



## PATIENT

Ellie Lewis

## SPECIES

Canine

## BREED

Boxer

## SEX

FS

## AGE

8 years

## WEIGHT

38.1 kg

## PRESENTING CLINICAL SIGNS

### History:

- Ellie is a senior female dog presenting for evaluation following an acute episode of tenesmus with mucus stool, with improvement after supportive care but notable abnormal lab findings.
- Recent diagnostics revealed hypercalcemia, marked ALP elevation, proteinuria with relatively dilute urine, and a significantly elevated pancreatic lipase (PSL).
- She also has multiple chronic cutaneous and subcutaneous masses, including one larger firm axillary mass, and a prior history of hypercalcemia and liver enzyme elevation.
- Medications / treatments: - DES (for urinary incontinence), - Carprofen PRN, - Fortiflora (initiated), - Interceptor Plus (deworming)
- - Bland diet (chicken and rice)

Abnormal PE/Chem/CBC/UA Results: - BCS ~7/9 (overweight); Abdomen tense (limited palpation) Multiple masses: - Left axilla: 4 cm firm, attached SQ mass (most concerning) - Additional SQ and epidermal masses (likely benign vs lipomas) - No lymphadenopathy Rectal exam: - Mucus present Bloodwork: - Calcium: 12.0 mg/dL (↑) Liver enzymes: - ALP: 707 (markedly ↑) - ALT: 90 (mild ↑) - Precision PSL: 476 (↑) Renal values: - BUN, creatinine, SDMA: within normal limits CBC: - Mild neutrophilia (80%) - Mild lymphopenia - Platelets mildly increased T4: normal Urinalysis: - USG: 1.016 (relatively dilute for dog) - Protein: 2+ - Inactive sediment (no WBC, RBC, bacteria) Fecal: - Negative PCR panel Abdominal radiographs: no significant abnormalities reported

## INTERPRETED BY

R. McKenzie Daniel,  
DVM, DABVP  
(Canine and Feline)

## IMAGING PERFORMED BY

Patti Mayfield, DVM

## HOSPITAL NAME

Ridgeview VC

## REFERRING VET

Sarah Bird, DVM

## INVOICE

10691

## DATE

3/17/26

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 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 changes were noted.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination were 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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.8 cm in length. The right kidney measured 7.2 cm in length.

### *Adrenal Glands*

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.59 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.57 cm width at the caudal pole.



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### *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.

### *Liver/ Gallbladder*

The liver presented subjectively mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. 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. The gallbladder was non-distended in size containing primarily anechoic content with mild, nonorganized gallbladder debris. The cystic and common bile ducts were normal.

### *Gastrointestinal*

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty without evidence of retained ingesta, fluid, or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material.

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

### *Pancreas*

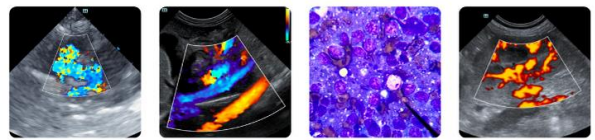
The parenchyma of the right pancreas was mildly hyperechoic to adjacent nonreactive or inflamed omentum with diffuse parenchyma remodeling. Normal size and contour was noted without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

### *Free Abdomen*

No overt lymphadenopathy or peritoneal effusion was present.

## ULTRASONOGRAPHIC FINDINGS

- Sonographically normal gastrointestinal tract / colon
- Suspect mild right limb chronic pancreatitis
- Hepatopathy
- Mild gallbladder debris
- Nonspecific mild chronic renal changes
- Normal adrenal glands
- Sonographically normal urinary bladder and visible proximal urethra



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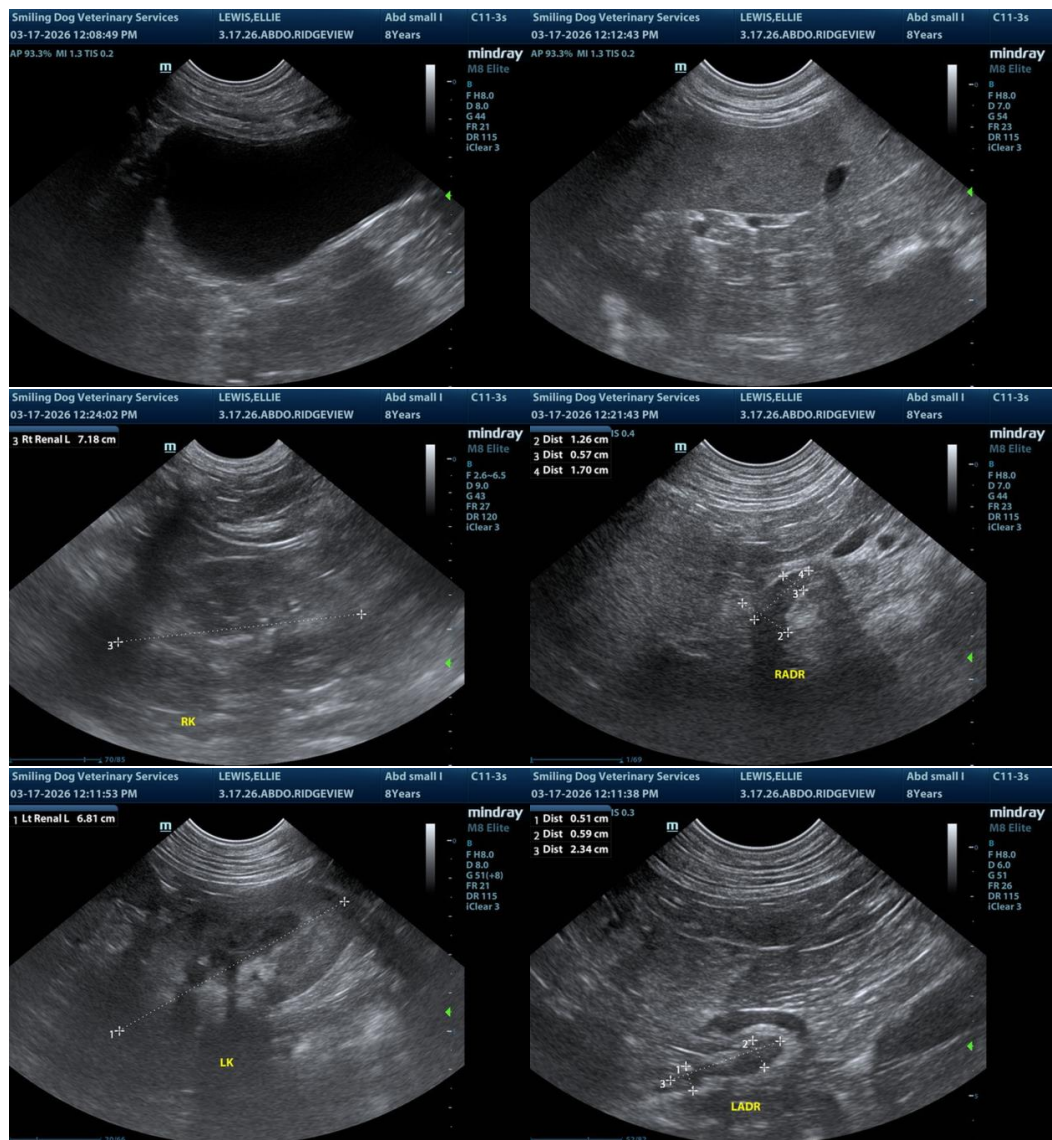
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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt evidence of neoplastic criteria with benign hepatopathy probable. Further assessment may include, assuming normal clotting status and using a 25-gauge needle, screening hepatosplenic FNA cytology, given the hypercalcemia. Correlation with three-view chest radiographs and rectal palpation is recommended. Monitoring of proteinuria with potential empirical therapy for protein-losing nephropathy, if UPC level is persistently >2.0, is recommended. Supportive care for suspect mild chronic pancreatitis is recommended if concurrent gastrointestinal signs are noted. Hepatosupportive medications may prove beneficial.





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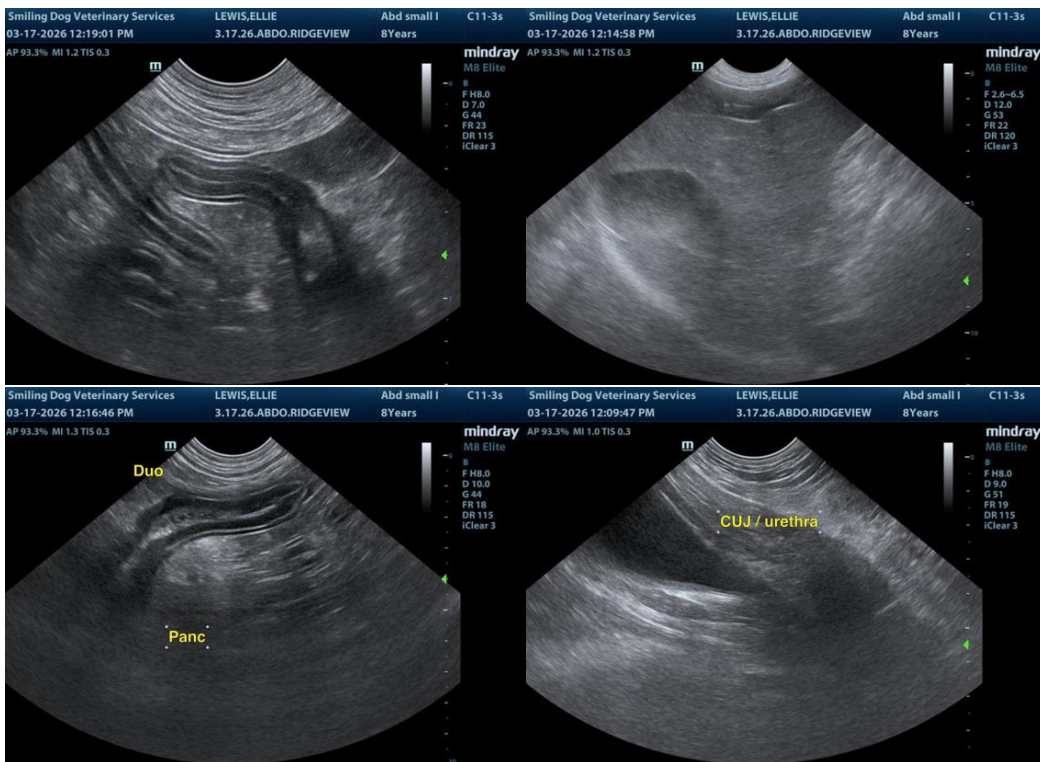
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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