



**PATIENT**

Luke Dellinger

**SPECIES**

Canine

**BREED**

Doberman Pinscher

**SEX**

MN

**AGE**

9yr

**WEIGHT**

104.2lb

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Sara Hansen

**HOSPITAL NAME**

Corvallis Veterinary  
Hospital

**REFERRING VET**

Dr Gross

**INVOICE**  
23902

**DATE**

02/16/2026

**PRESENTING CLINICAL SIGNS**

- Clinical Exam Findings:
- Pet presented for coughing and potential kennel cough on 2-9-26. Exam revealed a potential mass effect in caudal abdomen and harsher lung sounds. Radiographs confirmed an abdominal mass and left sided cardiomegaly wth pulmonary venous distention, interstitial pulmonary pattern; r/o cardiomyopathy and congestive heart failure. The origin of the mass in unknown; r/o splenic mass. r/o heart base tumors.
- ABNORMAL Labwork Values Chem panel indicates low albumin, increased alt, and all phos, decreased MGCBC shows leukocytosis with neutrophilic
- T4 low; r/o euthyroid sickUA 1+ proteinuria and elevated pH
- For ECHO Only: Blood Pressure pending
- HR/RR/BP:150/30/
- Is there a Heart Murmur? If so, please grade.no
- Current Medications furosemide 20 mg po TID

**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 7.3 cm in length. The right kidney measured 6.9 cm in length.

The area of the aortic trifurcation was free of pathology.

The residual prostate appeared normal and free of pathology.

**Adrenal Glands**

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.86 cm width at the caudal pole. The right adrenal gland was not definitively visualized.

**Spleen**

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

**Liver/Gallbladder**

The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a



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mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with mild non-organized debris. The cystic and common bile ducts were normal.

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**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.

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The visualized segments of 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.

**SEX**

Sonographically normal visible descending colon.

MN

**Pancreas**

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

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**Free Abdomen**

No overt significant peritoneal effusion was present.

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A large potentially encapsulated primarily fluid filled mass occupying majority of the abdomen cavity, was present generally extending from the level of the cranial urinary bladder to the caudal liver. The mass appeared to extend into area of the spleen without definitive splenic connection. The fluid within the mass was mildly echogenic, indicating potential for cellular component. The fluid filled mass measured at least 18 cm in diameter. Surrounding hyperechoic omentum present.

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Concurrent non-homogenous hyperechoic cranial abdomen nodule caudal to the ventral liver and potentially within the area of the cranial spleen was present, measuring ~ 2.2 cm in diameter.

**ULTRASONOGRAPHIC FINDINGS**

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**Primary**

- Unspecified fluid filled mass, occupying majority of the abdominal cavity
- Non-homogenous cranial abdomen nodule, possibly associated with unspecified mass, cranial omentum, or potentially cranial spleen
- Hepatopathy
- Mild gallbladder debris (non-mucocele)
- Sonographically normal overall spleen
- Non-specific mild age related renal changes

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**INVOICE**  
 23902

Considerations for the unspecified mass may include unspecified potentially cystic or necrotic neoplasia, granuloma, lipoma, or other. Definitive connection to the liver or spleen was not obvious, indicating hepatosplenic origin of the unspecified mass may be thought less likely yet not definitively excluded. No overt hepatosplenic macrometastatic criteria.

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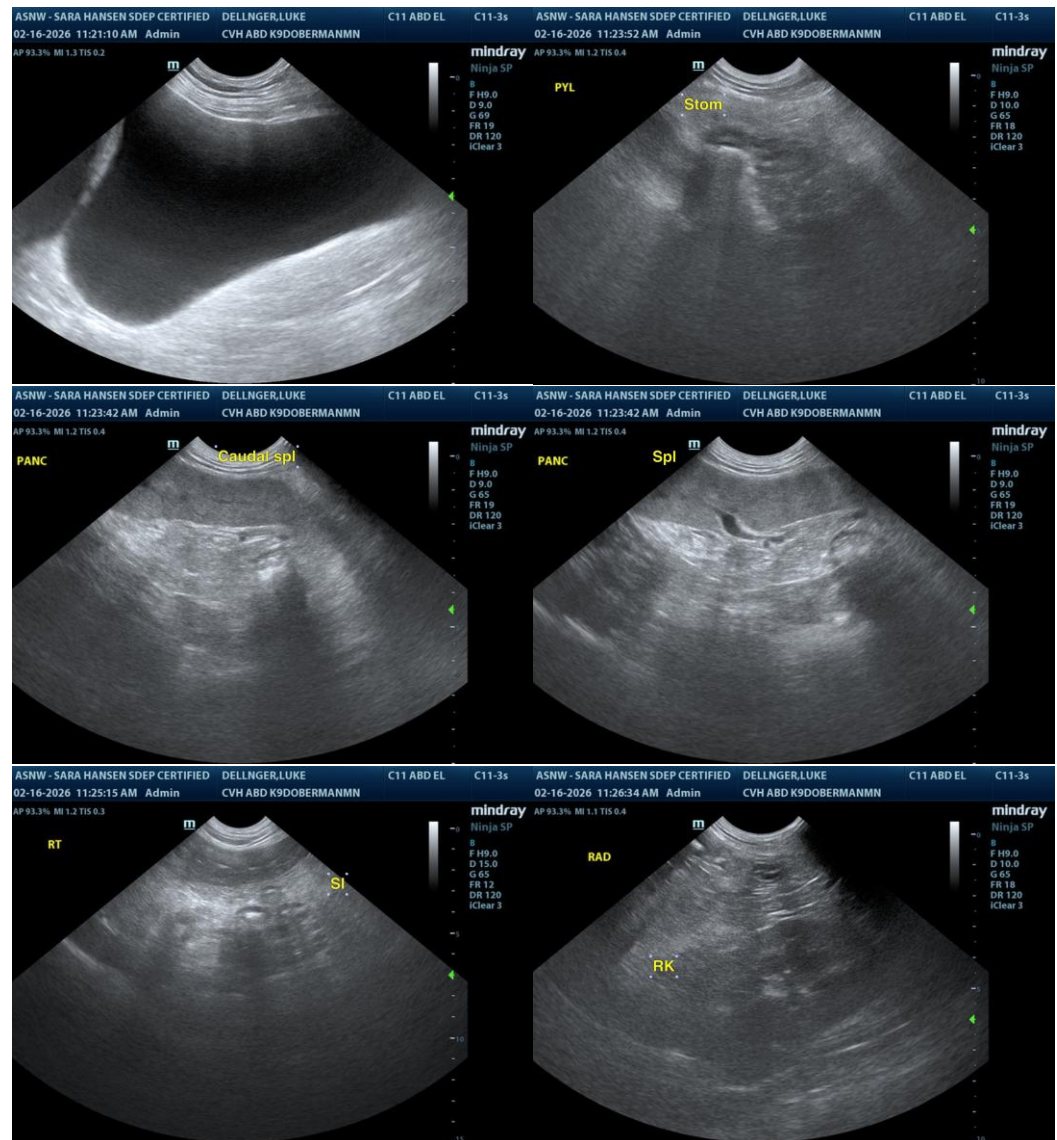
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Further assessment may include assuming normal clotting status, mass and screening hepatic FNA cytology, or mass centesis for fluid analysis cytology +/- C/S. Pending echocardiogram and assuming no pathology on three view chest radiographs, abdominal CT for further assessment and clarification of mass extent / origin, assessment for potential non-obvious metastasis and surgical planning if surgery is a potential would be ideal.

Otherwise, if cleared for anesthesia, direct exploratory laparotomy with gross inspection of the mass potential for mass / hepatic biopsy or mass resection may be considered.





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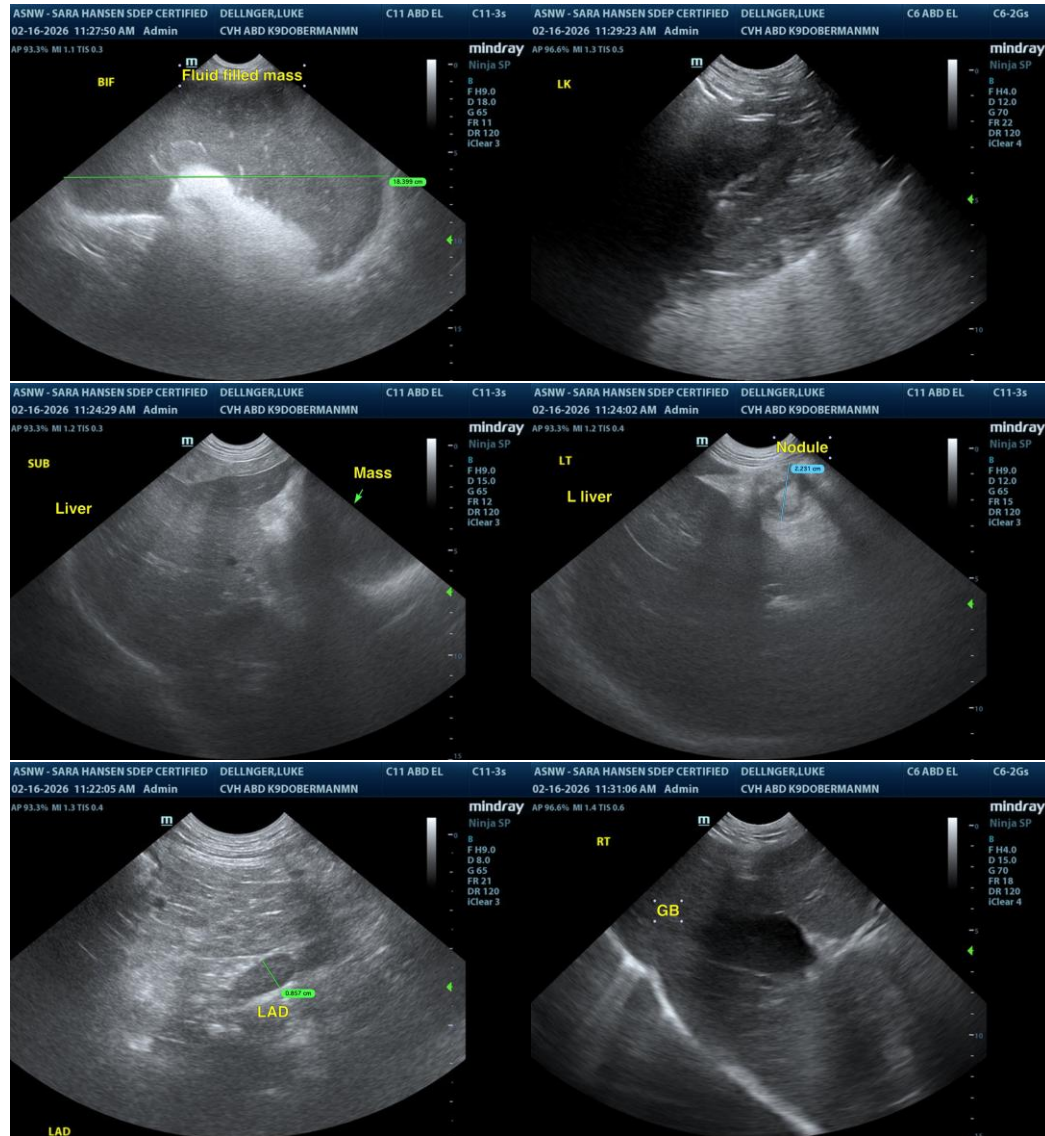
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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