



PATIENT

Skye Stringer

SPECIES

Canine

BREED

Siberian Husky

SEX

FS

AGE

12

WEIGHT

36

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Christensen

HOSPITAL NAME

Tranquility VC

REFERRING VET

Dr. Castellani

INVOICE

11939

DATE

5/13/2026

PRESENTING CLINICAL SIGNS

Lethargic, Azotemia, hepatopathy with severe ALT/ALP elevations, Anorexia with 1.5-2 lb weight loss over 6 days, Vomiting and regurgitation, Anemia.

Current meds: Phenobarbital 60mg BID.

Abnormal PE/Chem/CBC/UA Results: Anemia, creat increased, BUN increased, phosphorus increased, sodium increased, chloride low, TP increased, globulins increased, ALT increased, ALP increased, GGT increased, Cholesterol increased. -BW attached.

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 a mild amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 6.84 cm and the right kidney measures 6.88 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.49 cm at cranial pole and 0.64 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.61 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable 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. The liver contains an approximately 7.0 cm in diameter irregular, homogenous, hyperechoic mass in the mid deep 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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is 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 visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- The liver mass could represent a benign process such as nodular hyperplasia, fibrosis of an old hematoma, granuloma or other inflammatory lesion, myelolipoma, etc. However, infiltrative neoplasia including primary hepatic neoplasia, round cell neoplasia or even a metastatic nodule can't be definitively ruled out without tissue sampling.
- 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.
- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

SECONDARY FINDINGS

- Mild age-related kidney changes.
- A mild amount of echogenic urinary bladder debris.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

To further assess the azotemia and try to differentiate renal azotemia versus prerenal azotemia versus other underlying metabolic disease, etc. if not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

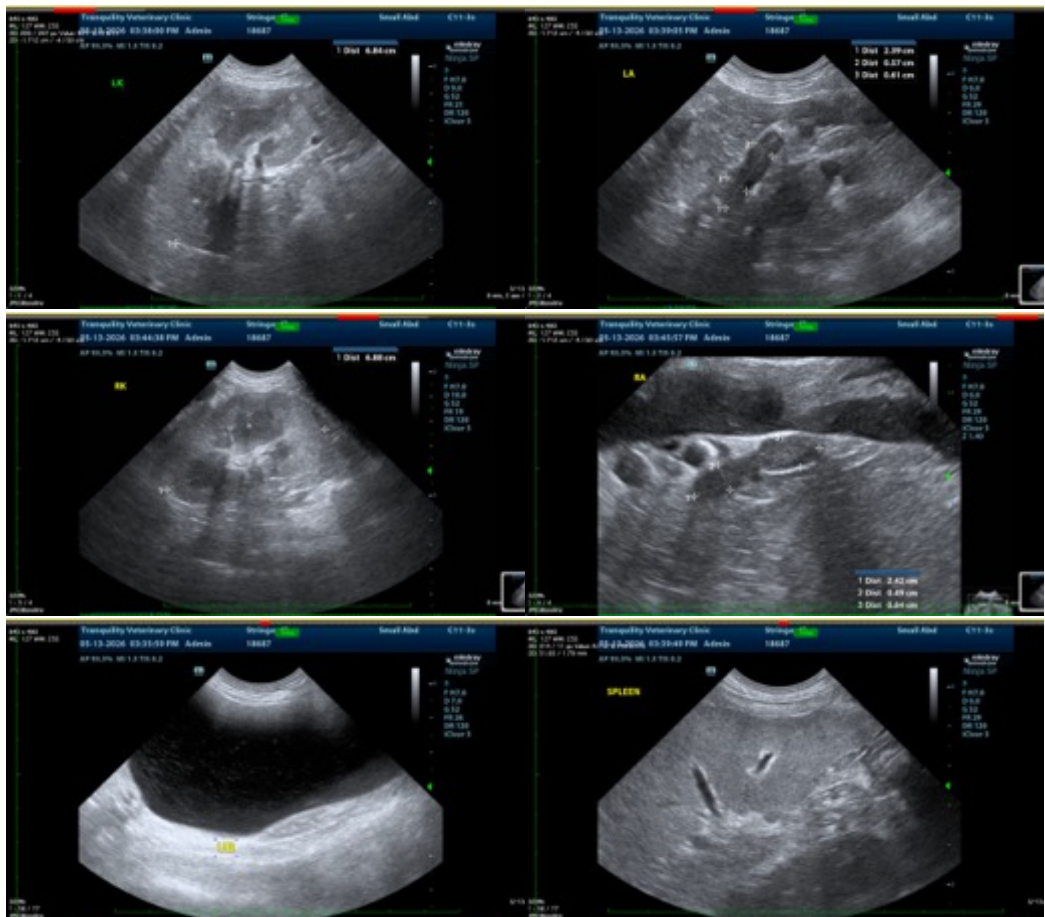
A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Given the concurrent azotemia and liver enzyme changes, testing for leptospirosis could be considered.

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 liver mass +/- spleen are recommended if patient's coagulation status is appropriate.

In the meantime, if it's possible to do so, a slow tapering and transition from phenobarbital to another antiepileptic medication could also be considered.





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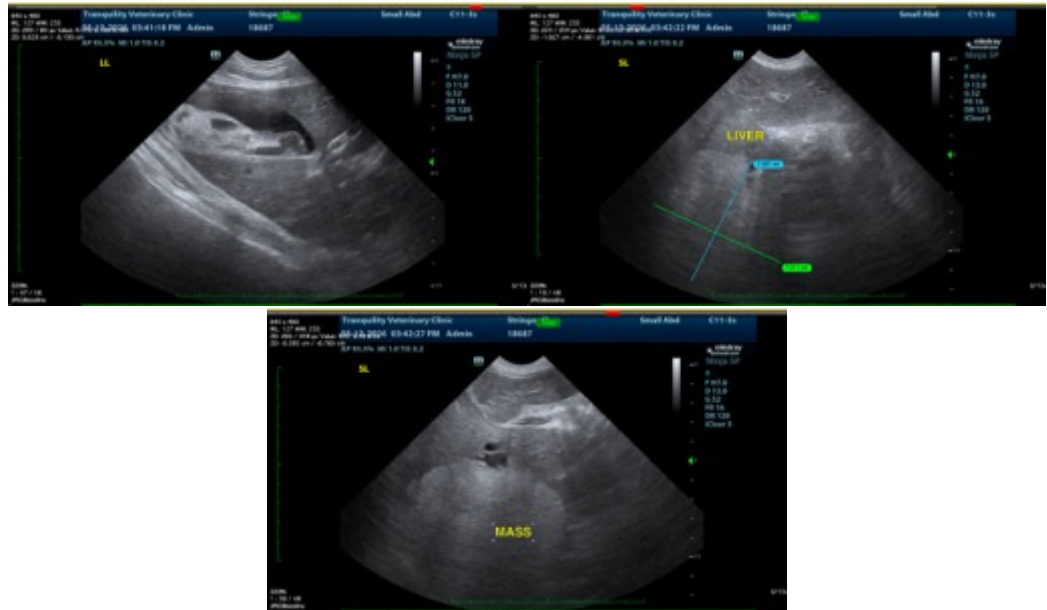
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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