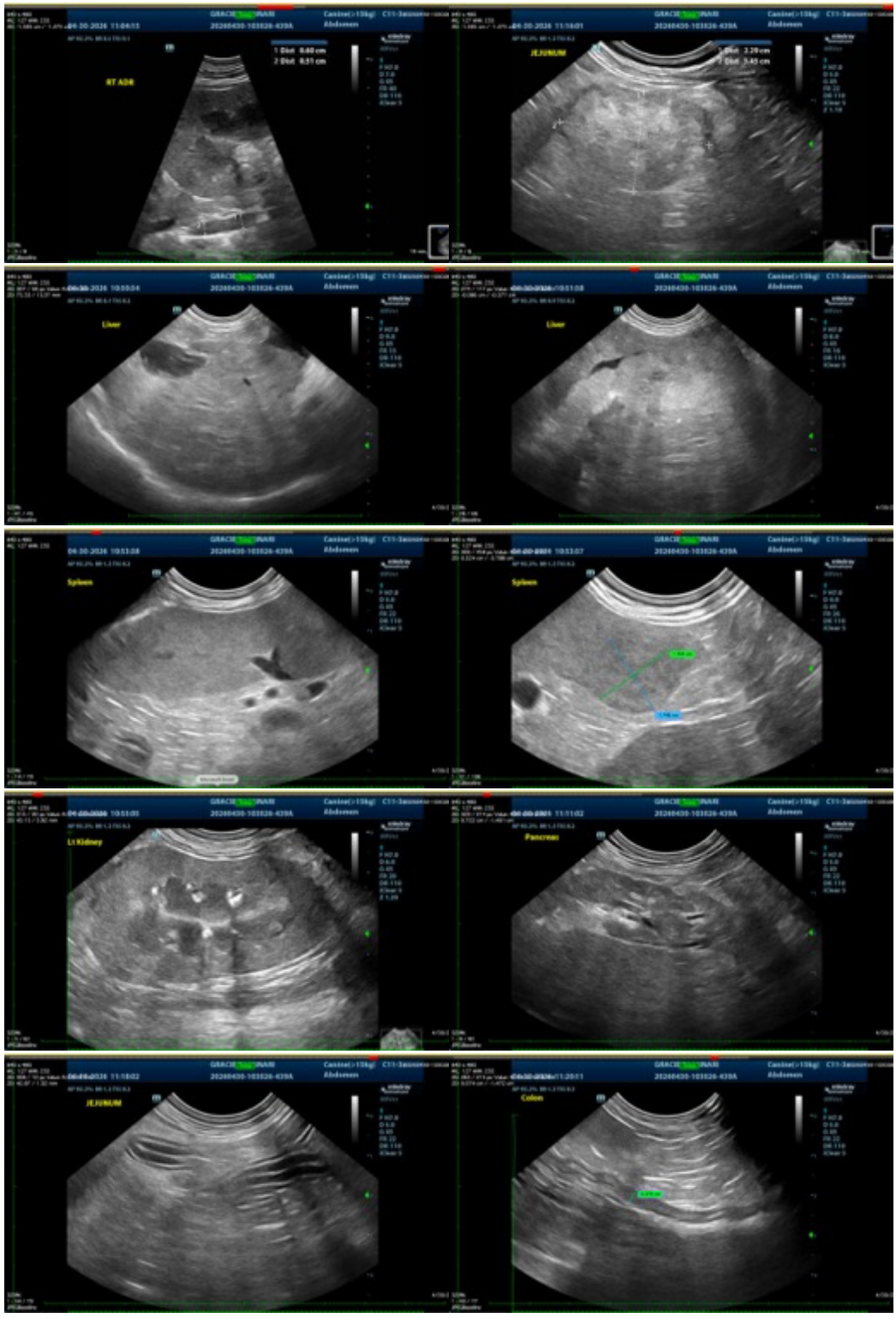

The information and recommendations provided are based on the images presented by the referring

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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