



**PATIENT**

Cozy McDaniels

**SPECIES**

Canine

**BREED**

Pomeranian

**SEX**

FS

**AGE**

14.5 years

**WEIGHT**

12 lbs

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Loetitia Saint-Jacques,  
LVT

**HOSPITAL NAME**

Incline Veterinary  
Hospital

**REFERRING VET**

Dr. Sovyk

**INVOICE**

11598

**DATE**

4/1/2026

**PRESENTING CLINICAL SIGNS**

Problem Assessment: Acute pancreatitis - confirmed via cPL. Acute kidney injury VS CKD Stage 2-3 - r/o secondary to pyelonephritis, toxin, infectious cause - leptospirosis-, underlying chronic kidney disease, others. Spinal pain and hind limb muscle atrophy - r/o intervertebral disc disease, spondylosis, degenerative myelopathy, others. Bilateral medial patellar luxation, Grade 3/4 - r/o congenital condition, secondary osteoarthritis, others. Periodontal dz stage 3: chronic, unmanaged, due to poor home dental care, others. Chronic degenerative valve disease causing trace mitral and mild tricuspid regurgitation. (historical finding 2024) - r/o congestive heart failure, secondary pulmonary hypertension, others. Mildly elevated liver enzymes -ALT, ALP- - r/o secondary to liver injury, pancreatitis, degenerative joint disease, age-related changes, others. Severe peritoneal effusion - r/o neoplastic process, reactive inflammatory process (pancreatitis), hemorrhage, others. Hepatomegaly. Left coxofemoral osteoarthritis. Mild to moderate bilateral stifle osteoarthritis (historical finding.)

Abnormal PE/Chem/CBC/UA Results: Abdominal fluid aspirate transudate appearance RADS - Radiographs: - 3-view thoracic and lumbar spine and abdominal views performed. - Images sent to a board-certified radiologist for interpretation. - In-house review of abdominal films reveals bone fragments in the GI tract. - Bloodwork - Senior Panel - CBC: WNL. Neutrophils are slightly elevated, suggestive of minor inflammation. - Chemistry Panel: - BUN: 100 -H- -was 22 in Oct 2024- - Creatinine: 2.7 -H- -was 0.8 in Oct 2024- - SDMA: 30 -H- -was 11 in Oct 2024- - ALT: Mildly elevated. - ALP: 419 -H- -ref 23-200- - GGT: WNL - Electrolytes: WNL - Glucose: WNL, not diabetic. - Pancreatitis test -cPL-: >1000 -H- -ref 0-200-, confirming pancreatitis.

**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 (3.62 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 (4.01 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 0.49 cm at the cranial pole and 0.5 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 0.42 cm at the cranial pole and 0.55 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.



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**Spleen**

The spleen is subjectively normal in size (1.4 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a subtle small hypoechoic nodule in the parenchyma measuring 0.37 cm.

**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 vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is significantly distended. The gallbladder wall is prominent and hyperechoic measuring at 0.2 cm, with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

**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 (0.56 cm), jejunum (0.32 cm) and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. There is mucosal fogging visualized associated with the small intestine. 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 prominent and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of moderate regional mesenteric inflammation. Consistent with moderate pancreatitis.

**Free Abdomen**

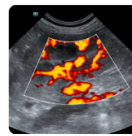
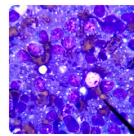
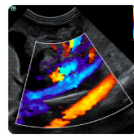
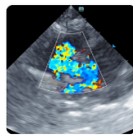
Evaluation of the peritoneal cavity revealed a large volume of mildly echogenic free fluid. There is no significant lymphadenopathy. The omentum is diffusely hyperechoic.

**Other**

There is a soft tissue structure most consistent with a thrombus within the vena cava, visualized at the level of the cranial aspect of the liver/diaphragm.

**ULTRASONOGRAPHIC FINDINGS**

- Bilateral renal changes consistent with age related renal disease.



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- Small, hypoechoic nodule in the spleen. There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Pancreatic changes consistent with chronic pancreatic remodeling and chronic active pancreatitis.
- Large, heterogenous liver. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy.
- Large, gallbladder debris with a slightly prominent/thickened gallbladder wall. A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.
- Diffusely thickened small intestine with some mucosal fogging. The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).
- Large volume of mildly echogenic free abdominal fluid. Recommend fluid analysis and cytology.
- Soft tissue structure within the vena cava-findings are most consistent with a thrombus.
- Ascites-likely secondary to congestion from the caval obstruction.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There's a soft tissue structure visualized in the vena cava at the level of the diaphragm most consistent with a thrombus. This is the likely source of the congestion and ascites observed. This typically occurs secondary to a hypercoagulable state. In this situation, pancreatitis could certainly be a factor causing chronic inflammation, vasculitis, etc. Evaluation for other factors is warranted. If there is any evidence of hypoalbuminemia (protein losing nephropathy, protein losing enteropathy, etc.) this could also be a factor.

Direct treatment of the clot can be challenging. In a venous clot, anticoagulant therapy is typically recommended +/- the antiplatelet therapy. Initially, you could start with antiplatelet therapy (clopidogrel) and consider referral for further evaluation and consultation for therapy. A contrast CT scan may be helpful looking for any unseen small lesions, or other thrombi which could be contributing to the current symptoms. Continued monitoring of the clot could be considered.

The liver is large and heterogenous. Possibly secondary to congestion, or a mild vacuolar hepatopathy. Additionally, the pancreas appears prominent and mottled in the right limb. Likely, consistent with previous episodes of pancreatitis and possible chronic active pancreatitis. There are small intestinal changes consistent with thickening and mucosal fogging. Some of the changes observed can be secondary to the large amount of ascites present. (edema)



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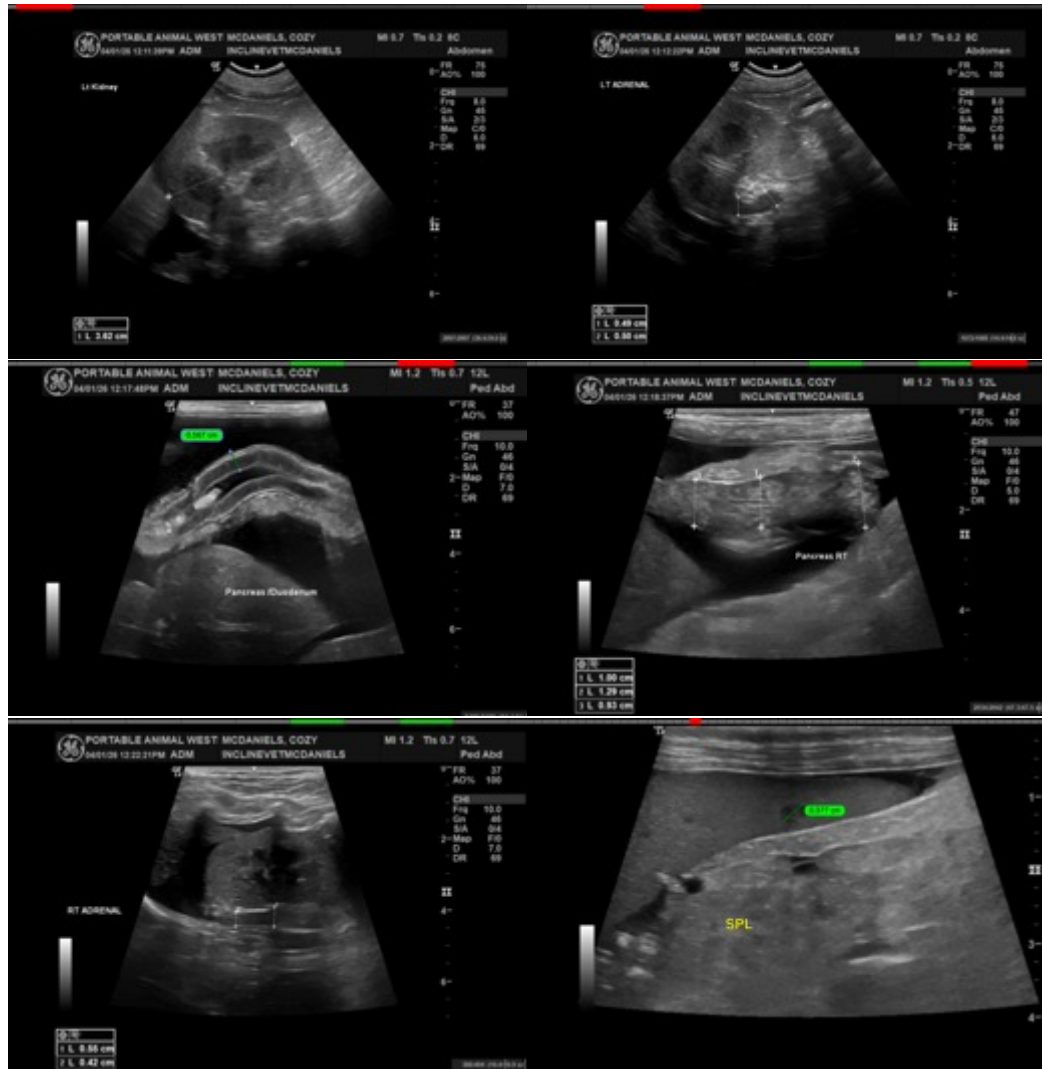
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Based on evaluation of the gall bladder on today's exam, you could consider starting chronic ursodiol therapy. You could consider further workup for concurrent renal disease +/- gastrointestinal disease.

If not already done, recommend three view thoracic radiographs.



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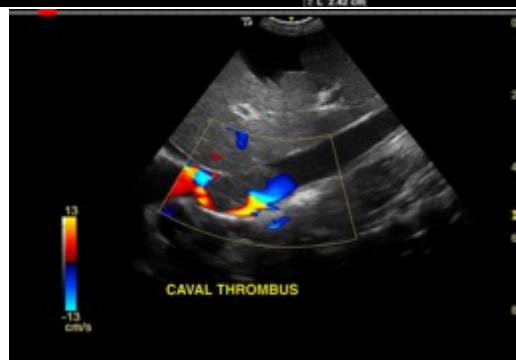
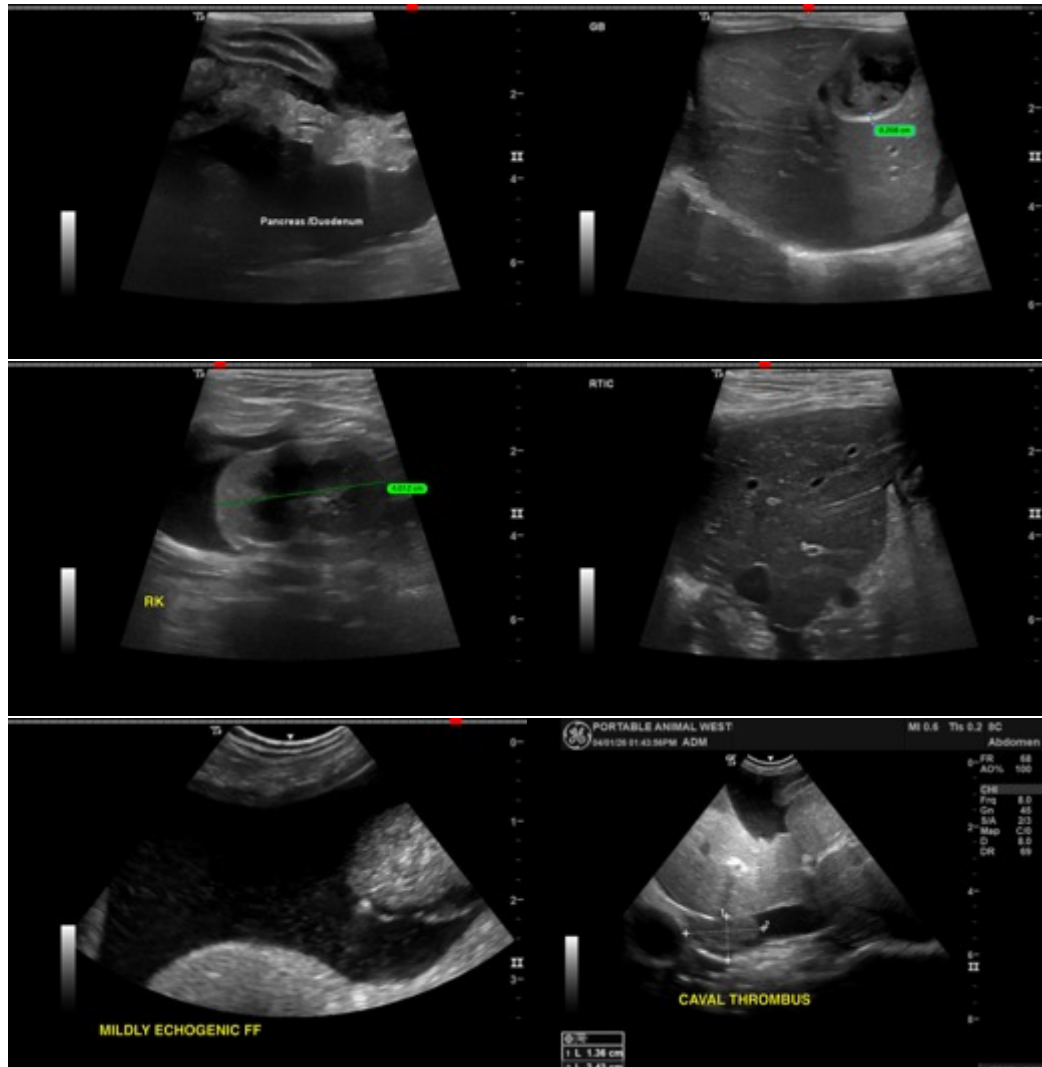
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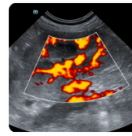
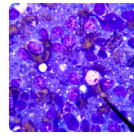
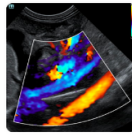
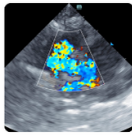


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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