



**PATIENT**

Maples Fuirst

**SPECIES**

Canine

**BREED**

Hound x

**SEX**

Spayed Female

**AGE**

11 Years

**WEIGHT**

22.7 kg

**INTERPRETED BY**

Dr Brittany Sinclair,  
 BVSc(hons),  
 DACVECC

**IMAGING PERFORMED BY**

Kelly Reschny

**HOSPITAL NAME**

Governors Road  
 Animal Hospital

**REFERRING VET**

Dr. Farooq

**INVOICE**

73924

**DATE**

3/23/26

**PRESENTING CLINICAL SIGNS**

The last few days P has been very tender in her abdominal area. Anytime O's try to pick her up or even touch her belly, P whimpers and cries out. P has Hx of pancreatitis. O concerned P could be having a flare up or issue with masses in the abdomen. P has been eating but not consistently. Has been grazing at food and O has to put food toppers to entice P to eat. O gave gabapentin last night to keep P comfortable. BMs have been normal. No vomiting or diarrhea. HR: 115bpm RR:25

Abdomen seems painful - owner reported much louder or severe cry out yesterday - has a history of pancreatitis, diabetes insipidus, concerns about liver and adrenal mass ( found in U/S last year). No C/S/V/D, decreased activity levels, abdomen more pendulous now as per owner and very protective of the abdomen.

Current Medications: Desmopressin , gabapentin

Abnormal PE/Chem/CBC/UA Results: CBC: Lymphocytes 0.87 (1.05-2.10) Chemistry: ALP 357 (23-212) , Catalyst Pancreatic Lipase 363 (0-200) rads and prev US report attached

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measures 6.45 cm. Right kidney measured 7.22 cm.

**Adrenal Glands**

The left adrenal gland is visualized and measured on still images only. Resolution is inadequate to assess glandular detail or confirm measurement. Left measures 1.07 cm in length x 0.33 cm at the caudal pole and 0.25 cm at the cranial pole.

The right adrenal gland is rounded, enlarged, and hypoechoic. Right measures 4.1 cm in length x 2.6 cm in thickness.

**Spleen**

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

**Liver**

The liver contains a well circumscribed heterogeneous mass measuring approximately 4.8 cm x 8.4 cm. There is a small cystic/cavitated area within the mass, but it is largely solid. There is scant surrounding free fluid. There are multifocal hypoechoic nodules noted throughout the liver parenchyma.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.



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***Gastrointestinal***

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

***Pancreas***

The area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

***Free Abdomen***

No clinically significant lymphadenopathy or abnormalities noted.

There is scant free fluid near the liver mass.

**ULTRASONOGRAPHIC FINDINGS**

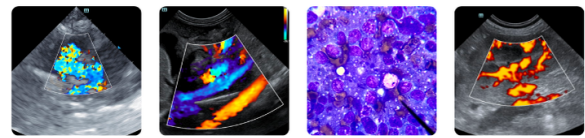
- Liver mass with scant surrounding free fluid
- Right adrenal mass.
- Aging renal changes.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Mass in the liver is most concerning for neoplasia. Malignant tumors are more common in the dog and may be of hepatocellular, cholangiocellular, mesenchymal, or neuroendocrine origins. Hepatocellular carcinoma is the most common primary hepatic malignancy of the dog. Metastatic rates are relatively low, although rates are higher with nodular and diffuse forms. Hepatocellular adenoma (i.e. hepatoma) is a benign hepatocellular tumor that is commonly found as an incidental finding in dogs at necropsy.

Other include cholangiocellular carcinoma, hemangiosarcoma, leiomyosarcoma, fibrosarcoma, hemangioma, histiocytic sarcoma, osteosarcoma, lymphoma and and myelolipoma. Secondary hepatobiliary tumors are more common than primary tumors as the liver is one of the most common sites of metastasis. Carcinomas metastasize to the liver more often than sarcomas. Common metastatic tumors include lymphoma, hemangiosarcoma, islet cell carcinoma, exocrine pancreatic carcinoma, intestinal carcinoma, renal carcinoma, and mast cell tumors.

Aspirate should be attempted for further information. Ultimately surgical removal should be considered because of risk of rupture and abdominal hemorrhage and this may be both diagnostic and curative. Pre-operative abdominal CT may be considered for surgical planning, to confirm hepatic origin and thoracic CT could be used to screen for thoracic metastasis that may be missed on thoracic radiographs. Serial monitoring with follow up sonograms could be considered to monitor for progression if definitive removal is not desired at this time.



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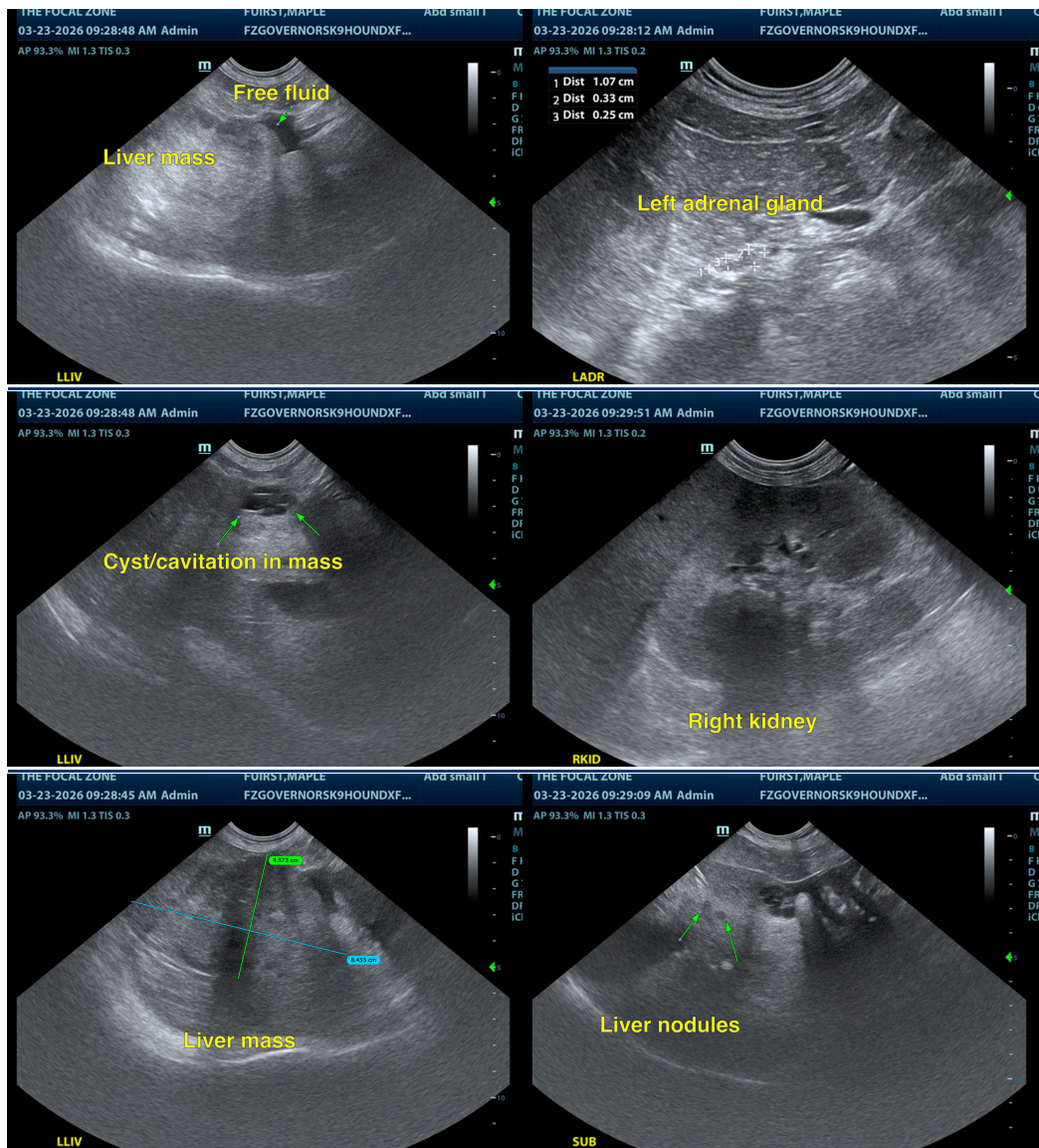
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Right adrenal gland enlargement is most consistent with adrenal mass which may be malignant or benign. It appears subjectively resectable with capsular expansion without obvious capsular escape or vascular invasion. Pre-surgical abdominal CT for surgical planning and thoracic CT for metastasis screen is recommended. Differentials owing to sonographic architecture and clinical history include carcinoma, pheochromocytoma, adenoma, hyperplasia, cortisol secreting tumor, myelolipoma less likely. I recommend urine catecholamine screen for pheochromocytoma detection if surgical removal is pursued as pre-surgical treatment of pheochromocytoma is essential. It is possible to have both cortisol and catecholamine secretion from the same adrenal tumor so presence of hypercortisolemia does not obviate the need for presurgical urine metanephrine screening. This is considered less likely to be the cause of patient's clinical signs.





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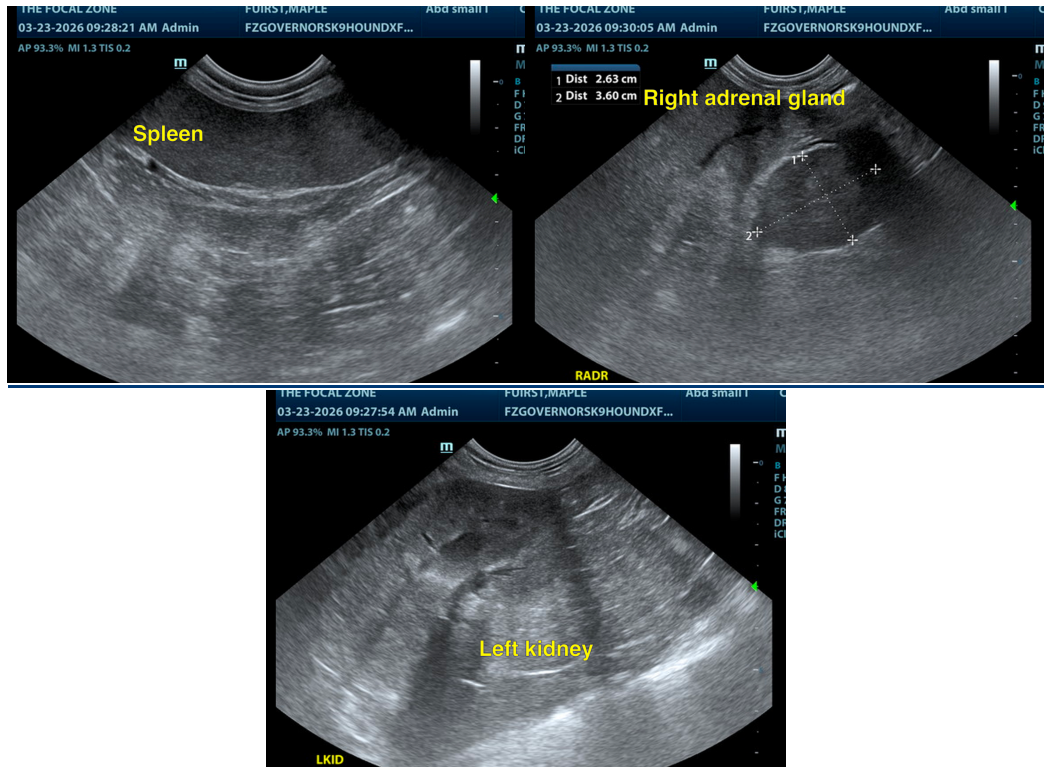
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com