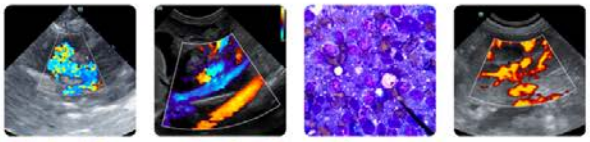

PATIENT

Henry Hylinski

SPECIES

Canine

BREED

Schnauzer

SEX

Neutered Male

AGE

12 Years

WEIGHT

21 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Vincent Tavella

HOSPITAL NAME

Williamsburg Veterinary Clinic

REFERRING VET

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INVOICE

73831

DATE

3/20/26

PRESENTING CLINICAL SIGNS

Trending elevations in ALP with a persistent high normal calcium and elevated triglycerides. Patient has history of allergic skin disease well managed with cytopoint. Patient had a resistant hookworm infection 6 months ago that was treated to resolution. Patient has a history of seizures when boarding which has been well managed with zonisamide.

Abnormal PE/Chem/CBC/UA Results: PE: Missing nearly all dentition from historical extractions. Intermittent pruritus of forelimbs. Chem: Trending elevation in ALP - 261 on 3/19/25, 467 on 3/17/2026 (5-131), Borderline elevated calcium - 11.5 3/19/25, 11.4 3/17/26 (8.9-11.4), Elevated triglycerides - 1136 3/19/25, 1214 3/17/26 (29-291) T4 wnl CBC wnl UA not screened.

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.

The right kidney is normal is size (4.7 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 (4.7 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

The right adrenal gland is normal in size (0.88 cm at cranial pole and 0.60 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal. **The adrenal gland is a little difficult to fully differentiate from surrounding tissue and in some views appears mildly plump, measuring up to 1.3 cm in size.*

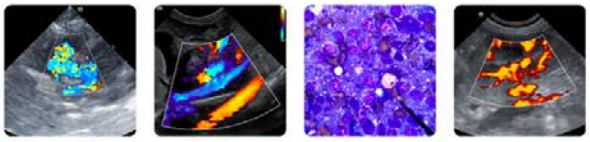
The caudal pole of the left adrenal gland is normal in size (0.68 cm), shape and overall architecture, echogenicity and echotexture. The cranial pole is difficult to fully visualize/isolate for measurement in these images. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal 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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.



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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 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.

Free Abdomen

There is a trace amount of anechoic free fluid noted adjacent to the spleen.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Mildly 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.
- 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.
- The trace/scant free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- 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.
- Possible mild right adrenomegaly should be interpreted in combination with patient's clinical history.

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SECONDARY FINDINGS

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Schnauzers with idiopathic hypertriglyceridemia can occasionally develop a secondary cholestatic hepatopathy. Therefore, given patient's signalment, if not already evaluated, a fasted triglyceride level is recommended, and if indicated therapy could be considered while monitoring ALP for improvement. Therapy could begin, if indicated, with a low fat diet if tolerated.

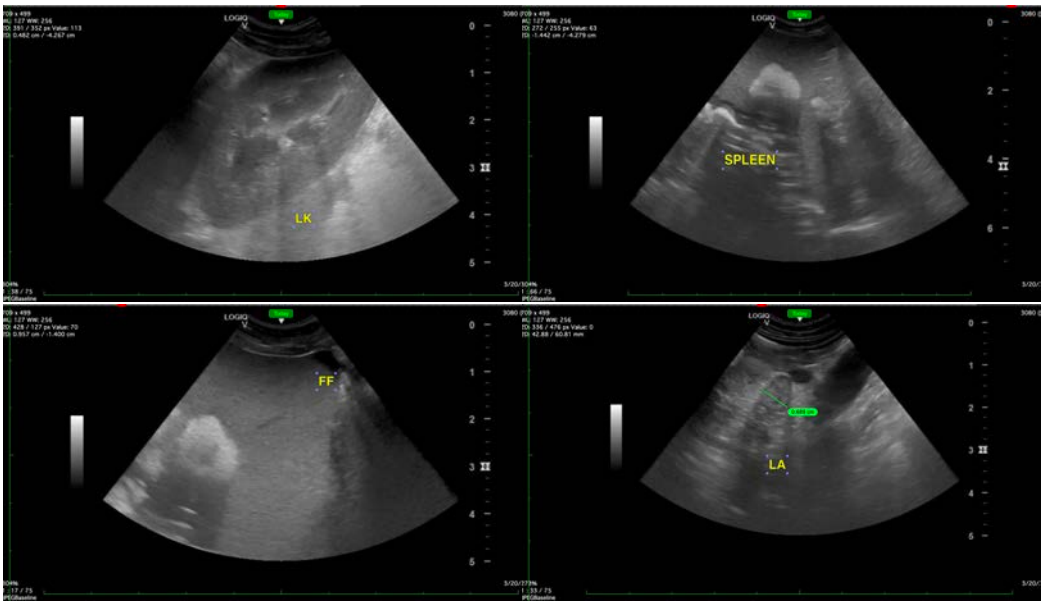
If patient has any clinical history consistent with hyperadrenocorticism, then hormone testing may also be appropriate, beginning with a low-dose Dexamethasone suppression test.

A blood pressure is also recommended if not recently evaluated.

The cause and significance of the trace free fluid is unknown but may warrant further investigation or at least monitoring. Cardiac evaluation could be considered, or if the pocket can safely be reached, sampling could be considered if patient's coagulation status is appropriate.

In the meantime, given the very mildly increased hypercalcemia, 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.

A malignancy panel (PTH, PTHrP, iCa) to Michigan State College of Veterinary Medicine is recommended for further investigation of the reported hypercalcemia.



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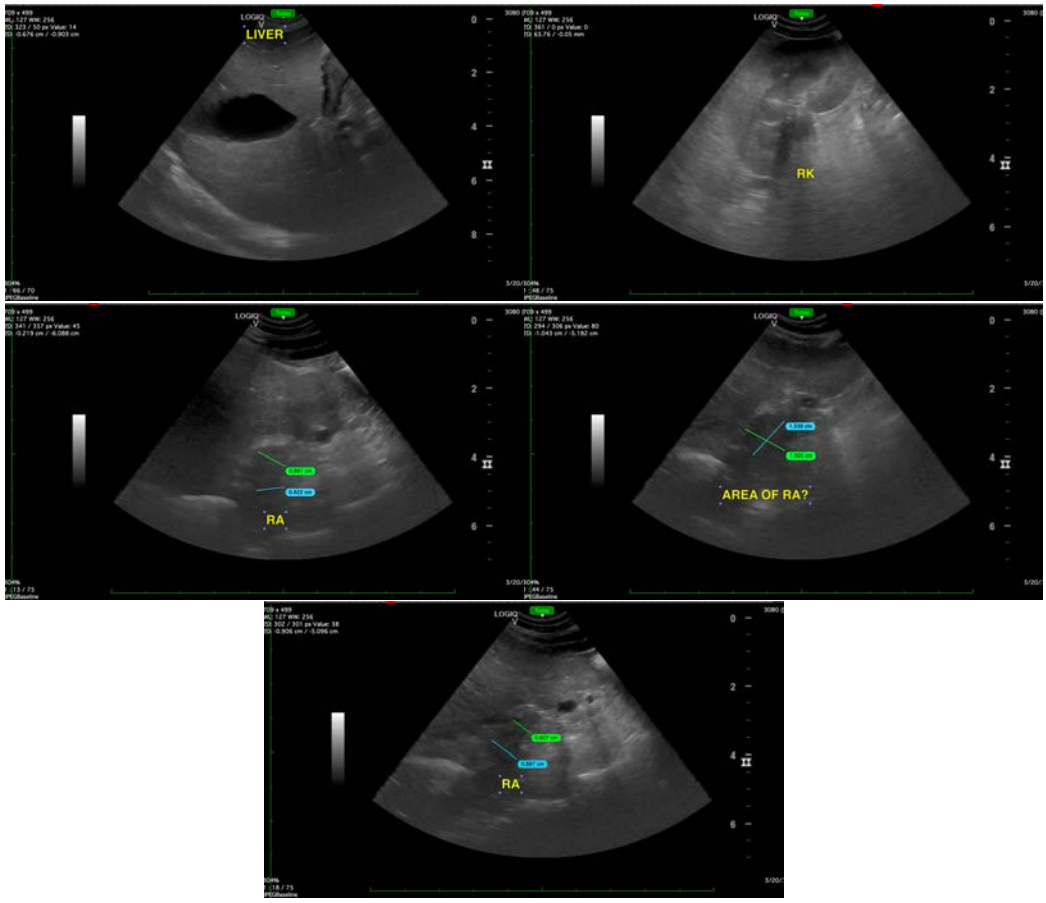

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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