



**PATIENT**

Ella Stanziale

**SPECIES**

Canine

**BREED**

Rottweiler

**SEX**

Spayed Female

**AGE**

7 Years 10 Months

**WEIGHT**

101 pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Kerri Becker

**HOSPITAL NAME**

Rockaway Animal  
Hospital

**REFERRING VET**

Dr. Brooks

**INVOICE**

14968

**DATE**

04/09/26

**PRESENTING CLINICAL SIGNS**

Acute vomiting and bloody diarrhea, not eating or drinking. Had sx on 4/6 for mass removal, went home on rimadyl and gaba, started vomiting food and bile since 4/6 diarrhea since 4/7

Abnormal PE/Chem/CBC/UA Results: mono-1.67 alp-291 panc lipase-554 cortisol-1.76 acthstim normal.

**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.

Left kidney is normal in size (6.83 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 (7.39 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 (0.86 cm at cranial pole and 0.54 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.0 cm at cranial pole and 0.75 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

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 3.5 cm x 4.2 noncapsule disrupting hypo- to anechoic nodule/mass in the mid spleen was present.

**Liver**

Liver is normal to subjectively small in size with slightly undulating or scalloped capsular contour or margins. Parenchyma is diffusely heterogenous with increased portal markings and coarse architecture. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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**

There's no definitively visible gastric distention or notable pathology in the area of the stomach but the stomach wall is difficult to fully assess and the pylorus is unable to be well visualized in these images due to dark cranial abdominal images and artifact.



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The visible small intestines are normal in wall thickness and layering. Bowel is diffusely mildly fluid distended without evidence of an obstructive pattern, plication and/or visible foreign material. Small intestinal hyperperistalsis is 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.

**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**

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

There is no apparent pathologic lymphadenopathy noted in these images.

**ULTRASONOGRAPHIC FINDINGS**

**WEIGHT**

101 pounds

- An obvious cause for the subtle liver changes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia, etc. cannot be definitively ruled out.

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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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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Further recommendations depend somewhat on what the mass removal was i.e. a mast cell tumor or other neoplasia would further support sampling of the spleen and liver if patient's coagulation status is appropriate. Otherwise, given patients reported clinical signs following surgery, discontinuation of non-steroidals are recommended if possible while offering supportive/symptomatic medical management of possible microulceration. If clinical signs persist and a diagnosis is not reached after that, a routine fecal/Giardia exam is recommended.

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If not recently evaluated, 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.

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A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

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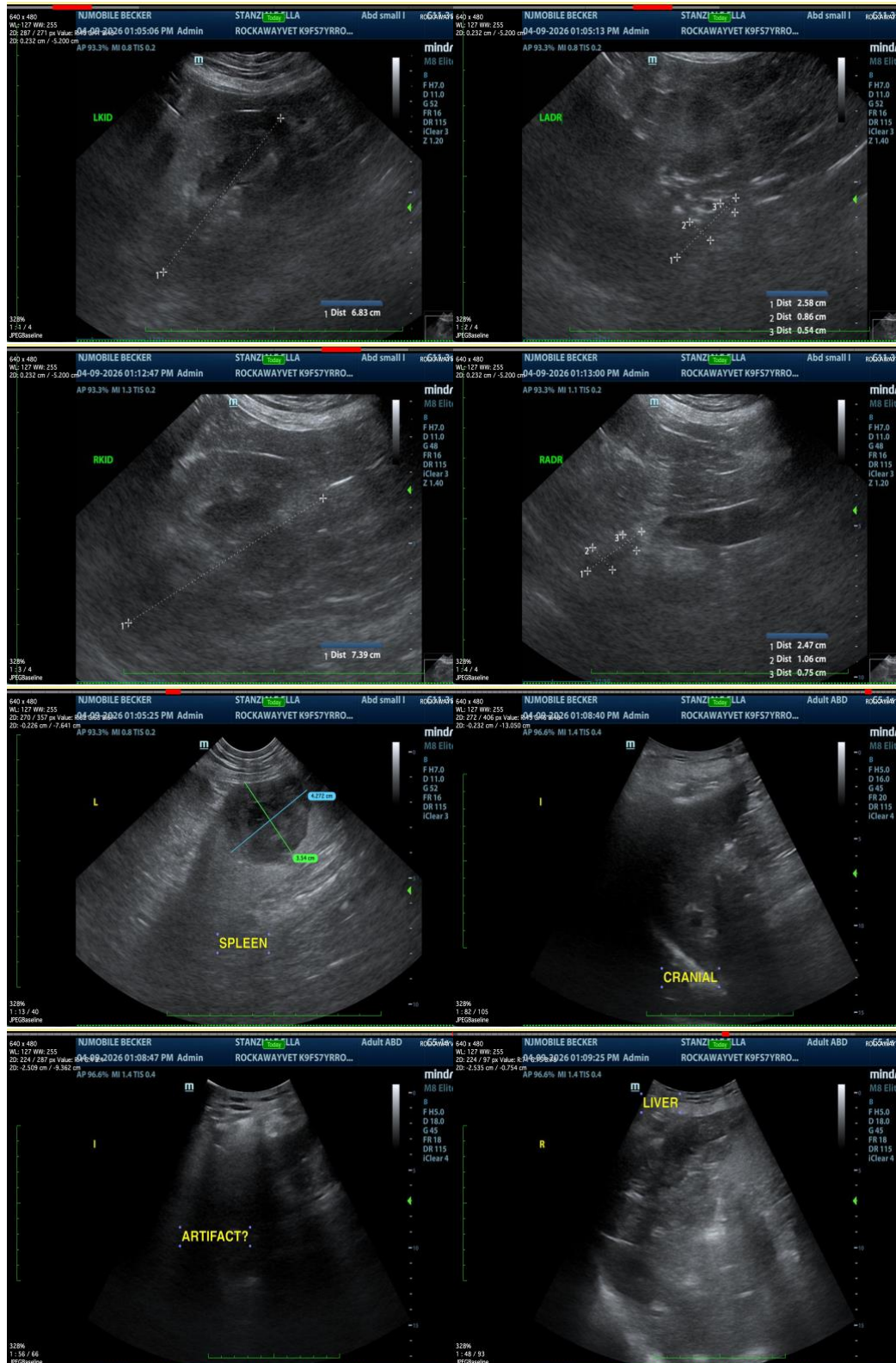
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**

info@sonopath.com