



## PATIENT

Arie Cantu

## SPECIES

Canine

## BREED

Chihuahua Mix

## SEX

Spayed Female

## AGE

13 Years

## WEIGHT

2.5 pounds

## INTERPRETED BY

R. McKenzie Daniel,  
DVM, DABVP (Canine  
/ Feline Practice)

## IMAGING PERFORMED BY

Dr. Karla Schultz

## HOSPITAL NAME

Northshore Veterinary  
Hospital

## REFERRING VET

Dr. Karla Schultz

## INVOICE

14411

## DATE

03/17/26

## PRESENTING CLINICAL SIGNS

- presented for annual wellness exam 3/12/2026, o reports doing great at home. On homemade diet mixed with Rx hydrolyzed diet. Pre-dental labwork 3/12/2026 revealed inflammatory and hepatic abnormalities (see below). Started broad-spectrum antibiotics (Clavamox, metronidazole) after sample collection today 3/17/2026; waiting to start ursodiol until cleared for obstruction on this US.
- previous episode of regurgitation and hyporexia May 2025 (US performed and submitted to Sonopath; treated successfully with omeprazole), and regurgitation again in Dec 2025 (restarted omeprazole, o reports p did worse with this and discontinued, o reports p improved after discontinuation)

Abnormal PE/Chem/CBC/UA Results: 3/17/2026 diagnostics: full body radiographs (submitted, pending- I see mineralization in gall bladder, mass effect with decreased detail in R cranial quadrant of abdomen); bile aspirate aerobic and anaerobic cultures (pending), FNA of enlarged liver lobe (cytology submitted, pending) 3/17/2026 PE: weight loss (6.26lbs Dec 2025, now 5.5 lbs); tense on abdominal palpation, during US reactive to cranial abdominal scan, temp fluctuated 102.7F-103.0F during the day. 3/12/2026 labs: CBC: neutrophilia (14.8K) and monocytosis (1.3K) Chem: hyperglobulinemia (5.4) with hypoalbuminemia (2.5); increased hepatocellular LEZ (ALT 926, AST 82) and cholestatic (ALP 1935, GGT 19) with normal bilirubin and cholesterol u/a: USG 1.025, pH 6.5, quiet stick/sediment

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

The area of the aortic trifurcation was free of pathology.

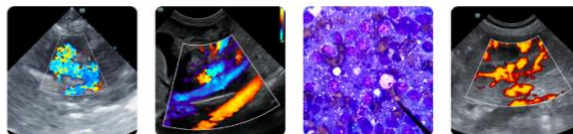
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. Areas of mild medullary mineral were present. The left kidney measured 3.5 cm in length. The right kidney measured 4.0 cm in length.

### *Adrenal Glands*

The adrenal glands were subjective borderline enlarged in size with normal contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.55 cm width. The right adrenal gland measured 0.56 cm width.

### *Spleen*

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.



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### *Liver & Gallbladder*

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The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. Mild lobar nonhomogenous parenchyma. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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The gallbladder was distended in size with mild regional thickened hyperechoic gallbladder wall. The gallbladder lumen was primarily occupied by congealed nonorganized gallbladder debris with concurrent dependent lumen to nondependent choleliths. The common bile duct was overtly normal in size without evidence of posthepatic obstruction.

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### *Gastrointestinal*

The stomach presented intact mildly prominent wall. Intact wall layering was maintained and distinct. The gastric lumen was empty with mild lumen gas.

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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Mild segmental nonobstructive intestinal ileus to the level of the colon.

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Normal visible colon wall layers were present with formed fecal matter in lumen.

### *Pancreas*

The parenchyma of the pancreas was hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

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### *Free Abdomen*

A solitary mildly enlarged nonhomogenous to cystic hepatic lymph node was present measuring 1.8 cm x 0.95 cm. No additional abdominal lymphadenopathy was visualized. No evidence of peritoneal effusion.

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## ULTRASONOGRAPHIC FINDINGS

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- Persistent mild gastritis.
- Sonographically unremarkable small intestine with minor segmental ileus.
- Chronic pancreatitis/fibrosis.
- Hepatopathy exhibiting mild lobar nonhomogenous parenchyma.
- Progressively congealed gallbladder debris with nonobstructive cholelithiasis.
- Age-related kidneys with mild medullary mineral.
- Bilateral borderline adrenomegaly.
- Sonographically normal spleen- no evidence of previously noted splenic nodules.

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Correlation with hepatic cytology as well as bile culture and sensitivity is recommended as chronic to acute on chronic hepatobiliary inflammation and cholestatic disease is suspected. Mild potential for emerging to occult hepatic neoplasia, not excluded yet thought less likely. Ursodiol therapy could be considered in conjunction with empirical antibiotics pending additional diagnostics owing to its poor



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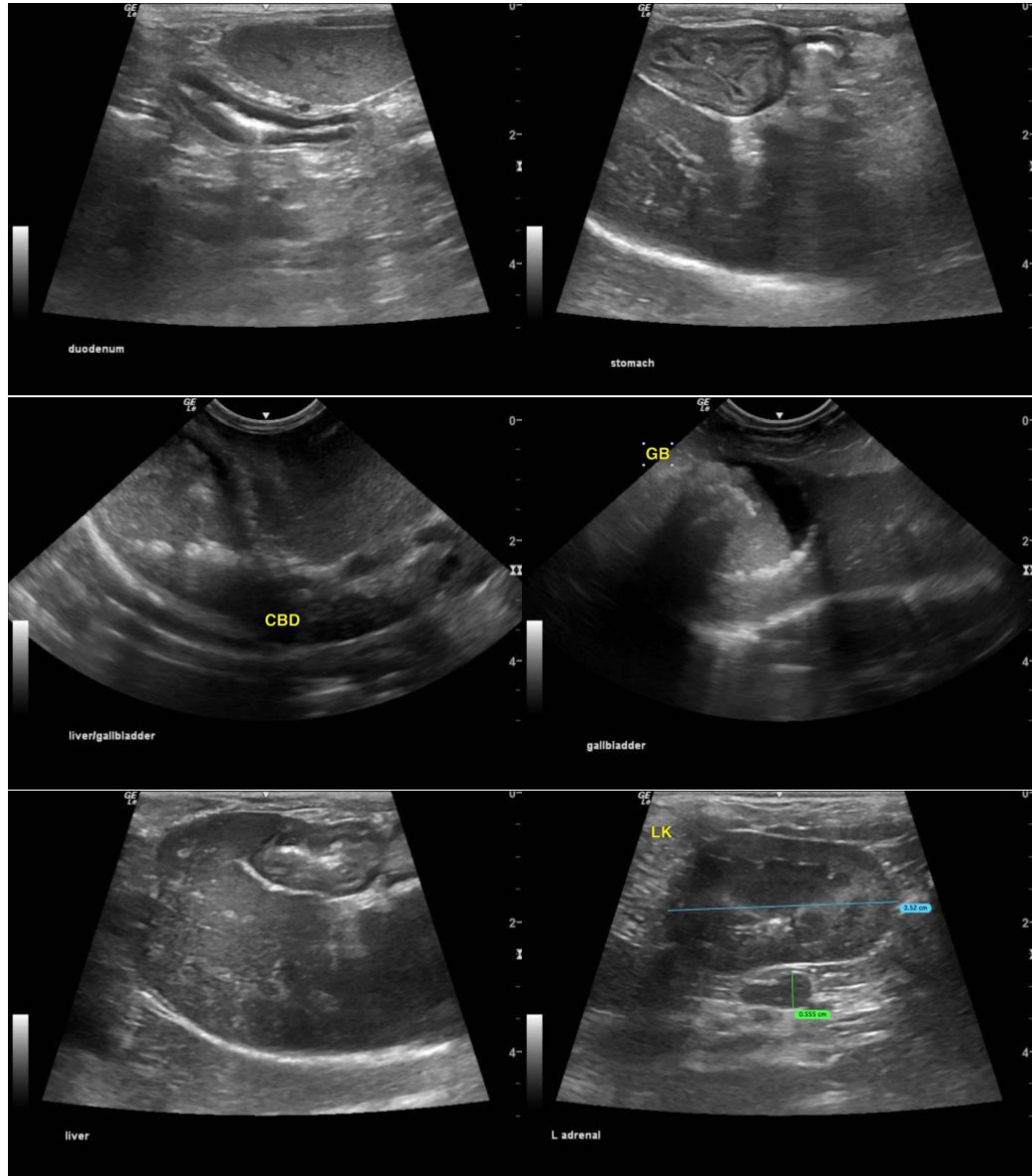
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colorectic property yet, use with caution is recommended with serial clinical and sonographic monitoring.

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Although current clinical signs are not overtly consistent with adrenal disease, adrenal screening could be considered if clinical signs suggestive of Cushing's syndrome arise. Continued gastrointestinal support is recommended.





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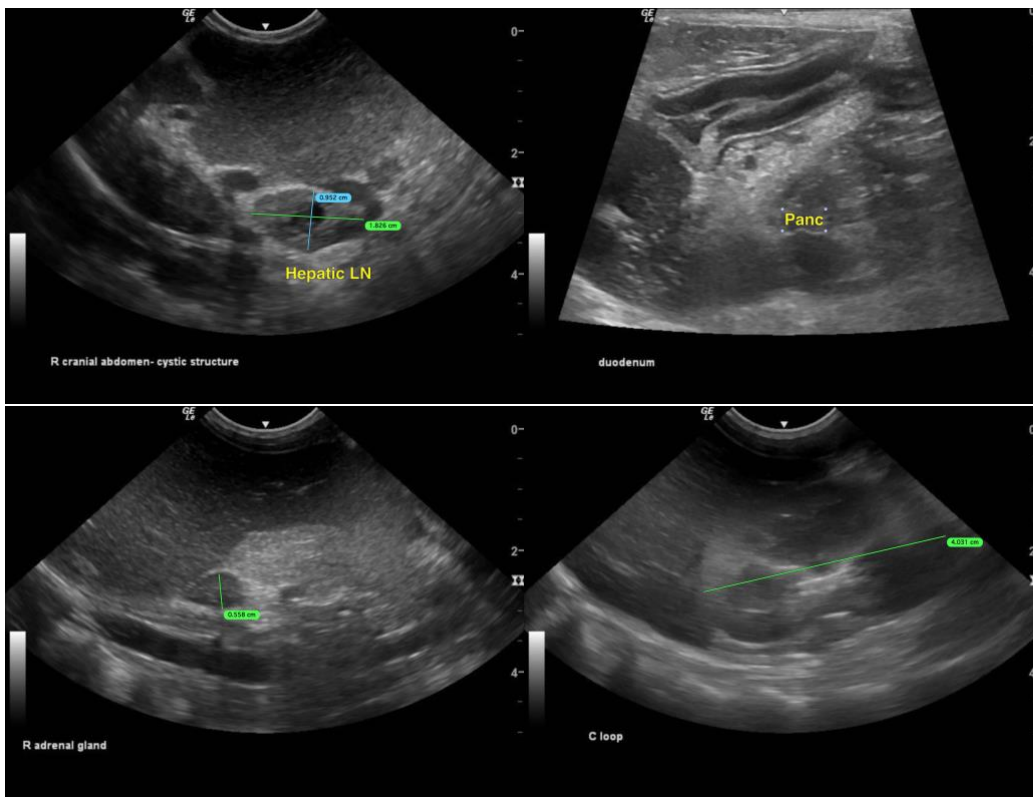
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

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