



PATIENT

Allie Schyve

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

10 Years

WEIGHT

9.56 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Danielle Shemanski,
DVM, MA

HOSPITAL NAME

Western New York
Veterinary Services

REFERRING VET

Tonia Minko, DVM

INVOICE

74825

DATE

4/29/26

PRESENTING CLINICAL SIGNS

Patient's ALT and ALP are still markedly elevated and getting higher. Owner reports that the pet seems to be doing well at home and not experiencing any clinical symptoms. RDVM recommended that they move forward with bile acid testing and a diagnostic ultrasound. Current Liver Values: ALT: 1496 ALP: 812 (dilution) History: Owner reports Allie is very food-driven and has gained weight. She is now on a diet, eating Purina Pro Plan once a day from a cookie sheet to slow her eating. She seems hungrier since starting the diet. She has a history of a broken front leg from jumping off furniture and has a rod in the leg. She is not on any chronic medications. CLINICAL SIGNS: None MEDICATIONS: None currently *was given 0.1mL torb IV for the ultrasound.

Abnormal PE/Chem/CBC/UA Results: April 17, 2026: ALT: Markedly elevated and increasing. ALKP (ALP): Markedly elevated and increasing. April 14, 2026: ALT: 1496 1:4 dilution ALKP (ALP): 812 U/L HIGH. February 27, 2026: ALT: Significantly elevated. ALKP (ALP): Significantly elevated. February 25, 2026: ALT: > 1000 U/L HIGH. ALKP (ALP): 463 U/L HIGH. January 30, 2026: Stool Sample: Positive for a tapeworm segment. January 12, 2026: ALT: 829 U/L HIGH. ALKP (ALP): 427 U/L HIGH.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.91 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 (3.83 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 0.40 cm at the cranial pole and 0.46 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 0.40 cm at the cranial pole and 0.41 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 (0.91 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.



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Liver

The liver is irregular in shape. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. The caudal border of the liver is irregular with a nodular appearance. There is the suggestion of ill-defined hypoechoic coalescing nodules, examples measure 1.39 cm x 2.31 cm and 1.8 cm x 2.65 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-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains moderate ingesta. 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. There is non-shadowing intraluminal material visualized within the stomach, possibly consistent with ingesta or a poorly defined mass effect/thick rugal folds etc...

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 0.26 cm. Jejunum wall measures 0.30 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 pancreas is visible/mildly mottled in the right limb. 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.

PRIMARY FINDINGS

- Heterogeneous, irregular liver with ill-defined iso- to hypoechoic nodules – 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 nodules reported could be consistent with benign regenerative nodules, irregular rounded areas of liver, or an early neoplastic process.
- Moderate gallbladder debris – 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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- Non-shadowing intraluminal material visualized within the stomach – Findings could be consistent with atypical ingesta or poorly defined soft tissue/mass effect. Consider evaluation with power doppler to evaluate the vascularity of this tissue as well as reevaluation after a more prolonged fast.

SECONDARY FINDINGS

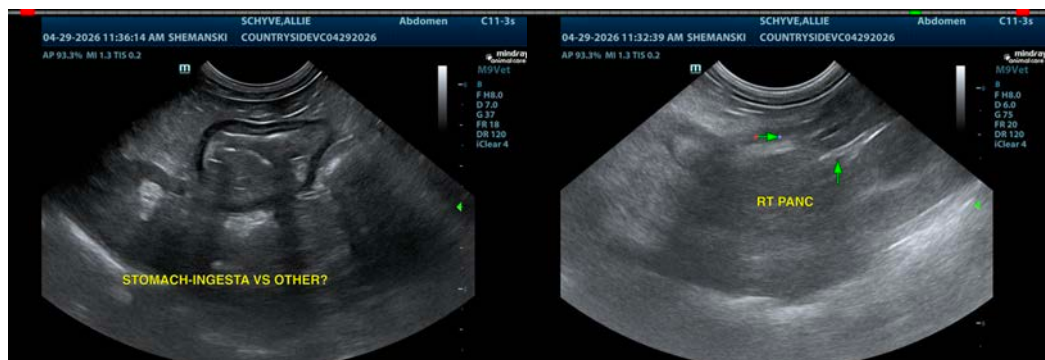
- Mild age related changes visualized associated with both kidneys.
- Pancreatic changes consistent with mild pancreatic remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is irregular with a somewhat scalloped appearing caudal border. This appears associated with some ill-defined hypochoic nodules. Recommend liver function testing and consider a fine needle aspirate of the “nodular” region of liver as well as the more cranial aspects (if a safe window for sampling is available and coagulation parameters are normal). If liver function is abnormal, ultimately biopsies of the liver may be warranted. Ideally a contrast CT scan would also be considered to further evaluate the irregularities described.

The majority of the stomach imaged appears relatively normal but there is an image with poorly defined intraluminal material, which is not shadowing. This could represent atypical ingesta, but abnormal tissue in this region (prominent rugal folds, mass effect etc..) cannot be ruled out. You could consider reevaluation of this region with a more prolonged fast, and evaluation with power doppler, looking for vascularity to further assess.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).





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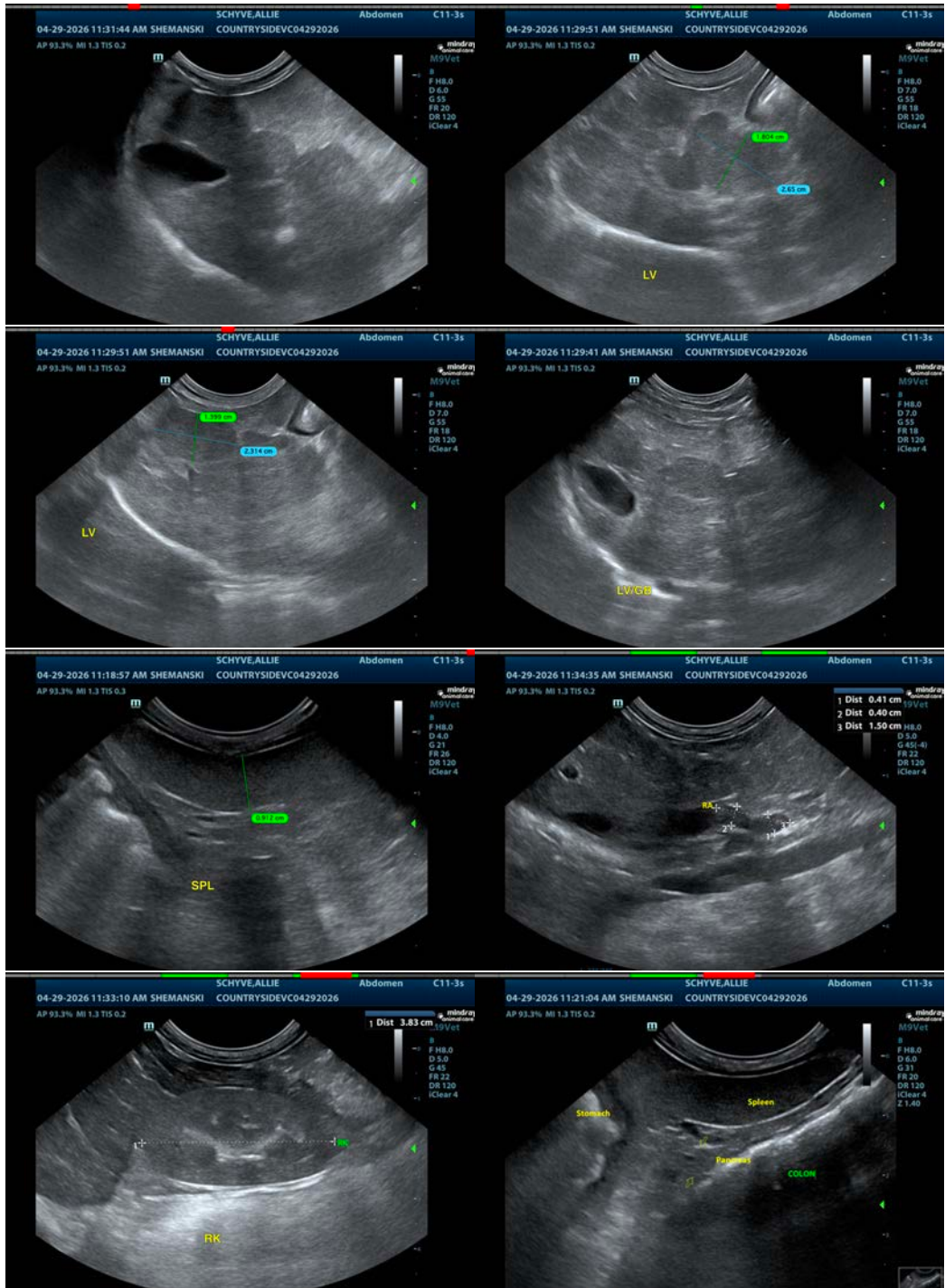
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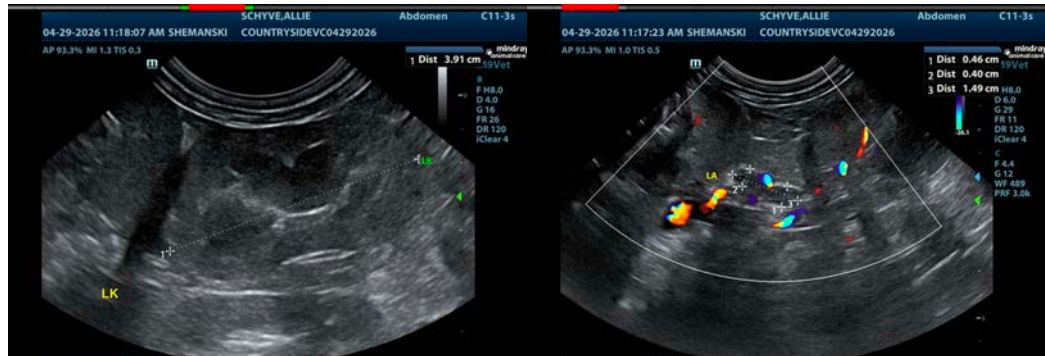
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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