

PATIENT

Shannie Marie
Hernandez

SPECIES

Canine

BREED

Mixed

SEX

FS

AGE

13yr

WEIGHT

48.0lb

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Gabriel Ferrer DVM

HOSPITAL NAME

Pulse Pet Ultrasound
Services

REFERRING VET

Dr. Jonathan De Jesus

INVOICE

24993

DATE

06/01/2026

PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound due to a suspected mass seen caudal to the liver in a radiograph. Px has a Hx of Osteosarcoma. Owner reports that Px presents with vomiting, lethargy, inappetence, and shows signs of abdominal pain. Owner reports that Px has been stranguric since yesterday. Px underwent a limb amputation procedure last month due to Osteosarcoma affecting the front right limb. Sample of spleen via FNA was collected, results are still pending. Urine sample collected via cystocentesis and sent to rDVM for Urinalysis and culture and sensitivity testing.

Abnormal PE/Chem/CBC/UA Results: Bloodwork attached below for your reference.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

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 mineral or infarcts observed. The left kidney exhibited mild pyelectasia, the right kidney exhibited trace pyelectasia. The left kidney measured 5.8 cm. The right kidney measured 5.9 cm.

Adrenal Glands

A hyperechoic nodule is noted in the cranial pole of the right adrenal gland. Nodule does not disrupt normal shape and/or architecture. The nodule measured 0.6 cm x 0.8 cm.

The left adrenal gland is enlarged (0.62 cm cranial x 1.5 cm caudal) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted without evident capsular escape or vascular invasion. The caudal pole left adrenal mass measured 1.4 cm x 2.2 cm.

Spleen

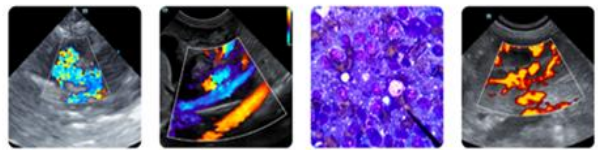
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Splenic vasculature appears normal. Multiple discrete homogenous non-capsule disrupting hypo to anechoic densities /nodules are noted throughout the spleen measuring between 0.5-1 cm in diameter.

Liver

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. Visible vasculature and biliary tree appear normal without distension or congestion. In the left caudal liver is a heterogeneous partially mixed primarily anechoic /cystic nodule measuring 2.1 cm x 2.3 cm in size. A second slightly smaller 1.8 cm x 2.1 cm in size hypo to anechoic density is noted in the mid left liver.

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



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The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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.

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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.

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Pancreas

Pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- The bilateral adrenal gland changes could indicate emerging adrenal disease with differentials including adrenal hyperplasia, adenoma/ adenomas, adenocarcinoma, pheochromocytoma, other. These findings should be interpreted in combination with clinical signs +/- hormone testing.
- Hypo to anechoic splenic nodule(s) – 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.
- Similarly the mixed largely anechoic / cystic liver nodules could represent a benign process such as cysts, hematomas, nodular hyperplasia, other although infiltrative neoplasia including potentially metastatic nodules cannot be ruled out without tissue sampling.

Secondary

- Mild to moderate age-related kidney changes with mild bilateral pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. 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.
2. FNA of the spleen and liver are recommended if patient's coagulation status is appropriate.
3. Reportedly already pending 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.
4. Further recommendations are largely dependent on results of above as emerging adrenal disease cannot be ruled out but is likely not the cause of reported clinical illness including vomiting, lethargy, inappetence, etc. Having said that a BP is recommended if not recently evaluated. If the cause of the clinical illness is discovered and treated and clinical signs of adrenal disease begin or are present, hormone testing could be considered in the form of a low-dose dexamethasone suppression test. Treatment recommendations other than supportive/ symptomatic management of clinical signs are dependent on results of the above.

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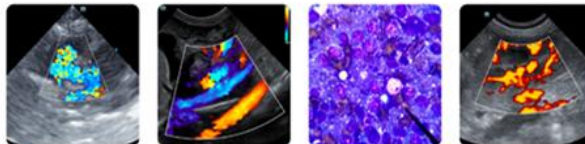
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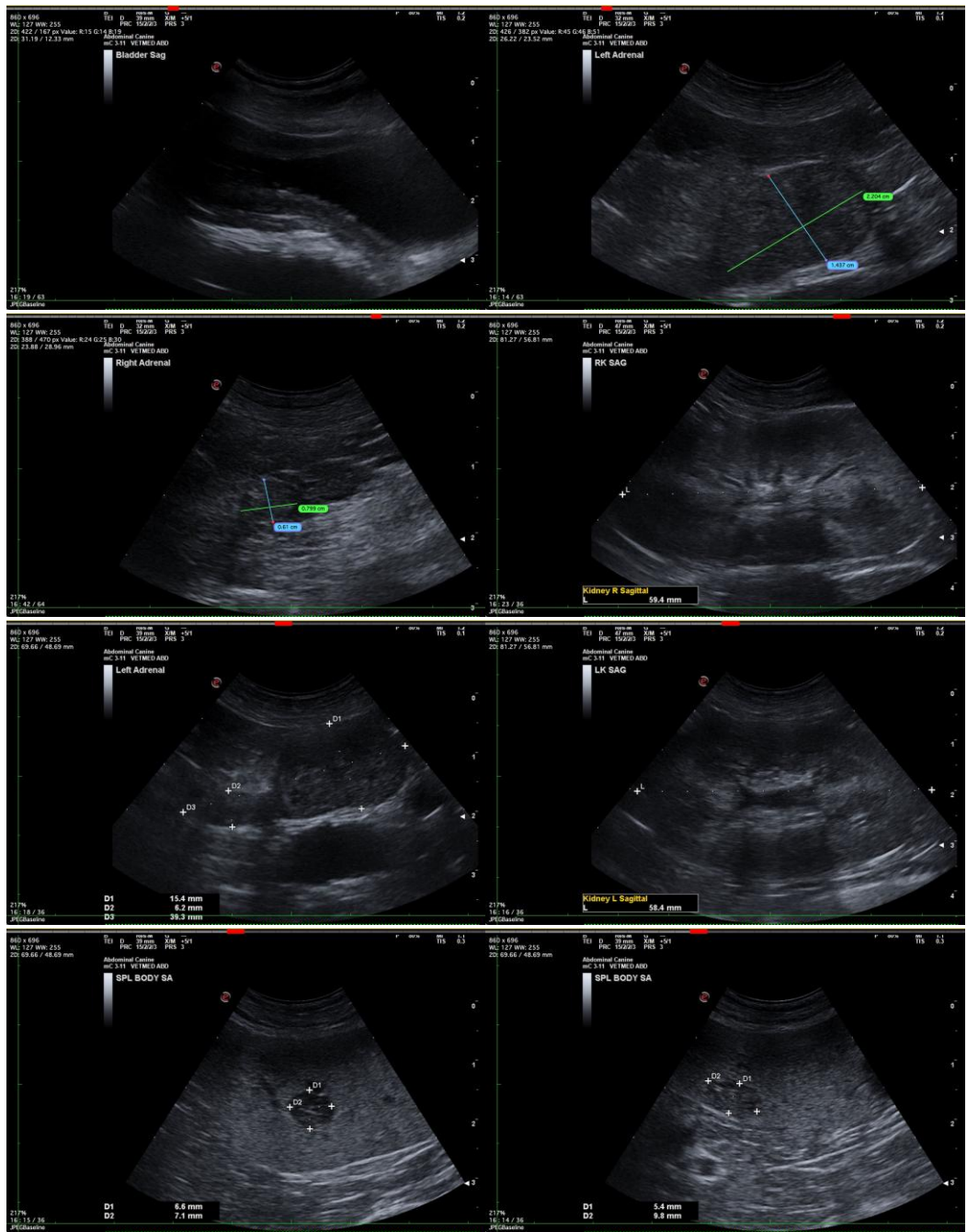
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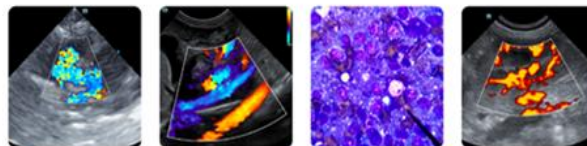
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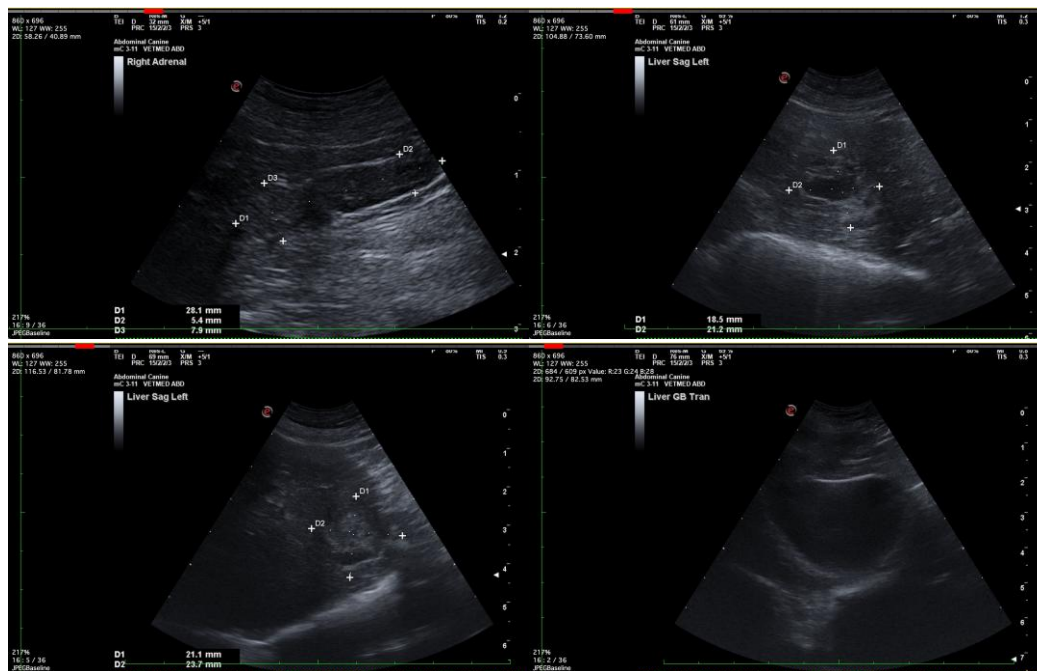
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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