



PATIENT

Winnie Wallace

SPECIES

Canine

BREED

Goldendoodle

SEX

Spayed Female

AGE

10 Years 7 Months

WEIGHT

58.4 pounds

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP (Canine
/ Feline Practice)

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Veterinary
Hospital

REFERRING VET

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INVOICE

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DATE

03/16/26

PRESENTING CLINICAL SIGNS

- Clinical signs: ALP elevation
- History: History of partial liver lobectomy (liver mass extending from left medial lobe). Histopath inconclusive (adenoma vs carcinoma). Ultrasound to assess liver for regrowth of mass or a new problem contributing to ALP elevation. History of PLN, hypertension, food allergy, atopy. Recent history over past couple months of hind end weakness.
- Current medications: Dexdom/Torb sedation for ultrasound. Trazodone prior to ultrasound. Benadryl, amlodipine, gabapentin

Physical exam: Dermal/fluctuant mass just caudal to left shoulder on dorsal thorax (FNA today and submitted to lab, suspect keratin cyst), 2 gingival masses on maxillary lip, mild dental tartar otherwise, multiple SC/round/soft masses all over body, normal ROM joints of hind limbs, no crepitus, no back pain or pain on tail jacking, CPS present both hind legs (slightly delayed left hind), slightly tense on abdominal palpation but anxious for exam Lab work: Cytology of suspect jj LN caudal/ventral to fundus of stomach pending cbc/chem/UA/fecal 2/24/26 ALP high 222 Leukocytes low 584 Remainder of CBC/CHEM normal USG 1.021 pH 7.5 Protein 2+ Clear appearance Quiet sediment otherwise

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 5.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

No evidence of medial iliac or sublumbar lymphadenopathy or masses.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 7.3 cm in length. The right kidney measured 7.4 cm in length.

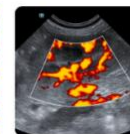
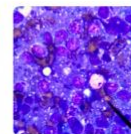
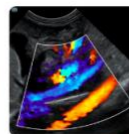
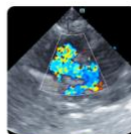
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.83 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 0.75 cm width at the caudal pole.

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.



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Liver & Gallbladder

The liver presented subjective borderline to possible 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 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 normal wall. Mild echogenic, nonmineralized, non-dependent biliary sludge is present. The biliary sludge is congealed without organization. No signs of peripheral inflammation.

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 ileus, obstruction or foreign material.

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

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.

Free Abdomen

Focal to intermittent cranial mesenteric to perihepatic lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example of the lymph nodes measured 1.3 cm in diameter.

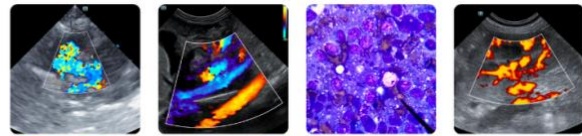
ULTRASONOGRAPHIC FINDINGS

- Hepatopathy- subjective benign, sonographically suggestive of metabolic, vacuolar or cholestatic hepatopathy given ALP elevation.
- Early immature gallbladder mucocele- nonspecific.
- Chronic renal changes.
- Normal adrenal glands.
- Sonographically normal spleen.
- Focal mildly prominent homogenous cranial mesenteric/perihepatic lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of recurrent hepatic neoplastic criteria or masses. Sonographically, the liver suggests benign criteria such as metabolic, vacuolar, or non-obstructive cholestatic hepatopathy in conjunction with elevated ALP.

Screening hepatic FNA cytology could be considered if normal clotting status for further clarification or assessment for non-obvious inflammation. The focal mild lymphadenopathy did not overtly meet



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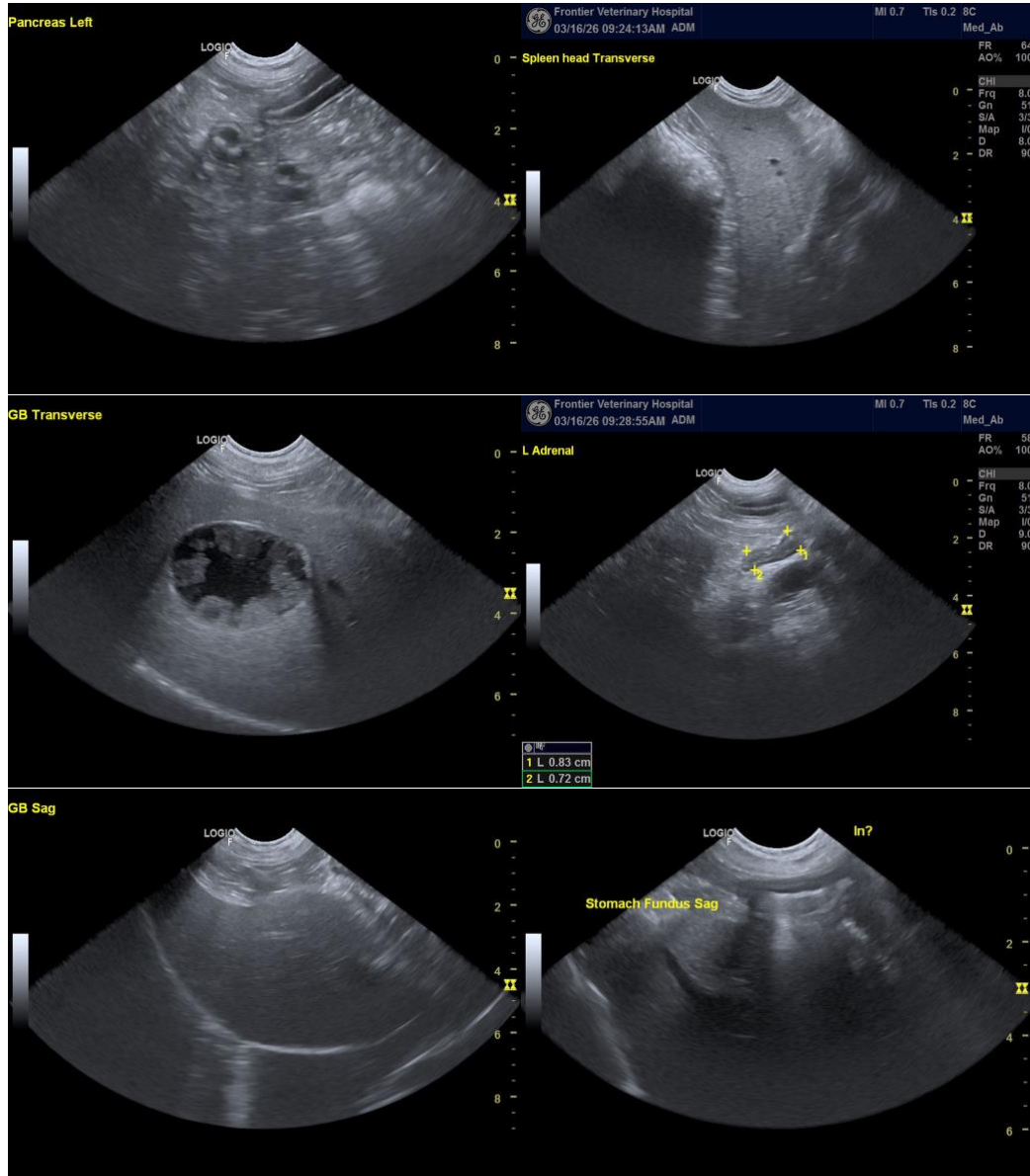
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neoplastic or metastatic criteria with incidental hyperplasia or possible lymphadenitis favored. If patient is non-clinical, hepatosupportive medications with sonographic monitoring of the liver, gallbladder, and lymph nodes for evidence of progression, if progressive hepatopathy or cholestasis, would be reasonable.





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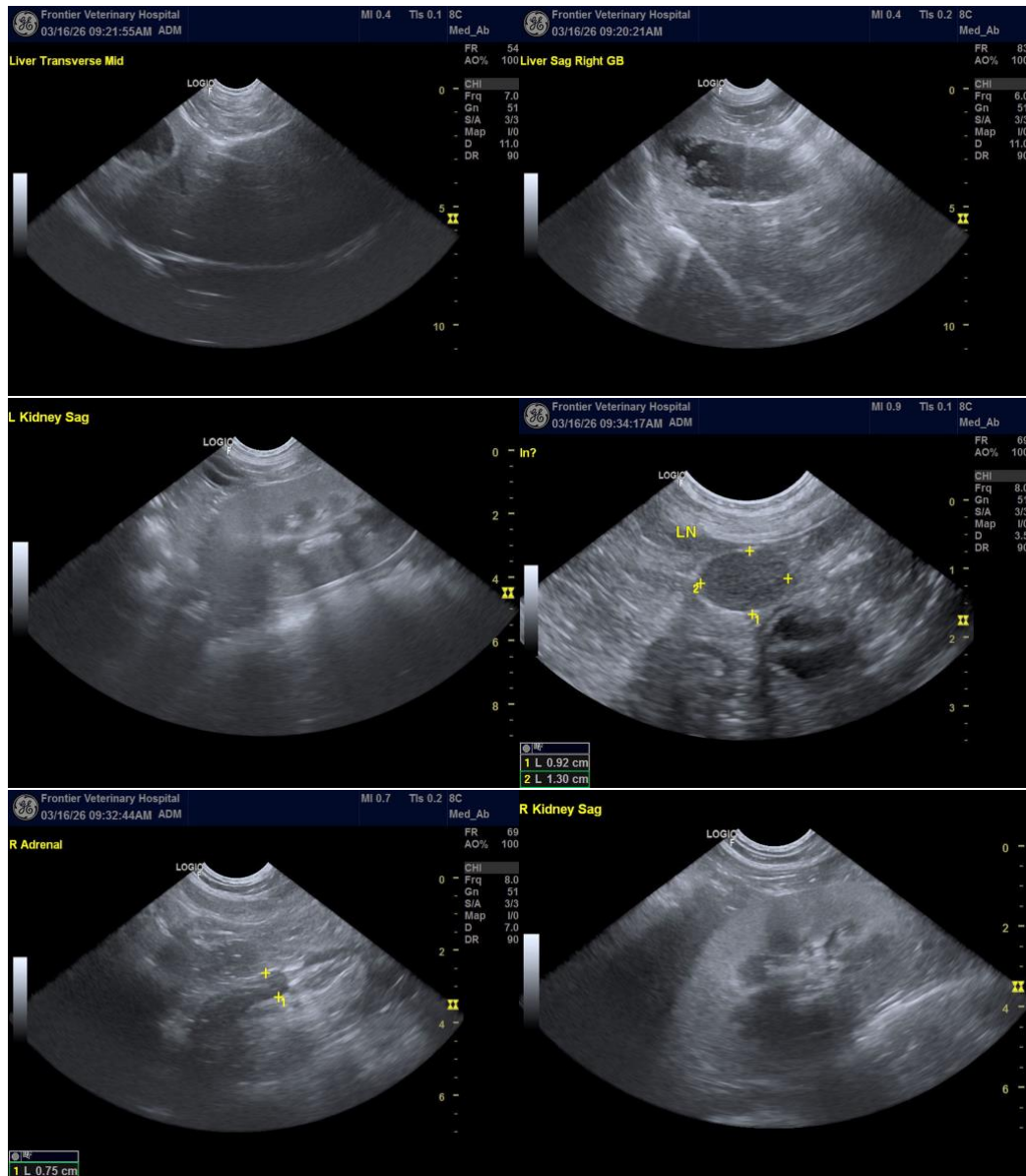
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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