



## PATIENT

Emmie Syrja

## SPECIES

Canine

## BREED

Am Cocker

## SEX

Spayed Female

## AGE

12 Years 3 Months

## WEIGHT

9.9 kg

## INTERPRETED BY

Kathleen Sennello DVM,  
MS, Diplomate ACVIM  
(Small Animal Internal  
Medicine)

## IMAGING PERFORMED BY

Dr. Jill Rankin

## HOSPITAL NAME

Chestermere Vet Clinic

## REFERRING VET

Dr. Bikram Grewal

## INVOICE

72896

## DATE

12/31/25

## PRESENTING CLINICAL SIGNS

The patient presents with a history of progressive liver enzyme elevation, weight loss, and decreased appetite, with recent imaging suggesting a possible liver mass. A recent FAST scan revealed an abnormal liver and a suspected mass. This finding is concurrent with an increase in liver enzymes; in May, the ALT was 160 U/L and ALP was 261 U/L, which have since risen to 858 U/L and 760 U/L, respectively. Amylase was also noted to be mildly elevated at 1749. Clinically, the patient has experienced a loss of appetite for at least the last two weeks, now eating only one meal per day instead of two. There has been a documented weight loss of approximately one kg since July. No vomiting has been reported. Other recent laboratory findings include lymphopenia (lymphocytes 0.73) and elevated platelets (565). A urinalysis was not available at the time of this report.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears mildly thickened and slightly irregular, measuring at 0.37 cm. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi.

The left kidney has a normal shape and size (4.7 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.72 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### Adrenal Glands

The left adrenal gland is normal in size measuring 0.45 cm at the cranial pole and 0.52 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.62 cm at the cranial pole and 0.63 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

### Spleen

The spleen is subjectively normal in size (1.36 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

### Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the



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vasculature and biliary tract appear normal. There is an ill-defined hyperechoic lesion/mass effect visualized in the right side of the liver measuring 1.7 cm x 2.9 cm.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-gravity dependent debris. The cystic and common bile ducts are normal/not visible.

### ***Gastrointestinal***

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. 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. Duodenum wall measures 0.40 cm. Jejunum wall measures 0.38 cm. Visualized peristalsis appears appropriate. 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 area of the pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

### ***Free Abdomen***

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

## ULTRASONOGRAPHIC FINDINGS

- Mildly thickened/irregular urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Large, heterogeneous liver with a hyperechoic focal lesion – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy. The hyperechoic lesion has the appearance most consistent with a focal hyperplasia, adenoma, other. A neoplastic lesion cannot be ruled out but seems less likely.
- Moderate non-gravity dependent debris visualized in the gallbladder – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.



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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

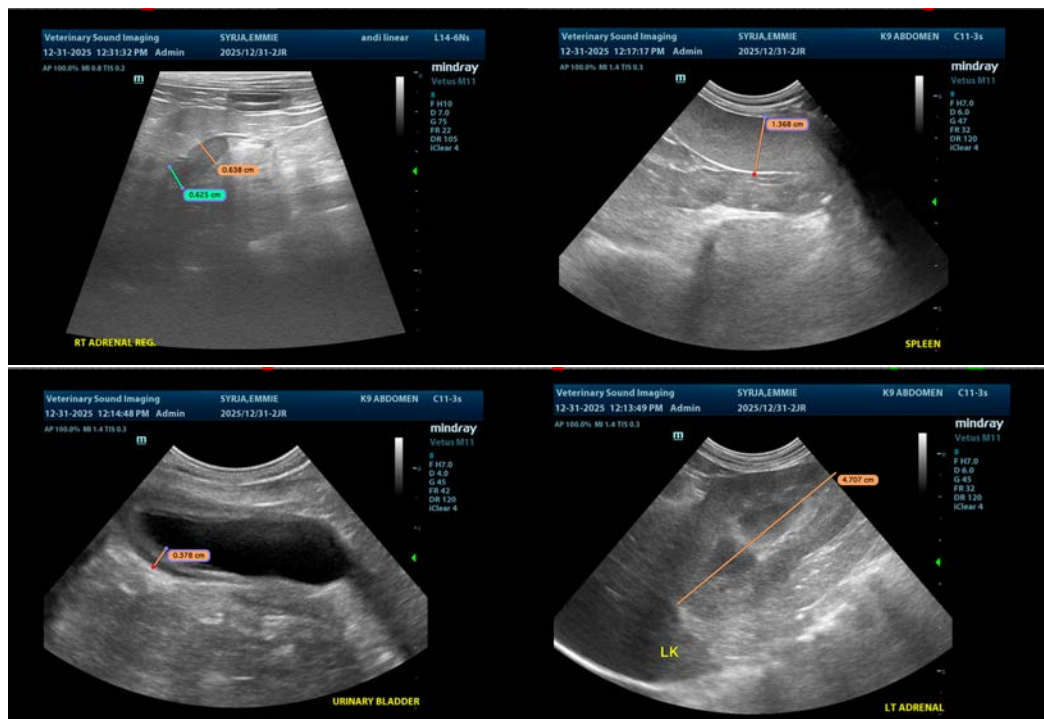
The liver is large and heterogeneous. This is a non-specific finding. Additionally, the gallbladder has a moderate amount of debris, but no evidence of wall thickening or surrounding inflammation. Findings are suggestive of a primary hepatopathy, although cholecystitis or other mild gallbladder disease is possible. Consider the following:

- Recommend pre- and post-prandial bile acids to assess liver function.
- Recommend a fine needle aspirate of the liver (provided coagulation parameters are normal) to look for any evidence of infiltrative neoplasia or similar.
- If there is any clinical concern for Leptospirosis, recommend testing.
- Recommend empirical treatment for acute liver injury/cholangiohepatitis with a course of Ursodiol, Denamarin, and antibiotics.

If liver enzyme elevations are persistent, and a cause is not identified, consider biopsies of the liver with samples for histopathology, culture and copper levels.

The bladder wall is slightly thickened and irregular. Recommend urinalysis and culture to further evaluation.

A primary hepatopathy is suspected, but concurrent gastrointestinal disease cannot be ruled out. If there is concern for gastrointestinal disease, consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate. If these values are indicative of significant small intestinal disease, further evaluation may be warranted.





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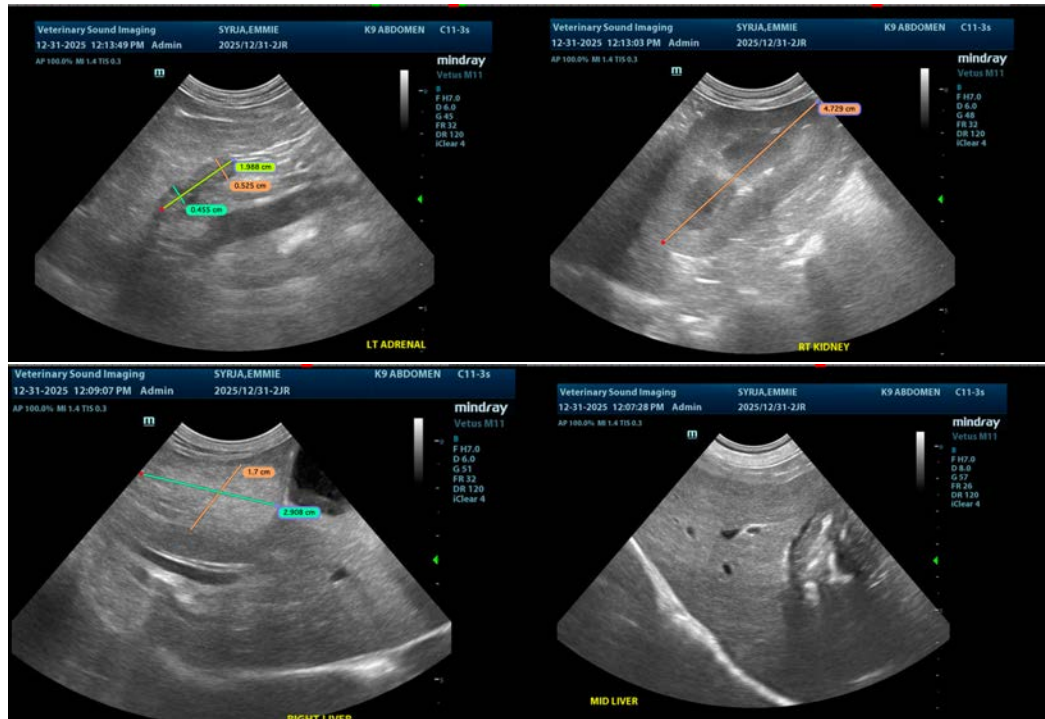
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

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