



PATIENT

Holly Shupp

SPECIES

Canine

BREED

English Springer
Spaniel

SEX

Spayed Female

AGE

13 Years 8 Months

WEIGHT

38.2

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Jessica Green

HOSPITAL NAME

Stanglein Veterinary
Clinic

REFERRING VET

Dr. Laura Green

INVOICE

72257

DATE

12/2/25

PRESENTING CLINICAL SIGNS

Hx elevated liver values. Presented today for being ataxic. Poss vestib but there's no nystagmus? Vs intracranial neoplasia.

Abnormal PE/Chem/CBC/UA Results: ALT 1692 (was 1202 in Oct), AlkP 678 (was 562 in Oct)

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.

The right kidney is normal is size (5.39 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (5.65 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Adrenal glands are mildly "plump". Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.40 cm at the cranial pole and 1.0 cm at the caudal pole. The cranial pole of the right adrenal gland is unable to be well visualized, the caudal pole measures 0.76 cm.

Spleen

The spleen is subjectively normal in size (1.5 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.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is markedly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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 very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.



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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 pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. 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.

ULTRASONOGRAPHIC FINDINGS

- The markedly heterogeneous, almost honeycomb-appearing liver could represent a benign process such as marked nodular hyperplasia, steroid or vacuolar hepatopathy, extramedullary hematopoiesis, chronic inflammatory disease, etc. However, infiltrative neoplasia including round cell neoplasia, metastatic neoplasia, other can't be ruled out without tissue sampling.
- 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.
- Bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Bile acids are recommended if patient's total bilirubin is not increased.

Fine needle aspirates of the liver are recommended if patient's coagulation status is appropriate.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

If not historically tested, testing for Leptospirosis could also be considered.

While likely unrelated to the ALT history, early or emerging adrenal disease can't be ruled out and should be suspected if patient's clinical signs are appropriate. Regardless of clinical signs, however, given the possible vestibular event, if not recently evaluated a blood pressure is recommended.



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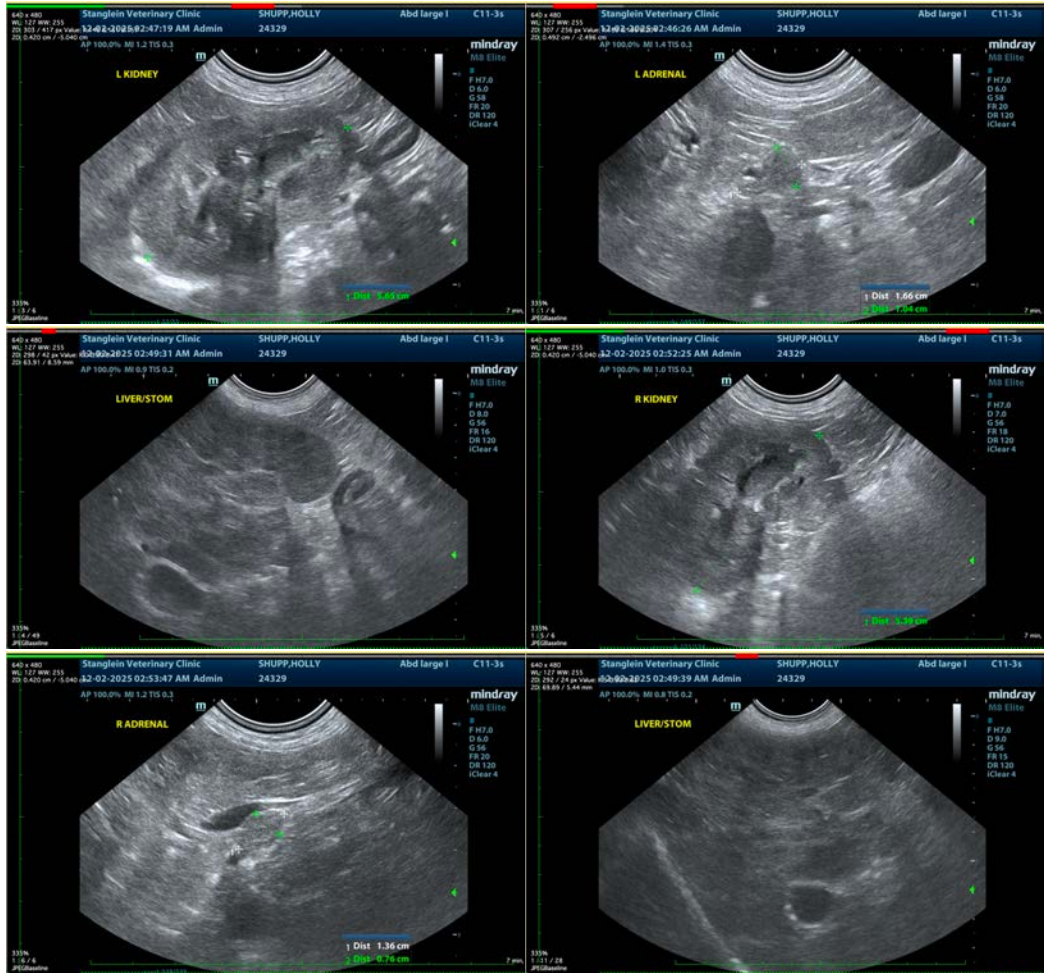
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Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.



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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