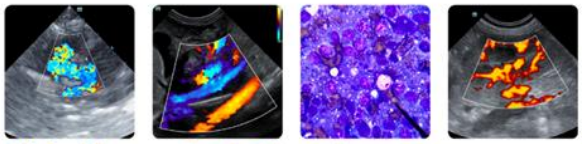


PATIENT

Flyte Mallyon

SPECIES

Canine

BREED

Australian Shepherd

SEX

MI

AGE

10yr

WEIGHT

26.8kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Thrive Vet Care

REFERRING VET

Dr. Emma Foxcroft

INVOICE
23643

DATE
01/21/2026

PRESENTING CLINICAL SIGNS

- Flyte, an Australian Shepherd, presented for an acute onset of lethargy, inappetence, and gastrointestinal signs, with a workup revealing a mild kidney elevation and a suspected liver nodule, while occasional vomiting has persisted.
- Flyte was evaluated for lethargy, inappetence, soft stool, and one to two episodes of vomiting. Since that visit, his stool has normalized, but he remains slightly lethargic and continues to have occasional vomiting. The owner is notably concerned about pancreatitis due to a previous negative experience with another dog.
- Diagnostic testing on the day of presentation included bloodwork that showed a mild kidney elevation (Creatinine 181, BUN 12) with a low-normal lipase. A urinalysis performed on a catheterized sample revealed a specific gravity of 1.037 with numerous white blood cells, which were suspected to be an artifact of collection in an intact male. A physical exam was unremarkable, with a small, symmetrical, non-painful prostate. A FAST scan raised concern for a possible liver nodule, prompting the owner to schedule a full abdominal ultrasound for further evaluation.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.3 cm in length. The right kidney measured 6.6 cm in length.

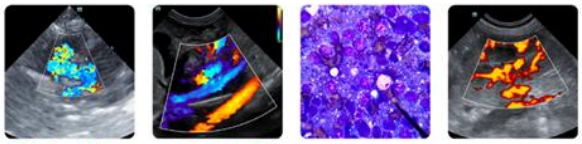
The area of the aortic trifurcation was free of pathology.

The prostate was mildly enlarged in size with intact, symmetrical capsule contour. The margins of the gland were intact and able to be differentiated from the surrounding tissue. The prostatic parenchyma was mildly echogenic to heteroechoic without parenchymal mineralization. The prostate measured 3.1 cm in diameter.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.52 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.60 cm width at the caudal pole.

Spleen



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The spleen exhibited subjective normal size with mild asymmetrical splenic capsule contour. Several to multiple non-capsule deforming non-homogenous hypoechoic splenic nodules were present. An example measured 1.1 cm in diameter.

Liver/Gallbladder

The liver presented mildly enlarged in size with symmetrical yet swollen contour. The parenchyma exhibited conserved uniform parenchyma with normal echogenicity isoechoic to the spleen and falciform fat. The hepatic vasculature was mildly dilated in appearance, most notable at the level of the hepatic vein / caudal vena cava junction, without evidence of thrombosis. The caudal vena cava was not definitively visualized. Focal to intermittent intraparenchymal nodules exhibiting mild central hyperechogenicity with mild hypoechoic periphery. An example of a liver nodule measured 1.7 cm in diameter.

The gallbladder was non-distended in size with thin walls and mild non-organized debris. No evidence of gallbladder/peripheral gallbladder inflammation or wall edema was present. The common bile duct was not visualized without overt evidence of dilation or post hepatic obstructive criteria.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The right pancreas was sonographically normal.

Free Abdomen

Mild to moderate volume peritoneal effusion.

Mild non-homogenous hyperechoic generalized omentum.

No visualized significant omental lymphadenopathy.

Transdiaphragmatic view of the caudal thorax revealed evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary

- Mildly enlarged subjective congested liver with intermittent intraparenchymal nodules.
- Several to multiple splenic nodules
- Sonographically unremarkable empty gastrointestinal tract
- Sonographically normal visible pancreas.
- Mild age-related renal changes
- Peritoneal effusion with non-homogenous hyperechoic omentum
- Concurrent transdiaphragmatic pericardial effusion

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Secondary

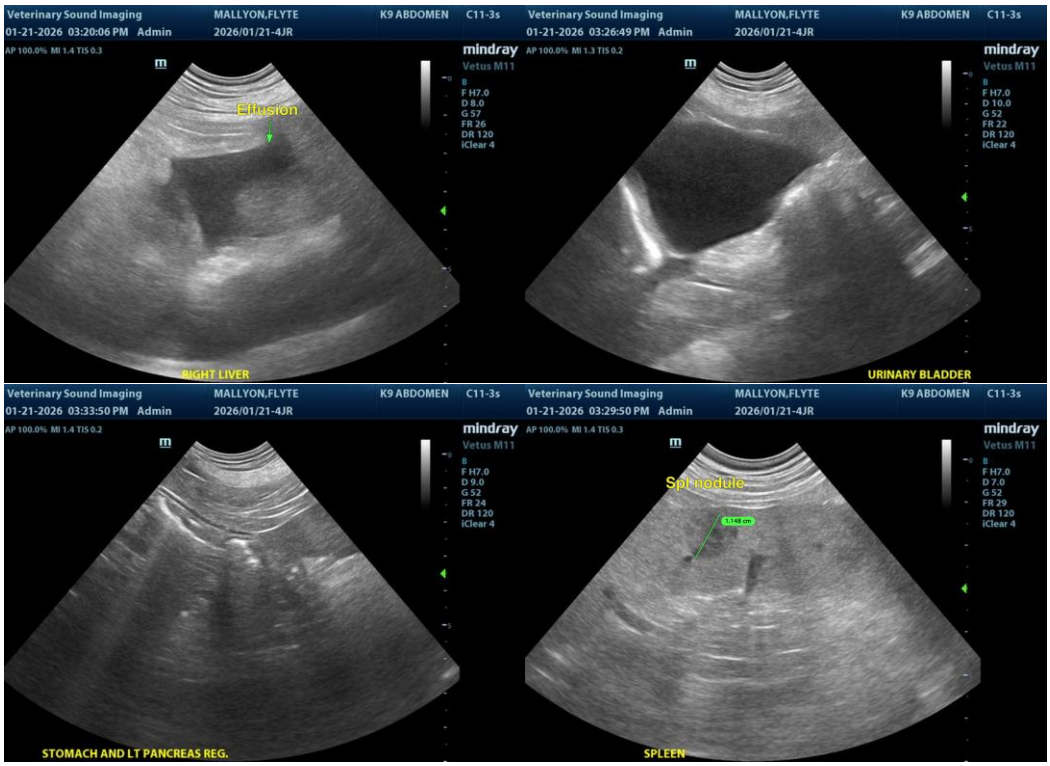
- Mildly enlarged non-homogenous hyperechoic prostate gland - most consistent with benign prostatic hyperplasia, potential for prostatitis, no evidence of prostatic neoplasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver nodules are most concerning for target lesion type nodules which are often associated with neoplastic criteria. Multicentric hepatosplenic neoplasia with high concern for concurrent cardiac neoplasia or metastasis given transdiaphragmatic pericardial effusion is indicated.

Further assessment may include assuming normal clotting status and using 25ga needle, hepatosplenic and nodule FNA cytology in conjunction with effusion analysis cytology +/- C/S and full echocardiogram.

No evidence of gastrointestinal obstruction or overt significant or active pancreatitis as an obvious contributing factor.



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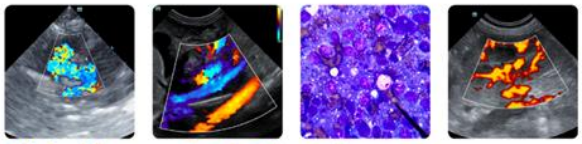

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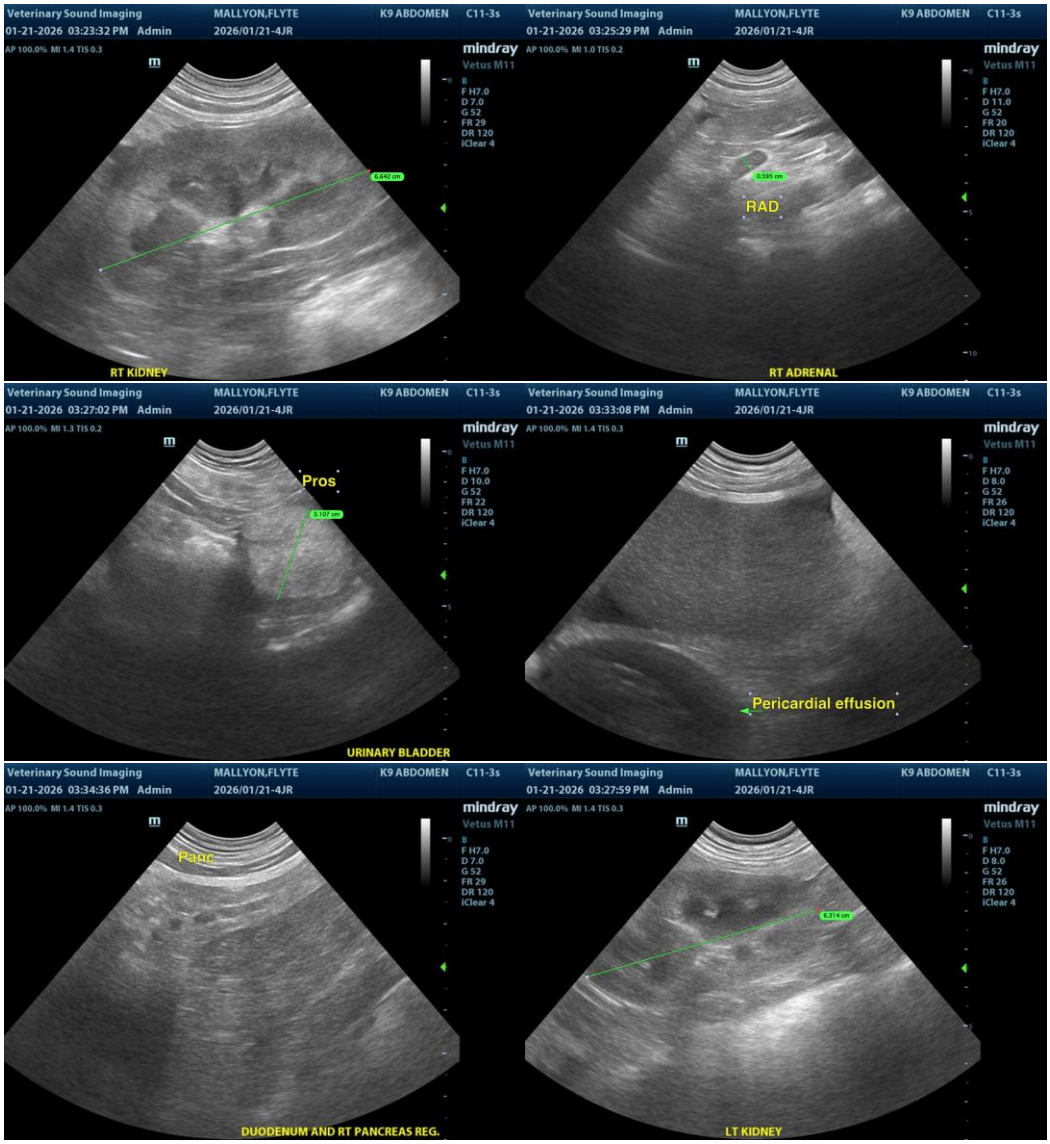

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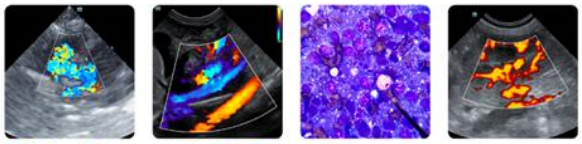

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com