



**PATIENT**

Molly Figliola

**SPECIES**

Canine

**BREED**

Labrador X

**SEX**

Spayed Female

**AGE**

10 Years

**WEIGHT**

48 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Jose

**HOSPITAL NAME**

AC of Queens

**REFERRING VET**

Dr. Kwasnik

**INVOICE**

35969

**DATE**

3/1/22

**PRESENTING CLINICAL SIGNS**

Hx of losing weight, possible PU-PD, BAR appetite normal, no medical HX in the pass. Abnormal PE/Chem/CBC/UA Results: MM: Pale/pink, distended abdomen, possible mass palpated on mid abdomen, BCS 4.5/9 (losses weight), BW: Not performed UA: Not Performed X rays : Liver vs splenic mass.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Mild non-dependent particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The area of the aortic trifurcation was free of pathology.

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 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. The right kidney measured 5.9 cm.

**Adrenal Glands**

The adrenal glands were not definitively visualized.

**Spleen**

The spleen exhibited normal subjective size and contour. Mild generalized splenic parenchyma heterogeneity noted. A focal area of hyperechoic parenchyma was noted adjacent to the hilus without evidence of capsular expansion.

**Liver**

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild non-dependent non-organized luminal debris. No evidence of gallbladder or peripheral gallbladder inflammation. The cystic duct and common bile ducts were normal without evidence of dilation.

**Gastrointestinal**

The stomach and small intestine were ill-visualized in this patient owing to the presence of a large mid to cranial abdominal mass. The segments of small intestine visualized exhibited wall layering and subjective maintained 1:3 muscularis/mucosa ratio.

**Pancreas**

The pancreas was not definitively visualized.

**Free Abdomen**

Large, expansive, non-homogeneous to cavitated mass occupying the majority of the mid to cranial abdomen. The mass measured at least 10-11 cm in diameter, but larger, as the mass would not fit into a



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single viewing window. The mass appeared to directly efface the caudal aspect of the liver, and was noted directly caudal to the gallbladder. Mild reactive mesentery noted around the mass and in the caudal abdomen along with small pockets of scant free fluid.

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**ULTRASONOGRAPHIC FINDINGS**

- Large mid to cranial abdominal mass – most likely hepatic origin.
- Indistinct, hyperechoic splenic nodule adjacent to the hilus – likely benign myelolipoma, potential for previous infarct.
- Urinary bladder sediment – cellular debris/protein suspected.
- Bilateral age related kidneys
- Scant peritoneal free fluid

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given the size of the mass, potential for non-hepatic origin (i.e., non-obvious splenic origin) cannot be definitively excluded, but is thought less likely. The mass is consistent with probable neoplastic criteria. Assuming normal clotting status, ultrasound guided FNA of the mass for cytology could be considered. Correlation with full lab work recommended. If surgical options are a potential in this case, referral for further assessment and/or abdominal CT for further clarification +/- surgical planning could be considered. Potential for concurrent gastrointestinal disease.

**AGE**

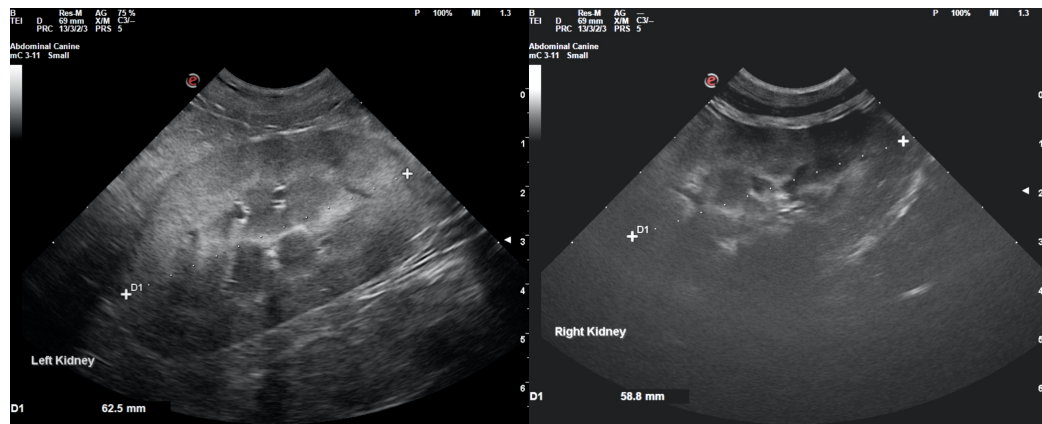
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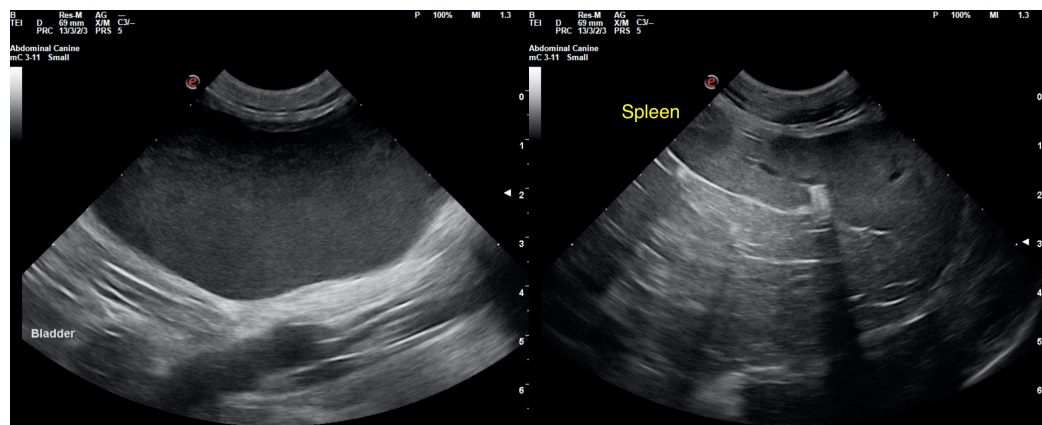


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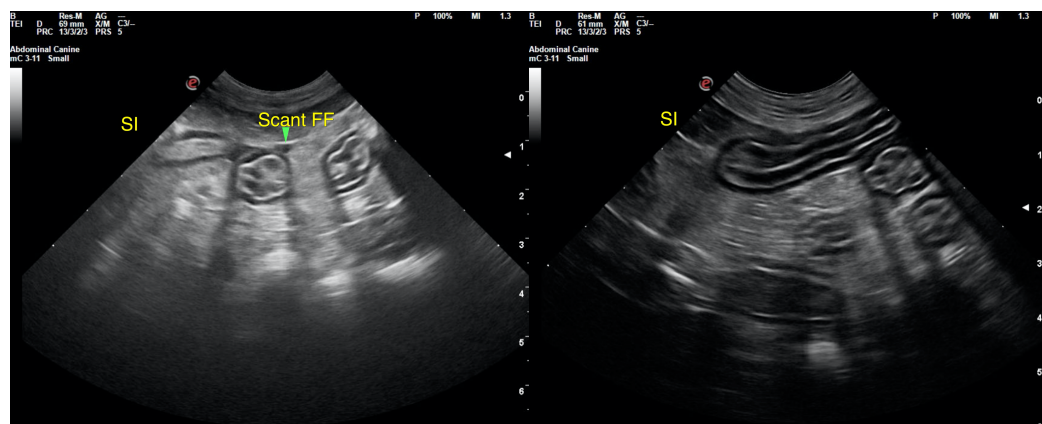
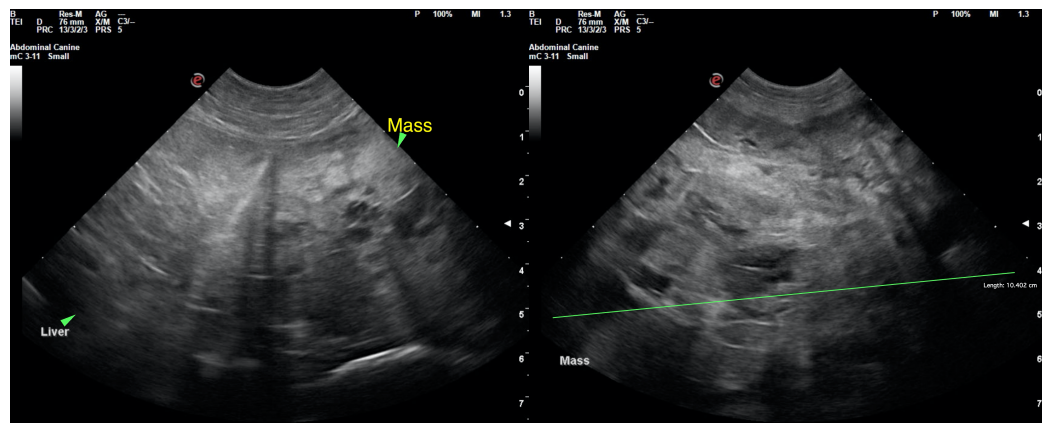
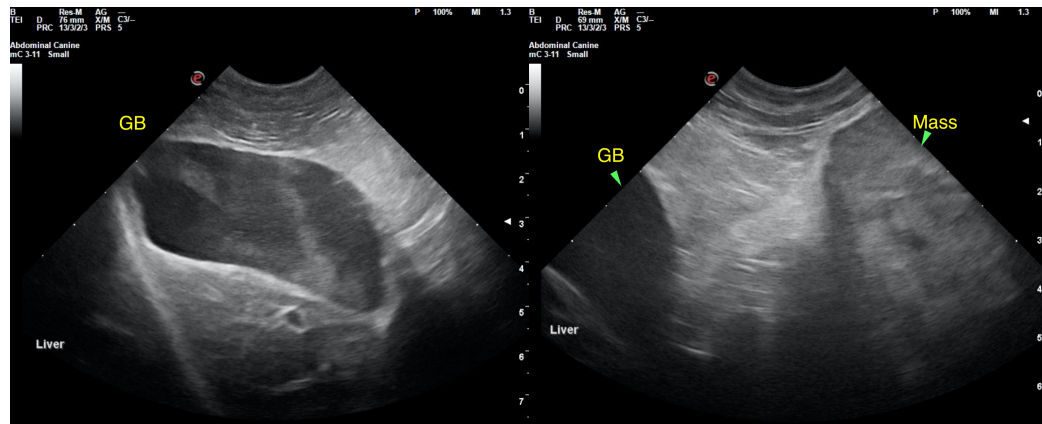
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)**

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