



## PATIENT

Teddy Friedman

## SPECIES

Canine

## BREED

Mini Schnauzer

## SEX

Neutered Male

## AGE

10 Years 6 Months

## WEIGHT

28.5 lbs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Megan Cassels-Conway, DVM

## HOSPITAL NAME

Central Broward  
Animal Hospital

## REFERRING VET

Janeez Lezcano, DVM

## INVOICE

72522

## DATE

1/28/26

## PRESENTING CLINICAL SIGNS

P presented to us in 7/2025 for a second opinion after developing SARD's. At the time initial DVM had performed CBC/Chem/UA/thyroid panel/chest rads and AUS. On presentation p was noted to have a moderate pendulous abd, grade 3/6 systolic HM and vision loss. We performed a fasted Chem, ACHT stim test. The liver enzymes were stable and results were borderline for HAC. Since o was leaving on extended over seas trip and p was still adjusting to vision loss a LDDS test was recommended in 1-2 months. P then presented last week for marked halitosis and drooling, o interested in doing dental. O also reported PU/PD, urinary accidents, panting and shacking of legs. We repeated fasted bw which showed marked elevation of ALP and ALT, as well as hypercholes, protenuria.

Abnormal PE/Chem/CBC/UA Results: 1/2026: CBC: plt ct: 498H, Chem: glob: 3.7H, ALP: 1736H, ALT: 521, choles: 720, amylase: 1358H, Ca: 11.2, T4: 1.4, UA: SG: 1.016, 3+ prot, quiet sediment, UCS: no growth detected, fecal: NPS 7/2025: Chem: glob: 3.7H, ALP: 471H, ALT: 144, , choles: 433H, Ca: 11.5HUA: SG: 1.025, 4+ prot, bacteriuria, quiet sediment ACTH stim: -cortisol: 8.0H, 1hr post: 18.5H 6/2025: CBC: NSF, Chem: ALP: 506H, ALT: 131H, Ca: 13.0, choles: 343, UA: SG: 1.030, 3+ prot, quiet sediment chest rads: no evidence of cardiomegaly, moderate hepatomegaly

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is mildly enlarged (1.1 cm wide in the transverse view). Parenchyma is diffusely homogenous and relatively hyperechoic. Normal distinct margins and symmetrical bilobed shape are maintained. This finding is likely normal patient variant, especially if patient was neutered as an adult; however, if patient was neutered as a puppy, prostatitis or, less likely, infiltrative neoplasia cannot be ruled out. This finding should be interpreted in combination with clinical signs, urinalysis results, etc. and either further investigated or monitored, as indicated.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 5.75 cm. Right kidney measures 5.42 cm.

### Adrenal Glands

The right adrenal gland is normal in size (0.59 cm at cranial pole and 0.67 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.52 cm at cranial pole and 0.67 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### Spleen

Spleen is subjectively large in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). There is an approximately 0.80 cm x 0.90 cm non-capsule disrupting hypo- to anechoic density



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near the caudal aspect of the spleen. Splenic vasculature appears normal. The spleen is folded upon itself, which is a positional non-pathologic variant.

### *Liver*

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Additionally, several small anechoic densities/hepatic cysts are noted. Visible vasculature and biliary tree appear normal without distension or congestion

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

### *Gastrointestinal*

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

### *Pancreas*

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

### *Free Abdomen*

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

There are several discrete homogeneous, hyperechoic densities within the left cranial abdomen, the most significant measuring approximately 1.1 cm in diameter.

### PRIMARY FINDINGS

- Splenomegaly– can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.



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- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.
- Moderately heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Moderate gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- Subtle/mild mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.

## SECONDARY FINDINGS

- Mild subjective prostatomegaly as described above.
- Age related kidney changes.
- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Suspect fat granulomas in the left cranial abdomen, likely incidental/trending in appearance toward benign.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes above are largely mild/subtle and trend in appearance toward benign. Given patient's reported history and laboratory changes, if the proteinuria is persistent in an otherwise quiet sediment, quantification is indicated via a urine protein to creatinine ratio. Similarly, a blood pressure is recommended if not recently evaluated.

If patient is hypercalcemia or even intermittently hypercalcemia, a malignancy panel (PTH, PTHrP, iCa) to Michigan State College of Veterinary Medicine is recommended for further investigation of the reported hypercalcemia.

Given the concern for possible hyperadrenocorticism, it is important to know that patients with SARDs can almost exactly mimic the clinical signs associated with hyperadrenocorticism. Having said that, hormone testing could be considered in the form of a low-dose Dexamethasone suppression test.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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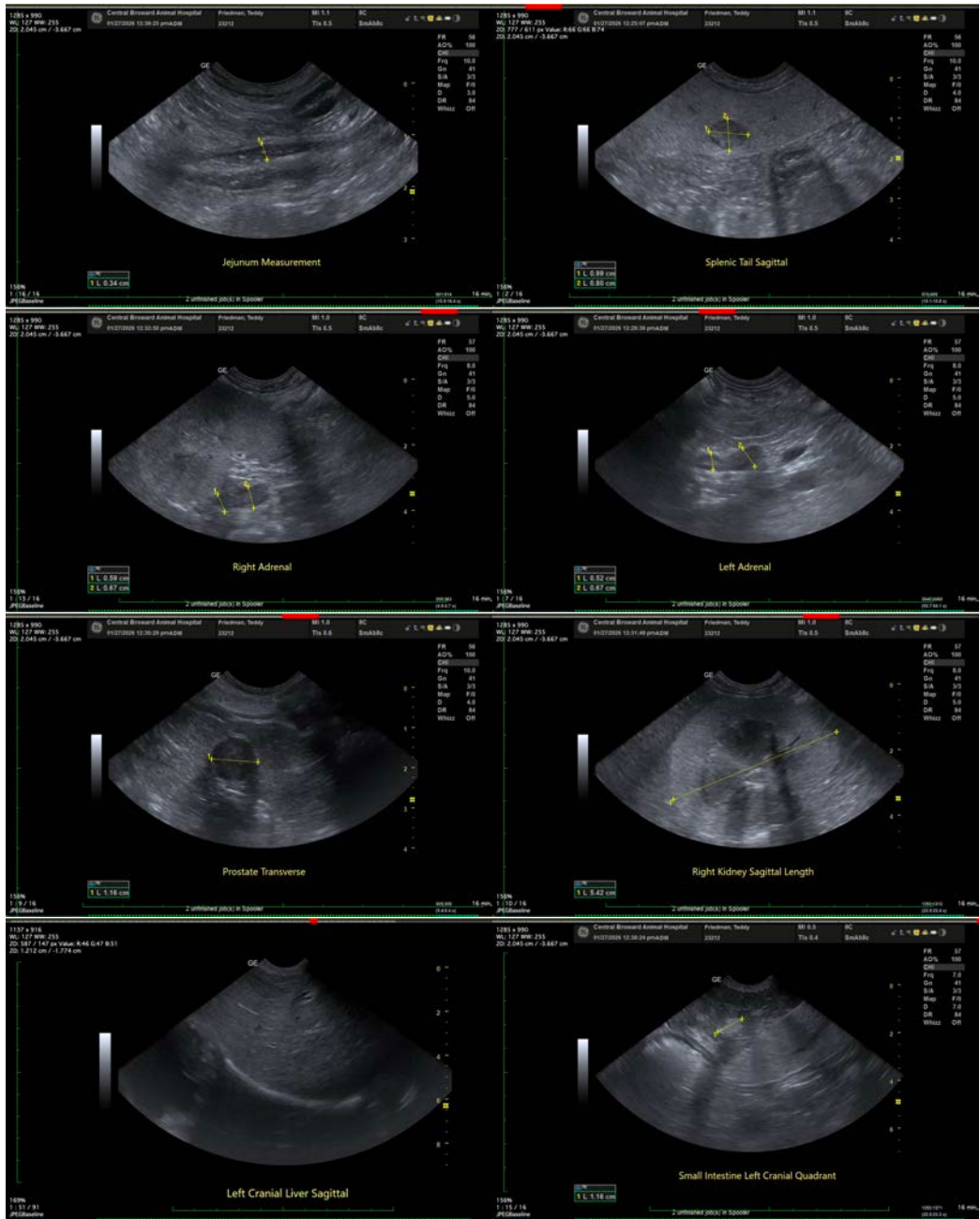
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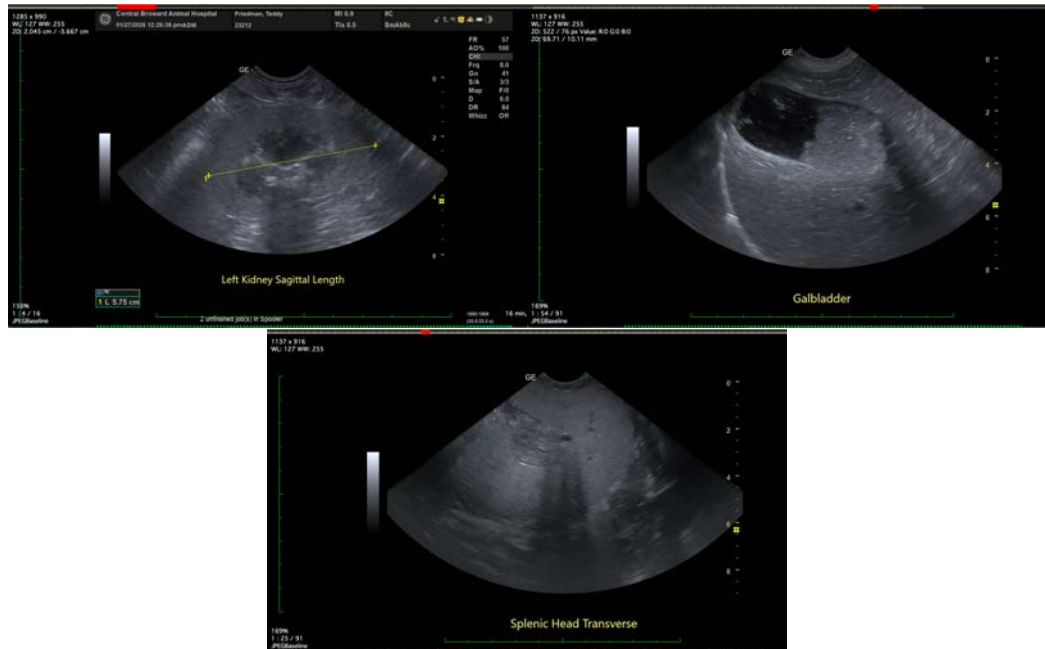
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Beth Johnson, DVM, DACVIM**  
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