



**PATIENT PRESENTING CLINICAL SIGNS**

Roxie Ellingson Progressive elevation in ALP since 2021. Eating and drinking well with no vomiting, diarrhea, or lethargy. History of multiple low-grade mast cell tumors removed in 2021.

**SPECIES**

Canine

Abnormal PE/Chem/CBC/UA Results: ABNORMAL Laboratory Findings ALP 862 Current Medications Glucosamine Radiographic Findings n/a

**BREED**

Pit Bull

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

**SEX**

Spayed Female

The urinary bladder is adequately distended with primarily anechoic contents and some echogenic as well as some mineral/sand suspended debris. There is a solitary, mildly heterogeneous, primarily hyperechoic mass lesion along the ventral apex with a 1.6 cm long base that extends 1.2 cm into the lumen of the urinary bladder. No discrete cystoliths are observed.

**AGE**

8 Years

The right kidney is normal in size (6.57 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 or infarcts observed. Tiny punctate non-obstructive nephroliths noted.

**WEIGHT**

60.6 Pounds

The left kidney is normal in size (6.42 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 or infarcts observed. Tiny punctate non-obstructive nephroliths noted.

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**Adrenal Glands**

The right adrenal gland is normal in size (1.4 cm at the cranial pole and 0.60 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**IMAGING PERFORMED BY**

Sara Hansen

The left adrenal gland is normal in size (0.59 cm at the cranial pole and 0.72 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**Spleen**

**HOSPITAL NAME**

West Eugene AH

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.

**REFERRING VET**

Dr. Powers

**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.

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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.

**DATE**

7/27/23



**PATIENT** *Gastrointestinal*

Roxie Ellingson The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

*Pancreas*

The 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.

*Free Abdomen*

There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**ULTRASONOGRAPHIC FINDINGS**

- Urinary bladder polyp/mass that trends in appearance towards a benign inflammatory change/polyp. Having said that, infiltrative neoplasia such as transitional cell carcinoma cannot be ruled out without additional information.
- Non-obstructive bilateral nephroliths

**IMAGING PERFORMED BY**

Sara Hansen

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**HOSPITAL NAME**

West Eugene AH

Urinalysis and urine culture, if indicated based on urinalysis results, are recommended. Submission of urine to look for BRAF gene mutation, which is associated with urinary bladder cancer, could be considered. Other diagnostic options include traumatic catheterization, fine needle aspirate (with small risk of tumor seeding/trailing) or cystoscopy for further sampling.

**REFERRING VET**

Dr. Powers

Differentials for an elevation in ALP are vast and non-specific. Differentials include, but are not limited to, benign nodular hyperplasia which occurs in 70% of older dogs and often does not result in an abnormal ultrasound, reactive or idiopathic/vacuolar hepatopathy, cholestasis and/or hyperadrenocorticism as well as many chronic non-hepatobiliary diseases such as chronic infections/inflammation from dental disease, IBD, neoplasia, hyperlipidemia, hypothyroidism, chronic pancreatitis, chronic stress, etc.

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There is no ultrasonographic evidence of cholestasis. Adrenocortical testing such as a low dose dexamethasone suppression test could be considered if clinical signs of hyperadrenocorticism are present. Ursodiol could be considered if gallbladder sludge is noted. A fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate. Otherwise, recommendations include



**PATIENT**

addressing any other concurrent disease and monitoring. If values are progressive, recheck imaging is recommended.

Roxie Ellingson

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**HOSPITAL NAME**

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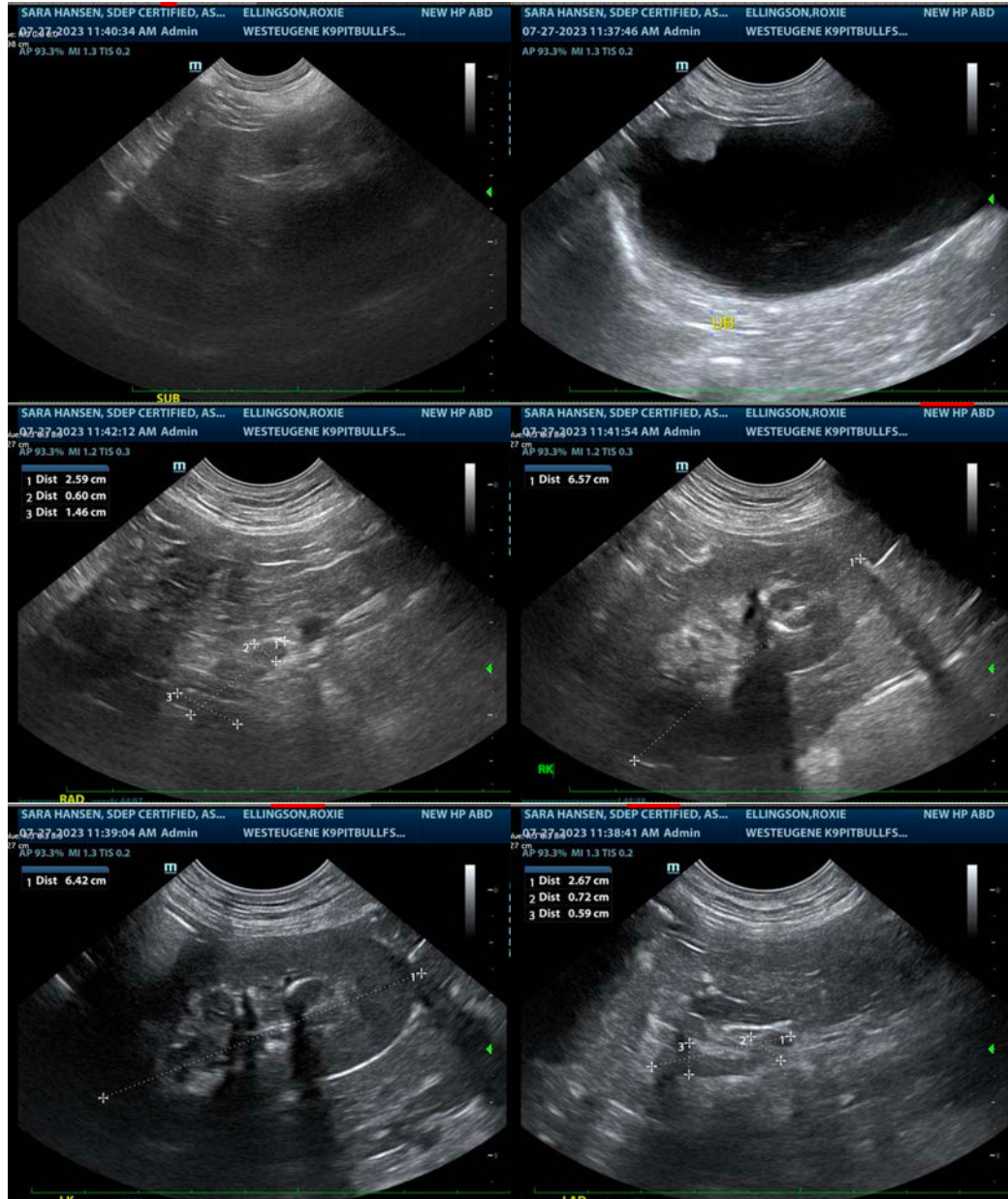
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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