



PATIENT

Sophie Herman

SPECIES

Canine

BREED

Cockapoo

SEX

Spayed Female

AGE

14 Years 11 Months

WEIGHT

6.5 kg

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP

IMAGING PERFORMED BY

Dr. Sookhoo

HOSPITAL NAME

Calusa Veterinary
Center

REFERRING VET

Dr. Nadrea Sookhoo

INVOICE

12210

DATE

11/12/25

PRESENTING CLINICAL SIGNS

SOPHIE presented yesterday for not wanting to eat dog food. O states that this happened after the mass removals procedure with dental. She was told to change from my perfect pet to Dr.Marty. O state that the P wants to eat but however she only is really wanting to eat human food and not her dog food. O also stated that the stool has been changing colors from dark to lighter color, but it is diarrhea. Sophie presents for decreased appetite and bilious vomiting Patient History: - Long-standing history of IBD and GI issues - Frequently switches foods due to food aversion - Previously eating My Perfect Pet low glycemic turkey, recently switched to Dr. Marty's food 2 weeks ago - Currently fed once daily at 3 PM per Dr. Turkell's recommendation - Bilious vomiting this morning (multiple episodes) and yesterday - Only ate a few pieces of freeze-dried chicken treats this morning - Showed interest in human food (turkey, egg whites) but owner avoided giving due to GI sensitivities - Diarrhea last night after eating salmon

Abnormal PE/Chem/CBC/UA Results: Painful on abdominal palpation CPL 886 (elevated)

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. The urinary bladder was nondistended in size. Mild asymmetrical luminal surface to micropolypoid changes were present likely associated with age related mural changes. Anechoic urine was present in the lumen with evidence of masses or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes 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 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 4.2 cm in length. The right kidney measured 4.8 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 0.41 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.38 cm width.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. A small perihilar nondisruptive hyperechoic nodule was present. 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 or neoplastic changes were not noted. The hyperechoic nodule tends to trend benign and is most consistent with benign hyperplasia or myelolipoma.

Liver



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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. 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 with mild nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with mildly thickened to prominent pylorus wall without evidence of obstruction to pyloric outflow and mild retained anechoic pyloric fluid. Pylorus wall measured 0.77 cm wall width.

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. Mild nonobstructive upper to mid duodenal ileus. The duodenum wall measured 0.39 cm width. The jejunum wall measured 0.37 cm width.

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

Pancreas

The pancreas was nonenlarged with indistinct capsule compared to adjacent omentum. Nonhomogenous mildly hyperechoic parenchyma with mildly prominent right limb pancreatic duct. 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

Primary Findings

- Mild chronic pancreatitis pattern with remodeling.
- Mild pyloric gastritis pattern, overall sonographically normal small intestine with mild nonobstructive duodenal ileus.
- Mild benign hepatomegaly.
- Mild gallbladder debris (non-mucocele).

Secondary Findings

- Benign splenic nodule- consistent with myelolipoma.
- Age-related kidneys, normal bilateral adrenal glands.
- Micropolypoid urinary bladder.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Continued gastrointestinal support including dietary trial, as needed gastroprotectants and empirical therapy for mild chronic pancreatitis is recommended. A full GI panel to include PLI, TLI, cobalamin



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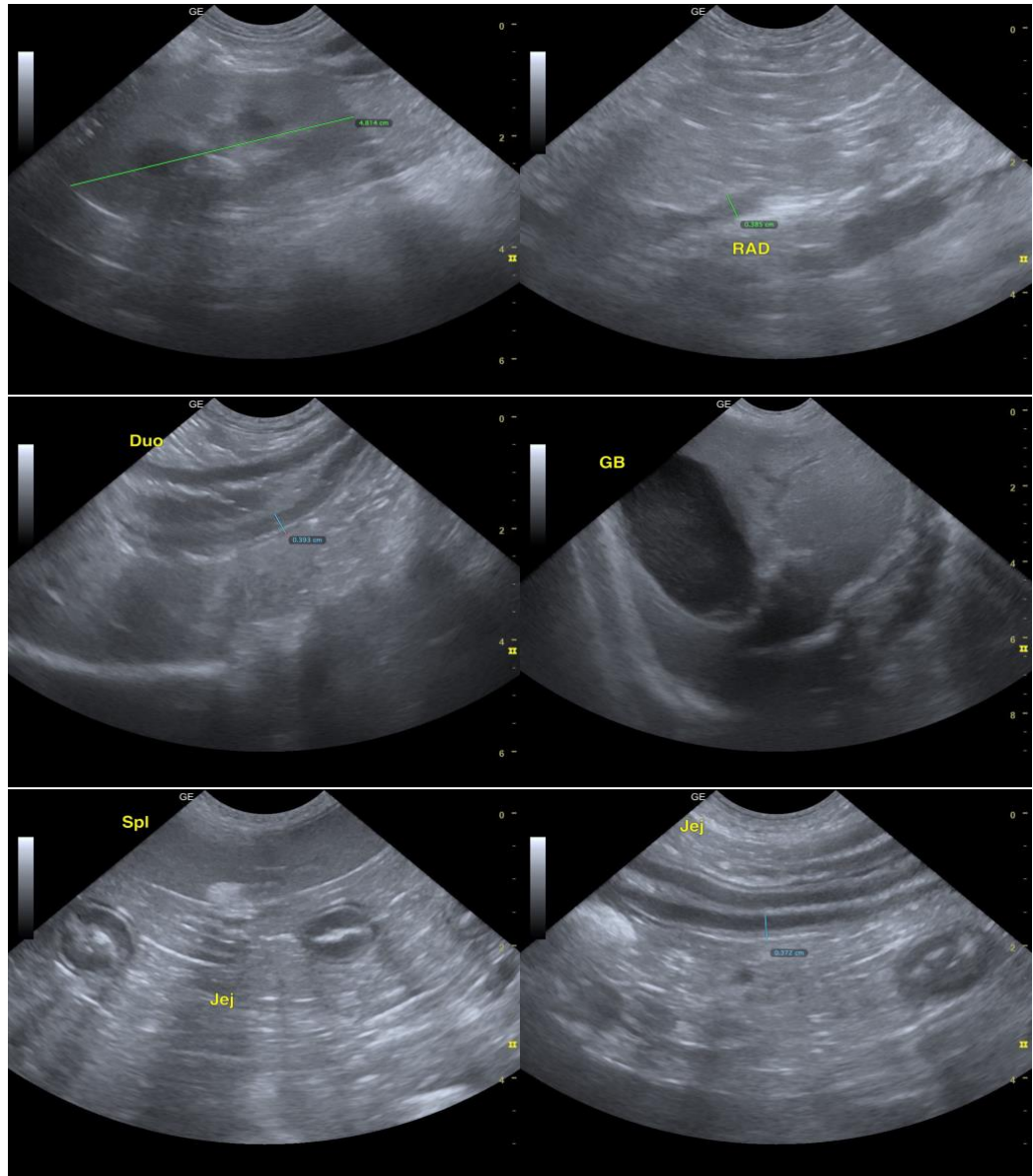
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and folate given patient's history may be considered. No evidence of abdominal neoplastic criteria. Full lab work and urinalysis to correlate with hepatomegaly and chronic renal changes is recommended.





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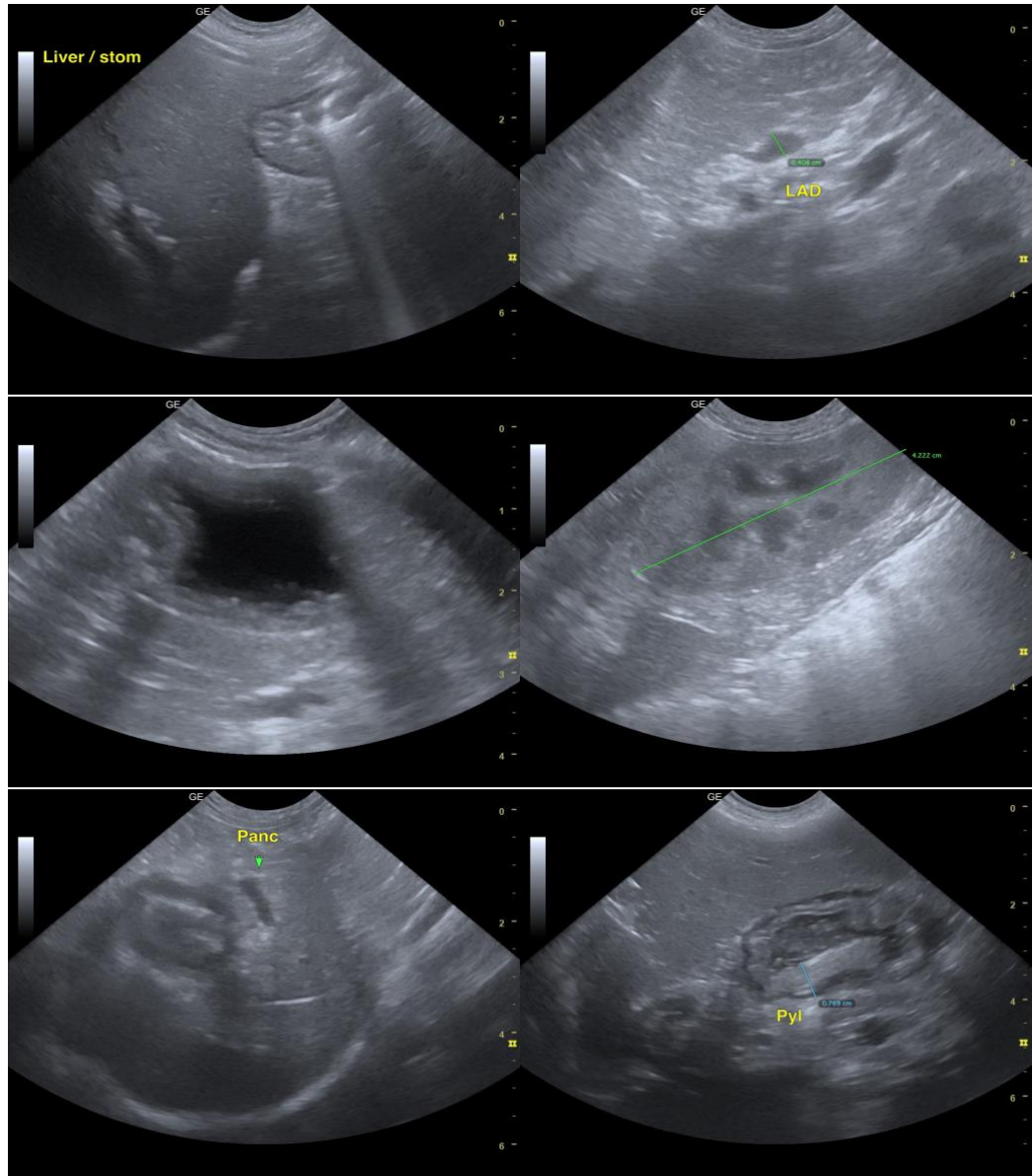
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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