



PATIENT

Sofie Kaufman

SPECIES

Canine

BREED

Schnauzer

SEX

Spayed Female

AGE

9 Years

WEIGHT

8.7 kg

INTERPRETED BY

Dr Brittany Sinclair,
 BVSc(hons),
 DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Woodstock Veterinary
 Hospital

REFERRING VET

Dr. DeVries

INVOICE

75382

DATE

5/22/26

PRESENTING CLINICAL SIGNS

History of hyperlipidemia. She presented for an examination where several new issues were identified. The owner reports a new, pea-sized mass on the right upper eyelid that has appeared recently. The owner also notes that Sofie pants a fair bit.

- A mass approximately the size of a pea was noted on the right upper eyelid.
- A large lump, suspected to be a lipoma, is present behind the left elbow in the axillary region.
- A new grade 2/6 left basilar systolic heart murmur was auscultated.
- Surgical removal of the right upper eyelid mass and the suspected lipoma in the left axillary area was discussed but U/S recommended to investigate the cause of the newly detected heart

Current Medications: 200 mg Gabapentin night before and morning of appt, 50 mg Trazodone night before and morning of appt. May need Butorphanol depending on level of sedation with Gaba/Traz

Abnormal PE/Chem/CBC/UA Results: BW elevations in calcium, TP, and sodium. albumin high end of normal. - ALK PHOS significantly elevated at 904 U/L (ref range 5-160 U/L). considerable increase from previous value of 233 U/L. - other liver values WNR - free T4 normal - SG > 1.050. - calcium secondary to being protein-bound on albumin and dehydration - 4DX Neg /Fecal Neg Primary Question to Be Answered in This Exam - echo recommended prior to a sx procedure to investigate the cause of the new heart murmur and assess anesthetic risk. - abd u/s rec with the echo. goal is to evaluate the liver for underlying pathology, (vacuolar hepatopathy) that could be causing ALP elevation. Cushings was a ddx but w/ SG / water consumption appr 27 mL/kg/day, unlikely. consuming more water later in the day compared to the morning

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. Left kidney measures 4.37 cm. Right kidney measures 4.28 cm.

Adrenal Glands

The left adrenal gland is visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Left measures 1.44 cm in length x 0.36 cm at the caudal pole and 0.33 cm at the cranial pole.

The right adrenal gland is visualized on still images only. It appears to have normal shape, size, position and echogenicity for this breed and age though this could not be confirmed on cine loops. Right measures 1.4 cm in length x 0.47 cm at the caudal pole and 0.61 cm at the cranial pole.

Spleen

The spleen is enlarged, extending caudally to the level of the urinary bladder. Parenchyma is smooth and homogeneous. There is a solitary hyperechoic nodule noted near the hilus, consistent with a benign myelolipoma.



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Liver

The liver is enlarged with slightly rounded borders. Parenchyma is diffusely hyperechoic. There are multifocal hypoechoic to somewhat heterogeneous nodules noted throughout the parenchyma. One nodule on the left liver measures 1.9 cm x 2.5 cm. A large nodule or early developing mass is noted in the right liver measuring 3.7 cm x 3.7 cm. Echogenicity is similar to the other liver nodules.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic hepatomegaly with diffuse nodules throughout parenchyma.
- Large nodule noted in the right liver deep to gallbladder – same pathology as other nodules versus developing liver mass.
- Splenomegaly with benign myelolipoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver changes are diffuse and may represent vacuolar hepatopathy. The number and size of nodules may also represent metastatic disease, with the larger liver nodule noted in the right liver being a possible primary tumor. The echogenicity and appearance of the nodules is more consistent with vacuolar hepatopathy, but ultimately this cannot be determined by ultrasound alone. FNA is recommended to further defined parenchymal changes. Ultimately, liver biopsy may be required for more definitive diagnosis.

Splenomegaly may represent reactive inflammatory or infiltrative disease. The hyperechoic nodule is likely a benign myelolipoma. General splenic aspirate should be considered to further defined the splenomegaly.



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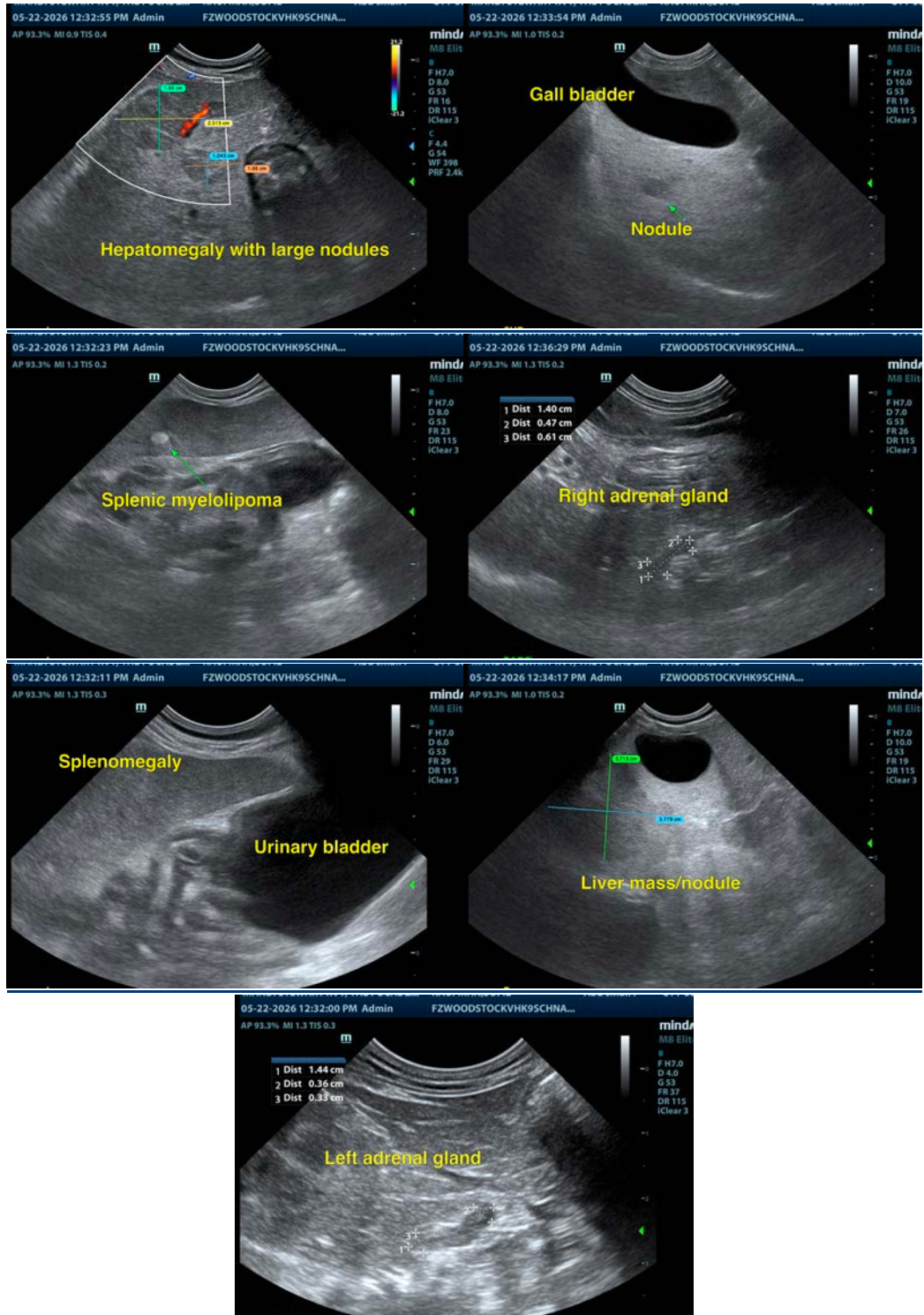
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

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