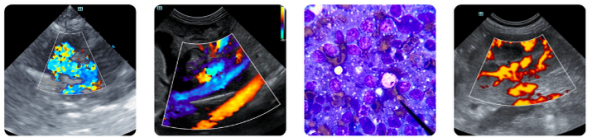


PATIENT

Maya Lester

SPECIES

Canine

BREED

Greater Swiss Mountain Dog

SEX

FS

AGE

6 years 3 months

WEIGHT

87.6 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershire Animal Hospital

REFERRING VET

Companion Animal Hospital

INVOICE

11827

DATE

4/30/2026

PRESENTING CLINICAL SIGNS

4wk Hx inappetance + wt loss. QW V +/ -bile. Painful Abd palp. New cutaneous lump on L shoulder, waxing +waning in size (3-4mo). Thoracic Rods unremarkable. Total Health profile unremarkable. Abd Rads: Pt ate 2hr prior to rads. Difficult to assess cranial abd. FNA/Cytology of mass - concem for mast cell. Does occ eat things we shouldn't, but O's report hasn't eaten in about 24 hours

Current Meds: Nexgard 60-121#, Cerenia 60mg 2t PO SID, Famotidine 40mg PO BID, Benadryl 4cap PO BID.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots, as well as dependent mineral "sand" (crystals) debris. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or discrete definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

My left versus right kidney description is based on timing of the visualized structure in the study, as no right versus left labeled images or stills are provided. Therefore, the chance that I'm imaging the same structure twice, if it was circled back to can't be definitively ruled out

The right kidney is normal is size (6.4 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 (6.7 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

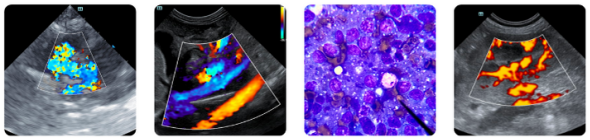
*My left versus right adrenal description is based on timing of the visualized structure in the study, as no right versus left labeled images or stills are provided. Therefore, the chance that I'm imaging the same structure twice, if it was circled back to can't be definitively ruled out *

Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left adrenal measures 0.33 cm at the cranial pole and 0.34 cm at the caudal pole. Right adrenal measures 0.34 cm at the cranial pole and 0.39 cm at the caudal pole.

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



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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.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is moderately overdistended with fluid and echogenic non-shadowing contents consistent with normal ingesta/chyme. Pyloric outflow tract appears patent. *See small bowel*

Diffusely 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. Except for, in the right cranial abdomen (and I can't tell if it's pylorus, proximal duodenum, or even the ileocecal colic junction area) there's a focal loop of small bowel that's diffusely thick measuring 0.8 cm thick with some emerging loss of layering in that area suspected. The bowel is dilated, just cranial to this focally thick area, which could indicate some degree of obstruction. There is no definitively visible foreign material, but the gastrointestinal tract is very full, and foreign material can't be definitively ruled out.

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. *See Free Abdomen*

Free Abdomen

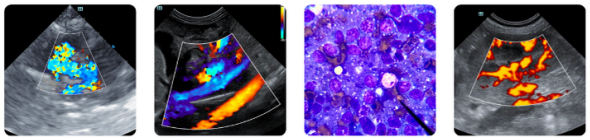
There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

Throughout the cranial abdomen, throughout the area of the pancreas and surrounding the focally thick loop of bowel described above, is diffusely hyperechoic nodular appearing connective tissue characterized by a hyperechoic background and then discrete homogenous, hyperechoic nodules throughout the hyperechoic background.

ULTRASONOGRAPHIC FINDINGS

- Suspect focal infiltrative bowel disease, both benign, parasitic, infectious, other benign inflammatory and infiltrative neoplastic disease are differentials. There's some concern for at least partial obstruction based on dilation cranial to that area, but the GI tract is full making evaluation difficult. No definitively visible foreign material is present, but it can't be ruled out.



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- Flat adrenal glands – This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.
- A moderate to large amount of echogenic urinary bladder mineral/sand debris.
- The hyperechoic nodular tissue throughout the cranial abdomen is of unknown etiology. It could represent focal inflammatory changes, myelolipomas, granulomatous change, etc. Infiltrative neoplasia is possible but considered less likely.

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.

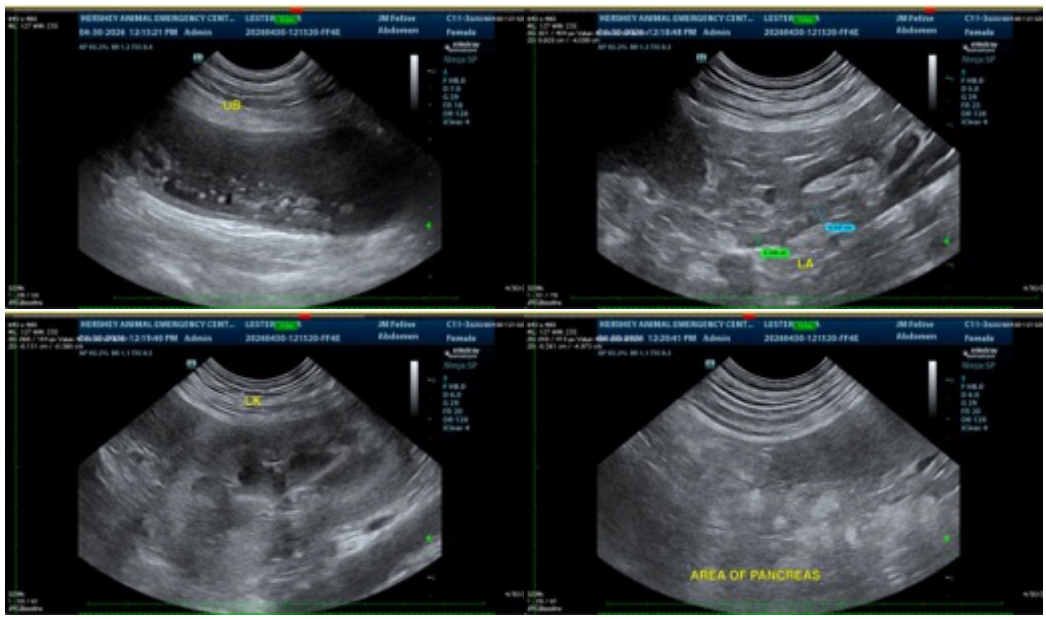
A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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 routine fecal/giardia exam is recommended if not recently evaluated.

Additionally, fine needle aspirates of the nodular cranial abdomen tissue as well as the focally thick bowel, if it can safely be reached, could be considered if patient's coagulation status is appropriate.

Alternatively, or if a cytologic diagnosis is unable to be obtained, and/or if the focal area is resulting in obstruction, an exploratory laparotomy for planned resection and anastomosis, and histopathology, may be necessary for ad definitive diagnosis and partial therapeutic approach.



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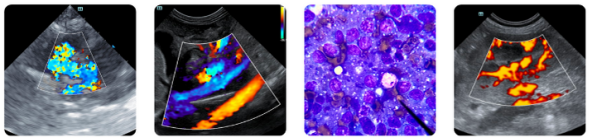

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Educational Teleconsultation Services™

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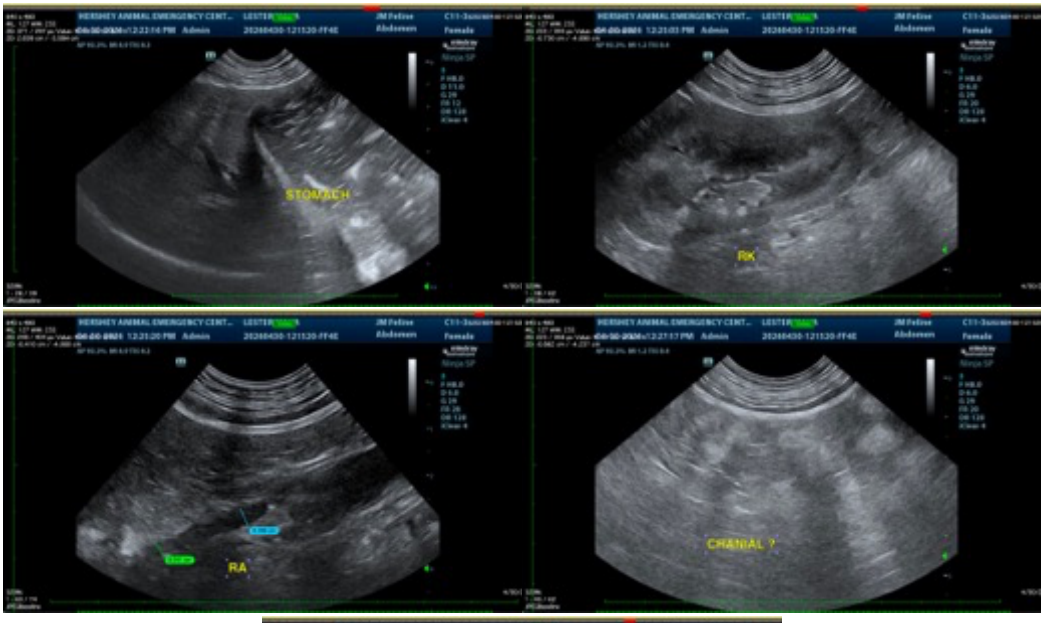

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com