



## PATIENT

Lexi Pence

## SPECIES

Canine

## BREED

Blue Heeler X

## SEX

FS

## AGE

9 years

## WEIGHT

51.2 lbs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Jessica Bailes

## HOSPITAL NAME

All Creatures Great &  
Small Veterinary Clinic  
- Corvallis

## REFERRING VET

Dr. Beth Marszekwski

## INVOICE

11823

## DATE

4/29/2026

## PRESENTING CLINICAL SIGNS

Acute onset vomiting 1 week ago. Prior hx of reactive hepatopathy (ALT elevations)- managed w/ strict diet and denamarin. HAC (PDH) diagnosed 4/2023 via LDDST d/t ALP starting to become elevated but no tx has been instituted as patient has been asymptomatic.

Abnormal PE/Chem/CBC/UA Results: Febrile, otherwise NSF on PE BW: CBC: HCT (46.6%), MCV (57.5)- slightly low, WBC (17.95), Neutrophilia (15.6) Chem: BUN (6), AP (301), K+ (3.3) Lytes: UR Lipase: (77) UR Abdominal rads: 2. Wispy soft tissue streaking in the abdomen consistent with peritonitis or effusion. Accuplex: negative UA: unremarkable.

## 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 (5.4 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 (5.57 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

The adrenal gland is enlarged (1.7 cm at the cranial pole and 0.67 cm at the caudal pole) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted (at the cranial pole) without evident capsular escape or vascular invasion.

The left adrenal gland is normal in size (0.38 cm at cranial pole and 0.53 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### 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. No focal lesions are observed. 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.



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## 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.

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.

## 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 apparent pathologic lymphadenopathy noted in these images.

In the mid abdomen there's an approximately 4.37 cm x 3.67 cm in size irregular, hypoechoic mass surrounded by trace free fluid and enhanced hyperechoic mesenteric fat that appears to be a bowel mass with a location that's difficult to definitively identify.

## PRIMARY FINDINGS

- Suspect bowel mass is concerning for infiltrative neoplasia such as round cell neoplasia i.e. lymphoma versus carcinoma versus other. Scant free fluid and enhanced mesenteric fat adjacent to the mass are suggestive of a focal peritonitis.

## SECONDARY FINDINGS

- The right adrenal nodule/mass is consistent with patient's reported previous history of diagnosed hyperadrenocorticism.
- 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.

Fine needle aspirates of the bowel mass could be considered if patient's coagulation status is appropriate.



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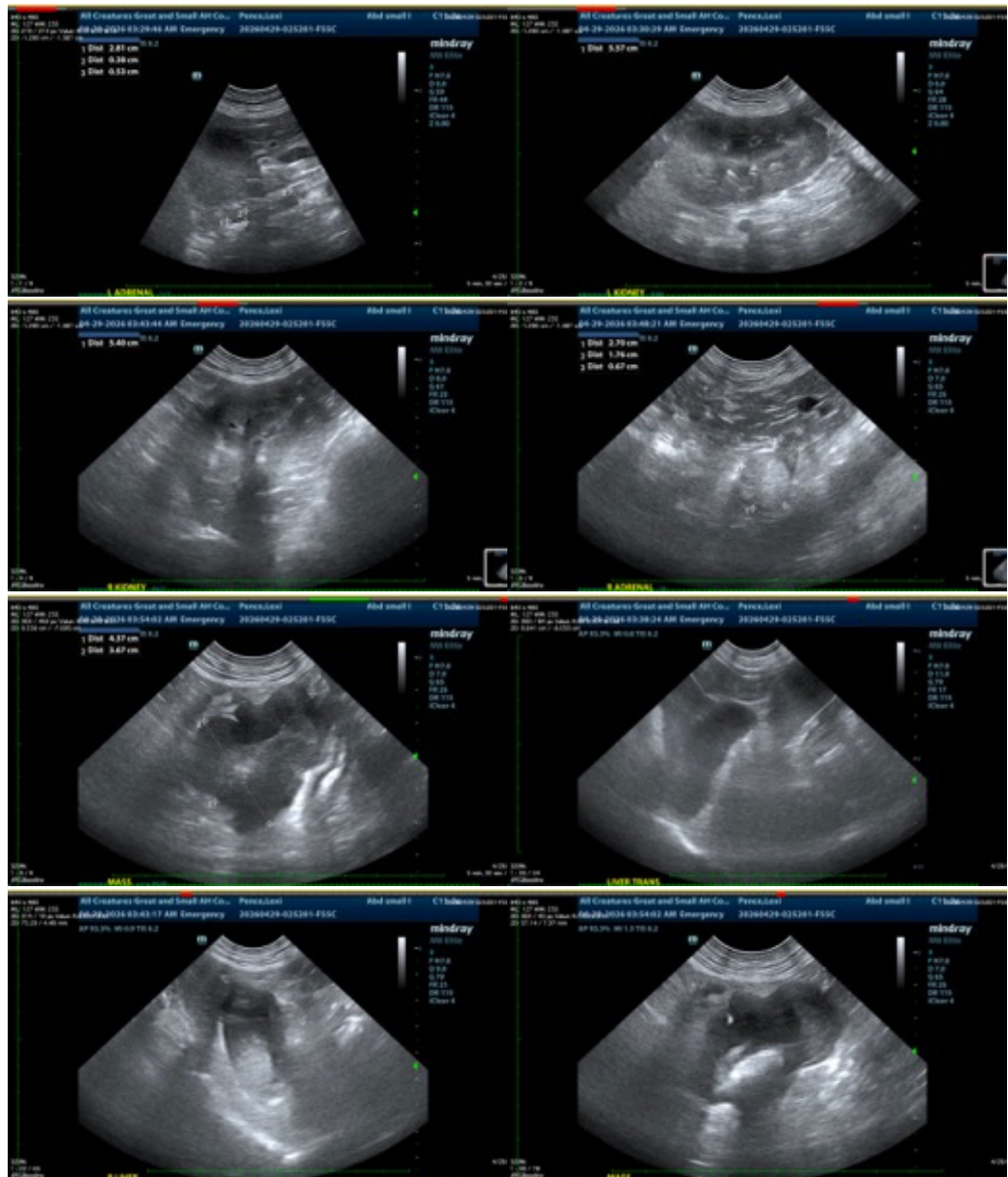
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Alternatively, and/or if a cytologic diagnosis is unable to be obtained, or if given patient's fever, etc. there's any concern for a septic abdomen, etc. an exploratory laparotomy for planned resection and anastomosis, and histopathology of the bowel mass may be warranted.



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.



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info@sonopath.com

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