

**PATIENT**

Sice Burnell

**PRESENTING CLINICAL SIGNS**

History: Anemia and elevated liver values

**SPECIES**

Canine

**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.

**BREED**

Mixed

If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

**SEX**

Spayed Female

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. The left kidney measures 5.1 cm. The right kidney measures 5.0 cm. Small cortical cysts are present bilaterally.

**AGE**

14.11 Years

**Adrenal Glands**

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

**WEIGHT**

19.8 Pounds

Right adrenal gland is normal in size (0.8 cm at cranial pole and 0.8 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**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). No focal nodules or masses are observed. Splenic vasculature appears normal.

**IMAGING PERFORMED BY**

Dr. Travis Cerf

**Liver**

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. A 3.0 cm x 4.0 cm heterogeneous mass is noted in the left lateral caudal aspect of the liver. Visible vasculature and biliary tree appear normal without distension or congestion.

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**REFERRING VET**

Dr. Travis Cerf

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.

**INVOICE**

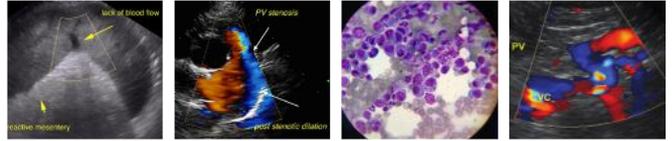
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**Gastrointestinal**

The visible stomach wall is normal in thickness 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. 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.

**SPECIES**

Canine

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

**BREED**

Mixed

**Pancreas**

Caudal to the stomach and medial to the duodenum, in the area of the pancreas, there is a hypoechoic, irregularly shaped heterogeneous structure that appears to be pancreas surrounded by enhanced hyperechoic fat and tissue.

**SEX**

Spayed Female

**Free Abdomen**

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

**AGE**

14.11 Years

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Hyperechoic hepatomegaly with a focal left lateral caudal liver mass – This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible but considered less likely. The mass is concerning for infiltrative neoplasia, such as primary hepatocellular carcinoma versus sarcoma versus other. A benign lesion is possible but considered less likely.

**WEIGHT**

19.8 Pounds

- Acute pancreatitis is suspected, potentially on top of age-related pancreatic remodeling. Infiltrative neoplasia of the pancreas cannot be ruled out but is considered less likely.
- 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.

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**Secondary Findings**

- Age-related kidney changes

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**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.

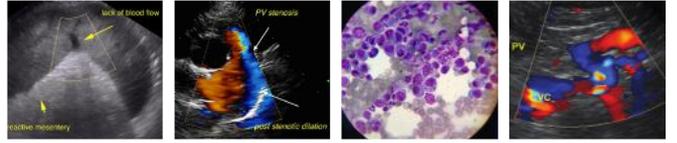
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A fine needle aspirate of the liver mass is recommended if patient coagulation status is appropriate. If possible, a fine needle aspirate of the pancreas could be considered at the same time. Alternatively, an exploratory laparotomy for liver mass removal and pancreatic biopsy could be considered. Given the location of the liver mass, full resectability appears likely possible.

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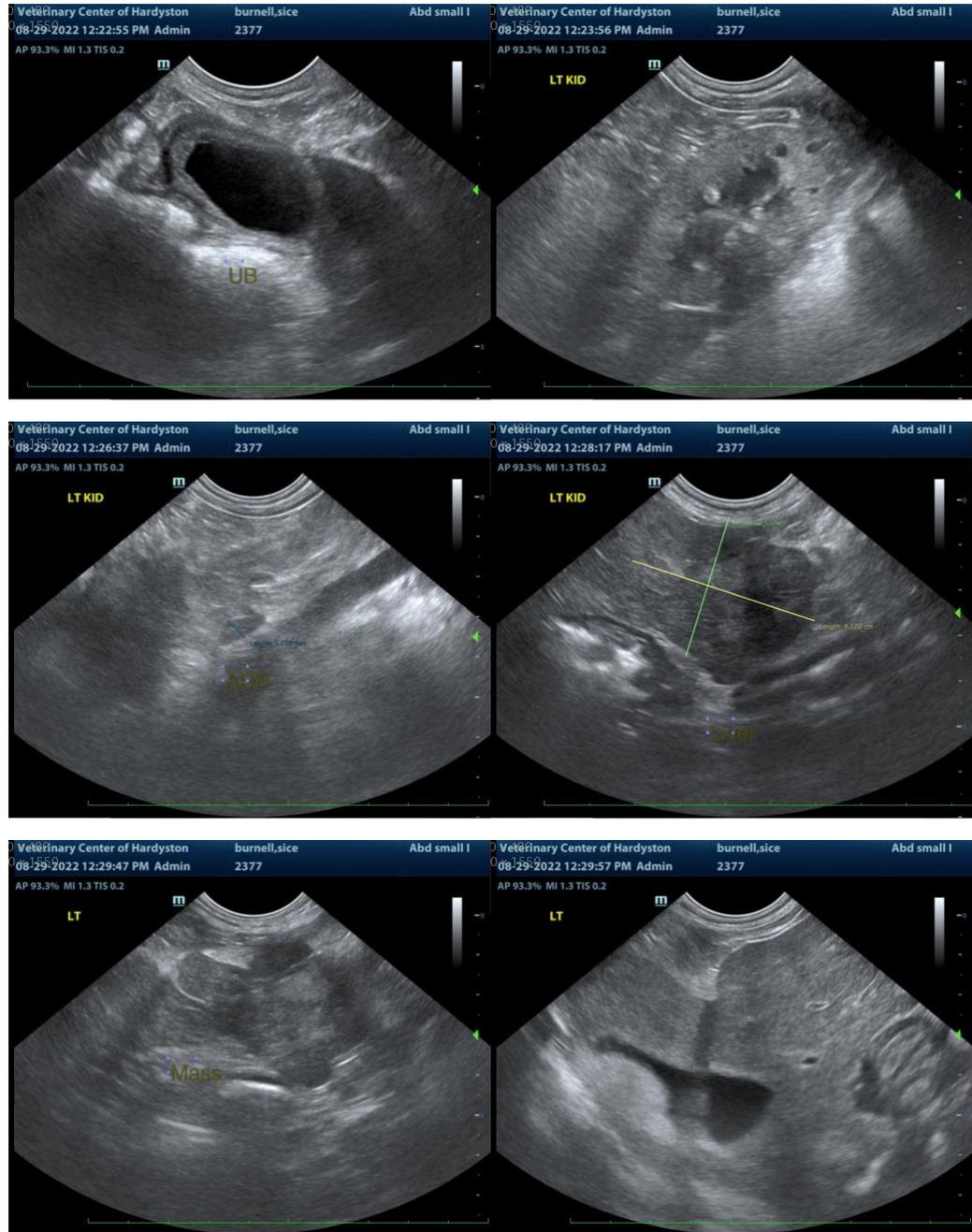
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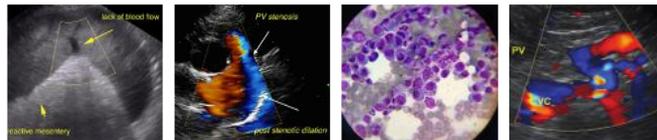
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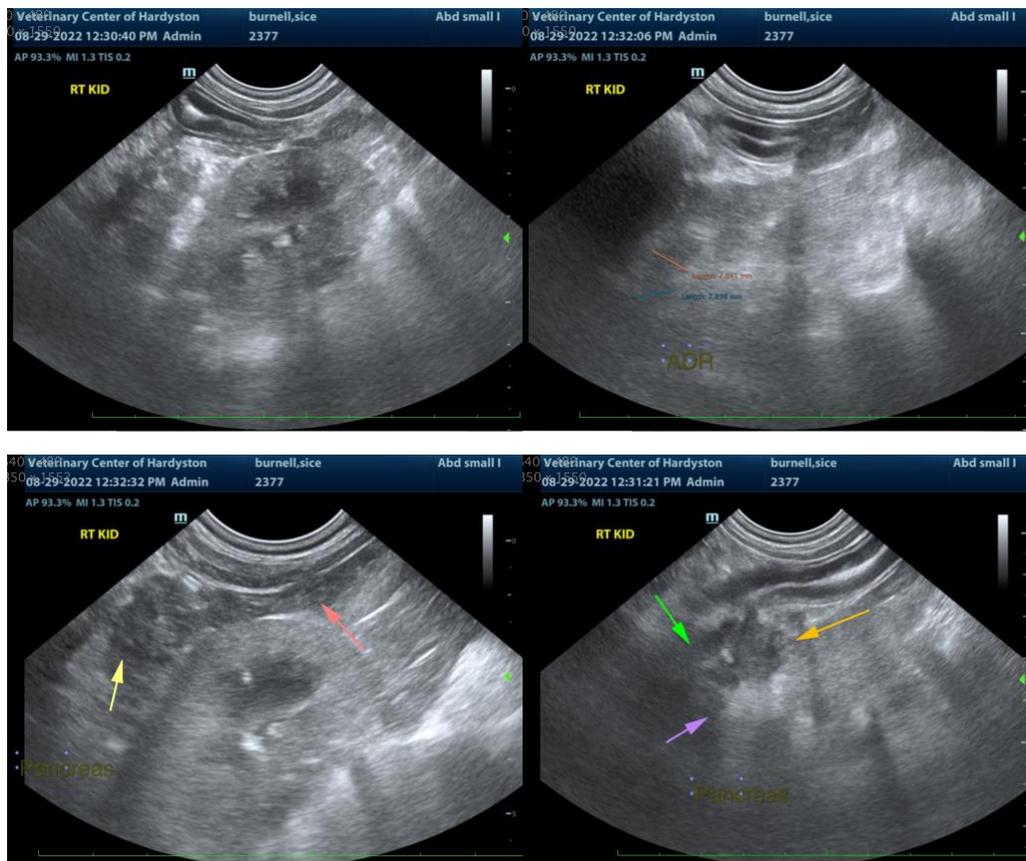
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**

Beth.Johnson@SonoPath.com