



PATIENT

Isis Hodges

SPECIES

Canine

BREED

Lab Mix

SEX

Spayed Female

AGE

12 Years

WEIGHT

100 lbs

INTERPRETED BY

Greg Kuhlman, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Julia Bakker DVM

HOSPITAL NAME

Orange Blossom
Veterinary Imaging

REFERRING VET

Kristen Hillard DVM

INVOICE

15694

DATE

05/01/26

PRESENTING CLINICAL SIGNS

Patient presented this evening for 1 week onset of lethargy, anorexia and a couple episodes of vomiting. Examination revealed jaundice. Rads showed a small liver, but no other significant findings. Bloodwork showed severely elevated liver values and decreased BUN.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with minimal urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen.

The left kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted. The left kidney measured 6.7 cm in length.

The right kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted. The right kidney measured 8.1 cm in length.

Adrenal Glands

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 6.4 mm and the caudal pole measures 7.3 mm.

The right adrenal gland presents irregular caudal pole shape and enlargement measuring 11.8 mm width. This is a possible incidental finding or may represent malignant adrenal neoplasia such as adrenal carcinoma, possibly a functional adrenal lesion.

Spleen

The spleen is normal in size, shape, margination and echogenicity. No masses are seen.

Liver

The liver does appear normal in size. Diffusely, it has a heteroechoic echotexture. There is a hypoechoic lesion within the liver that measures 9.5 mm in width, most likely benign regenerative nodule, less likely primary hepatobiliary neoplasia, such as hepatocellular carcinoma and less likely metastatic neoplasia.

The gallbladder presents normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention or obstruction.

Gastrointestinal

The stomach and intestines have normal wall layering and thickness. Colon contains normal contents with normal wall thickness.

Pancreas



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The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

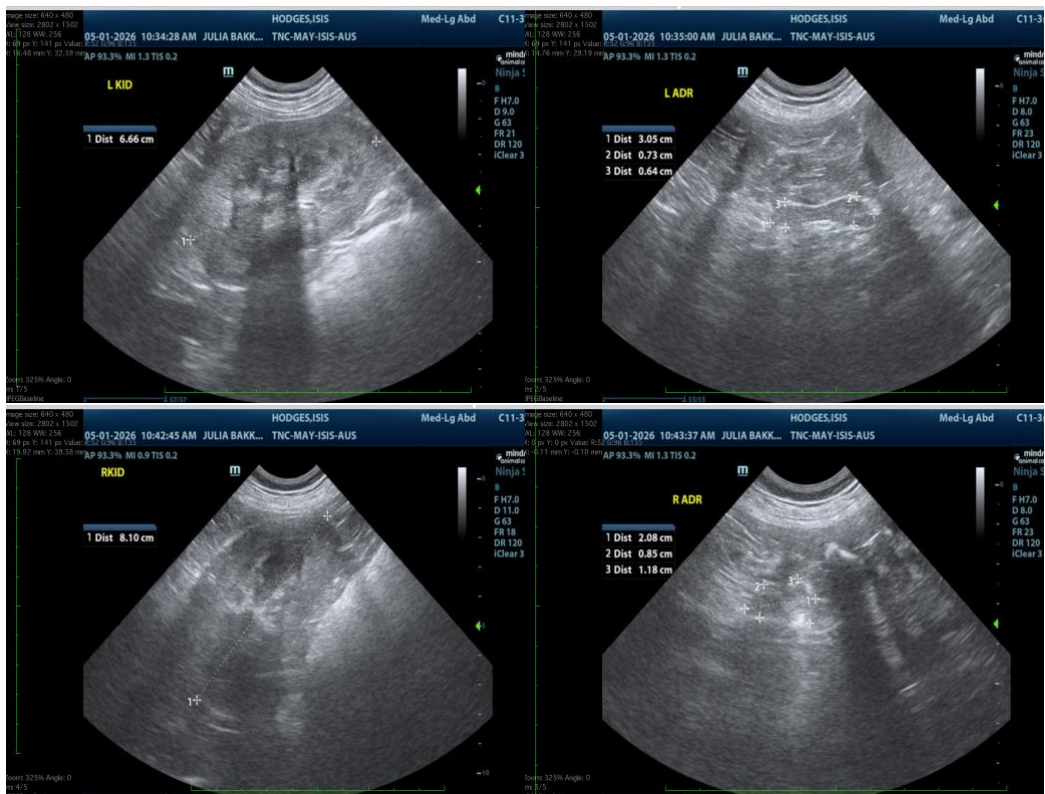
ULTRASONOGRAPHIC FINDINGS

- Irregular right adrenal gland.
- Hypochoic hepatic lesion.
- Mineralization in the kidneys.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consider screening patient for pheochromocytoma and hyperadrenocorticism. Either recheck ultrasound of right adrenal gland in two to three months to determine if there are any changes seen if this lesion is growing in size at that time. The other option would be at this time to consider CT scan of abdomen as pre-surgical planning for right-sided adrenalectomy.

Consider fine-needle aspirate of the hepatic lesion with submission for cytology to determine etiology. Recommend fine-needle aspirate of the liver itself with submission for cytology to rule out infiltrative neoplasia, such as lymphoma or mast cell disease as the cause of the markedly elevated liver values and appearance of liver. If these samples are non-diagnostic, then recommend liver biopsy.





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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.

Greg Kuhlman, DVM, DACVIM (SAIM)
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