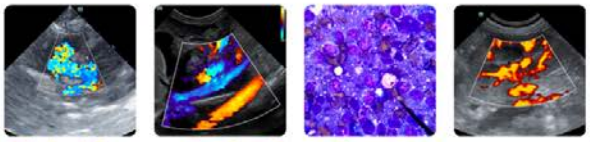


PATIENT

Snowy Woytko

SPECIES

Canine

BREED

Pomeranian x

SEX

Neutered Male

AGE

14 Years 2 Months

WEIGHT

32.0

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jessica Green

HOSPITAL NAME

Stanglein Veterinary Clinic

REFERRING VET

Dr. Nathaniel Stanglein

INVOICE

75317

DATE

5/20/26

PRESENTING CLINICAL SIGNS

History of splenectomy (benign hyperplasia) and cystotomy in spring 2025. Recent BW showed mild elevation in ALT and moderate ALP. High normal renal values but still with good urine concentration, early renal vs pre-renal.

Abnormal PE/Chem/CBC/UA Results: ALT 199, ALP 859

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a moderate amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The 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 measured 5.82 cm. Right kidney measured 5.47 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.70 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 (0.40 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 has previously been removed.

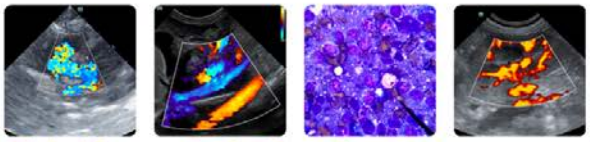
Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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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.

PRIMARY FINDINGS

- 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.
- Spleen has been previously removed.

SECONDARY FINDINGS

- Mild to moderate age related kidney changes.
- Moderate amount of echogenic urinary bladder debris.

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 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.

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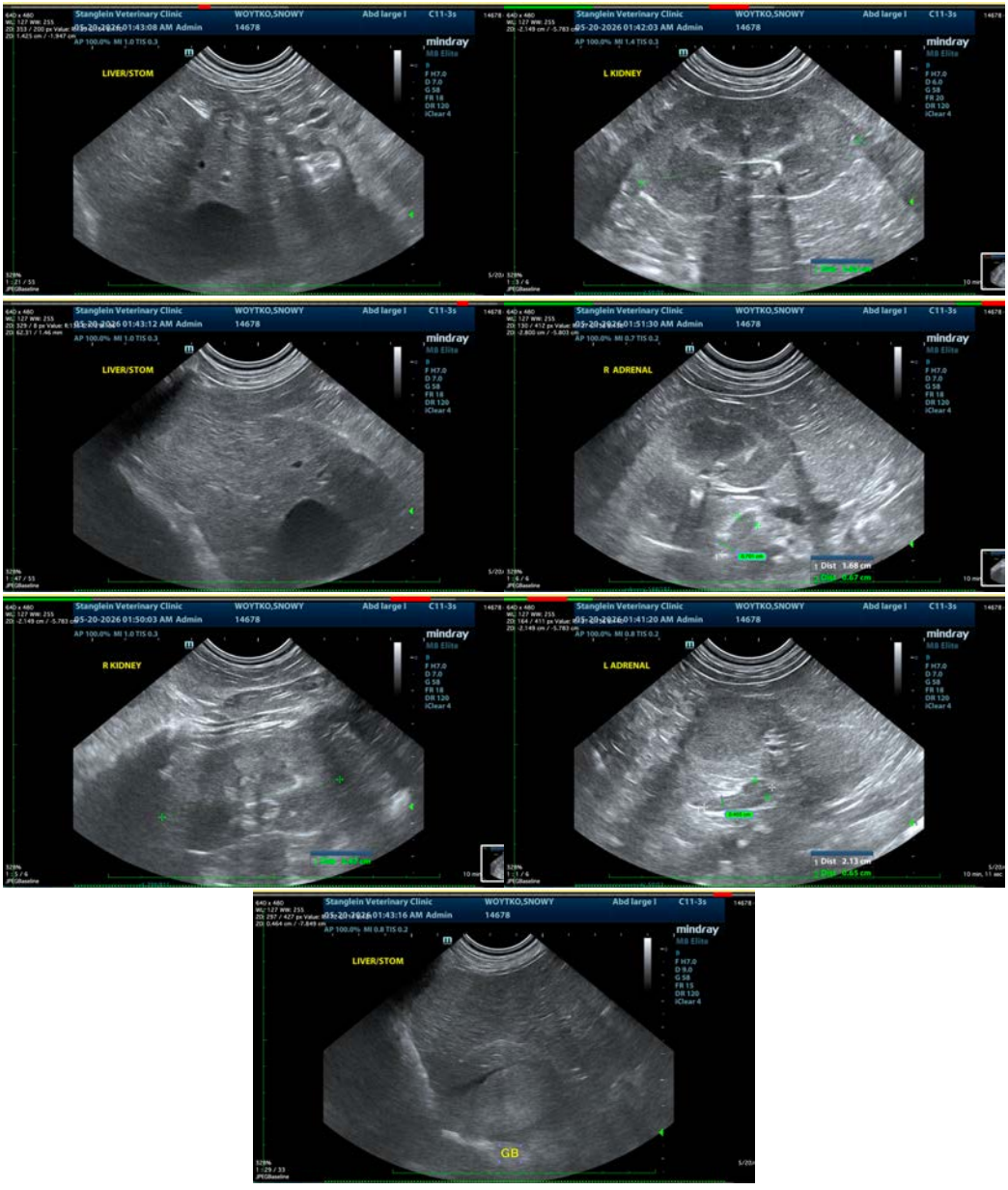
- Adrenocortical testing such as a low dose dexamethasone suppression test could be considered if clinical signs of hyperadrenocorticism are present.
- Given the gallbladder debris noted above, empirical hepatic nutraceuticals including Ursodiol could be considered while monitoring liver enzymes for improvement.
- 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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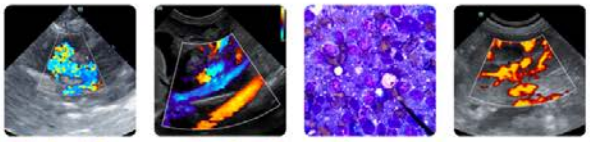

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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