

**PATIENT**

Harley Wyma

**SPECIES**

Canine

**BREED**

Havanese

**SEX**

Neutered Male

**AGE**

11 Years

**WEIGHT**

18.2 Pounds

**INTERPRETED BY**

Beth Johnson, DVM,  
DACVIM (SAIM)

**IMAGING  
PERFORMED BY**

Loetitia Saint-Jacques,  
LVT

**HOSPITAL NAME**

Mountain View AH

**REFERRING VET**

Dr. Pablo Mendoza

**INVOICE**

35953

**DATE**

2/23/26

**PRESENTING CLINICAL SIGNS**

- Evaluation of adrenal glands vs liver vs other. persistent elevation of ALP
- Relevant Medical History and Physical Exam Findings: Patient has persistent and worsening elevation in ALP for over 1 year. Patient had severe periodontal disease that was addressed in December of 2025. Patient had remained asymptomatic
- Abnormal PE/Chem/CBC/UA Results: 1/29/25 ALP 1,540 U/L 12/31/25 ALP 1,224 10/30/25 ALP 1,095 U/L 3/22/24 ALP 655 U/L 2/9/24 ALP 671

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, or echogenic sediment observed. There is a 0.18 cm in diameter mineral density with no definitive shadow noted within the trigone. 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.

Left kidney is normal in size (4.49 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.

Right kidney is normal in size (5.22 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**

Left adrenal gland is normal in size (0.63 cm at cranial pole and 0.73 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

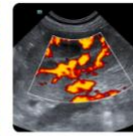
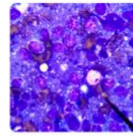
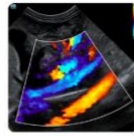
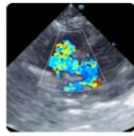
Right adrenal gland is normal in size (0.65 cm at cranial pole and 0.65 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

Spleen is subjectively normal in size (1.6 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 normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

***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 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.

Assessment of heart base images is included when/if a splenic nodule/mass is present (as a complimentary add on). They are also assessed when a specific request is made for assessment of a limited second cavity (heart base and/or thorax) for an additional charge. Images of the heart (and/or) thorax were not assessed for this study. Please contact us if you would like a second cavity.

**ULTRASONOGRAPHIC FINDINGS**

- Emerging gallbladder mucocele- 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.
- A punctate non-visibly-obstructive mineral density/cystolith is noted within the trigone. This is likely small enough to pass on its own.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

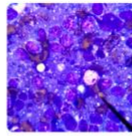
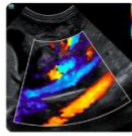
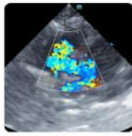
Differentials for a primary cholestatic liver enzyme pattern (increased ALP) are vast and non-specific. Differentials include, but are not limited to, benign nodular hyperplasia which occurs in 70% of older dogs and often does not result in an abnormal ultrasound, reactive or idiopathic/vacuolar



Imaging  
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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**

info@sonopath.com