



**PATIENT**

Francis Schreckengost

**SPECIES**

Canine

**BREED**

Chihuahua

**SEX**

Neutered Male

**AGE**

11 Years

**WEIGHT**

17 lbs

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Millburn Veterinary  
 Hospital

**REFERRING VET**

Dr. Mosquera

**INVOICE**

71944

**DATE**

11/19/25

**PRESENTING CLINICAL SIGNS**

Echo for worsening heart murmur, grade 3/6, mild hepatomegaly on exam, patient is slowing down per owner. no current meds.

Abnormal PE/Chem/CBC/UA Results: ALP 476 (last year 326) Creatine kinase 280, T4 0.8, PLT 605

**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 normal in size, echotexture and echogenicity for a neutered male.

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 4.48 cm. Right kidney measures 4.87 cm.

**Adrenal Glands**

The right adrenal gland is normal in size (0.90 cm at cranial pole and 0.37 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.50 cm at cranial pole and 0.60 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

The spleen is subjectively normal in size (1.0 cm thick at the hilus) with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

\*See other.

**Liver**

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

\*See other.

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.



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**Gastrointestinal**

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with 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. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with 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.

\*See other.

**Other**

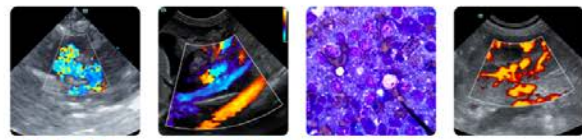
There is no definitive pathologic lymphadenopathy or free fluid noted in these images at this time. However, in the left cranial abdomen just medial to the cranial aspect of the spleen is an approximately 1.7 cm x 2.4 cm coarse, hypoechoic density that is unable to be identified or traced to origin in these images. Differentials include possible prominent pancreas or pancreatic mass, lymph node, spleen or liver mass versus other.

**PRIMARY FINDINGS**

- The hypoechoic density/mass in the left cranial abdomen is of unknown origination. Both benign and malignant differentials are possible.
- An obvious cause for the subtle liver changes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia, etc. cannot be definitively ruled out.
- Mild 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.
- 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.

**SECONDARY FINDINGS**

- Age related kidney changes.



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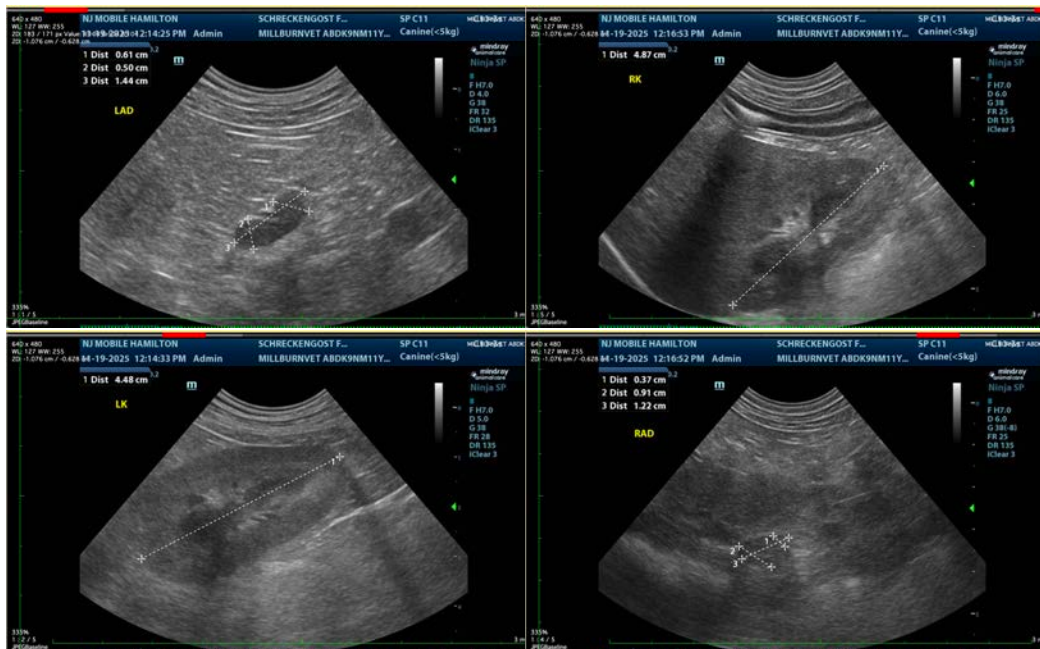
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Additional imaging/views of the left cranial abnormality and/or potentially advanced imaging such as an abdominal contrast CT scan could be considered. Additionally or alternatively, sampling of the structure via fine needle aspirate could be considered if patient's coagulation status is appropriate.

In the meantime, differentials for a primary cholestatic liver enzyme pattern (increased ALP) are vast and non-specific. Differentials include, but are not limited to, benign nodular hyperplasia which occurs in 70% of older dogs and often does not result in an abnormal ultrasound, reactive or idiopathic/vacuolar hepatopathy, cholestasis and/or hyperadrenocorticism as well as many chronic non-hepatobiliary diseases such as chronic infections/inflammation from dental disease, IBD, neoplasia, hyperlipidemia, hypothyroidism, chronic pancreatitis, chronic stress, etc.

- Adrenocortical testing such as a low dose dexamethasone suppression test could be considered if clinical signs of hyperadrenocorticism are present.
- Ursodiol could be considered if gallbladder sludge is noted as a finding.
- A fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate.
- Otherwise, recommendations include addressing any other concurrent disease and monitoring. If values are progressive, recheck imaging is recommended.





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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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