



PATIENT

Remy Engel

SPECIES

Canine

BREED

Terrier Welsh

SEX

Female Spayed

AGE

12 yrs 10 mos

WEIGHT

22.6

INTERPRETED BY

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

IMAGING PERFORMED BY

A Murphy
CVT

HOSPITAL NAME

Wauwatosa Vc

REFERRING VET

Dr. Elaine Binor, DVM

INVOICE

12808

DATE

11/13/25

PRESENTING CLINICAL SIGNS

History: History of anorexia and vomiting. 12 years old spayed female Welsh Terrier presented for vomiting with blood and decreased appetite. 2 days ago, patient became disinterested in food and remained outside longer than usual. Owner found a large pool of bright red mucus, bile-tinged vomit in hallway at 3 am. Patient had one episode of vomiting. No known toxin exposure but has unsupervised outdoor access. Normal urination and defecation prior to visit. Abdominal x-rays and UAS performed due to history of splenic mass (see previous report). Suspect splenic mass has increased in size. Was sent home with Metronidazole and Cerenia. Today was mildly dehydrated, but otherwise BAR. mm - pink, normal CRT. Has cataracts OU. Imaging to check status of spleen and check for other causes of clinical signs.

Meds: Currently on Atopica, Gabapentin, Apoquel and Cyclosporine.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was normal in size and tone with primarily normal wall. Small, potentially sessile based to mineralized mural lesion present in the area of the dorsal trigone measuring 1.0 cm diameter. Small, partially shadowing, dependent lumen urinary bladder calculus not excluded. The visible proximal urethra was normal in structure and tone to a depth of 2.0 cm,

The residual prostate 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. Minor medullary mineral was present. The left kidney measured 5.3 cm in length. The right kidney measured 5.6 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 0.56 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 0.43 cm width at the caudal pole.

Spleen

The spleen was normal in size and contour with mildly expansive, non-homogeneous mid splenic macro nodule to small mass without associated capsule distortion measuring 2.0 cm in diameter.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and parenchymal remodeling. Subtle, indistinct parenchymal nodular changes noted. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild, non-organized, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.



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Gastrointestinal

The visible gastric walls exhibited normal intact wall layering without mural pathology or hypertrophy. The stomach contained mild, focally shadowing ingesta without overt evidence of obstruction to pyloric outflow.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Segmental, mild, non-shadowing ingesta/chyme without obstructive pattern to the level of the colon. Segmental subtle hyperechoic jejunal mucosal speckling noted. Small intestine wall measured 0.30 cm.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Hepatomegaly exhibiting non-homogeneous subtle nodular parenchyma
- Non-organized gallbladder debris (non-mucocele)
- Mildly expansive non-homogeneous splenic macro nodule/small mass
- Structurally unremarkable overall gastrointestinal tract with mild focally shadowing gastric ingesta and possible nonspecific mild enteritis
- Pancreatic remodeling
- Mild chronic renal changes with mild medullary mineral
- Small sessile based lesion area of dorsal trigone, potential associated mineralization

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small dorsal trigone lesion may indicate emerging mass, cystitis or possible adhered to embedded calculus. Correlation with urinalysis and screening BRAF assay is recommended. The splenic macro nodule to small mass appears mildly progressive in size compared to the previous study yet without evidence of splenic capsule distortion, benign vs etiology is possible. Likewise, the liver consistent of chronic hepatopathy may indicate hyperplasia, fibrosis, vacuolar changes, inflammation, non-obstructive cholestasis with hepatic primary or metastatic neoplasia thought less likely. Further assessment may include, assuming normal clotting status, splenic lesion and hepatic parenchyma FNA cytology. Diagnostic and prophylactic splenectomy with hepatic biopsies may be considered. Correlation with most recent meal ingestion is recommended. If reported NPO, 12-hour fast and sonographic reassessment of the stomach to assess for gastric emptying is recommended with concurrent gastrointestinal support. A spec cPL could be considered to assess for chronic pancreatitis.



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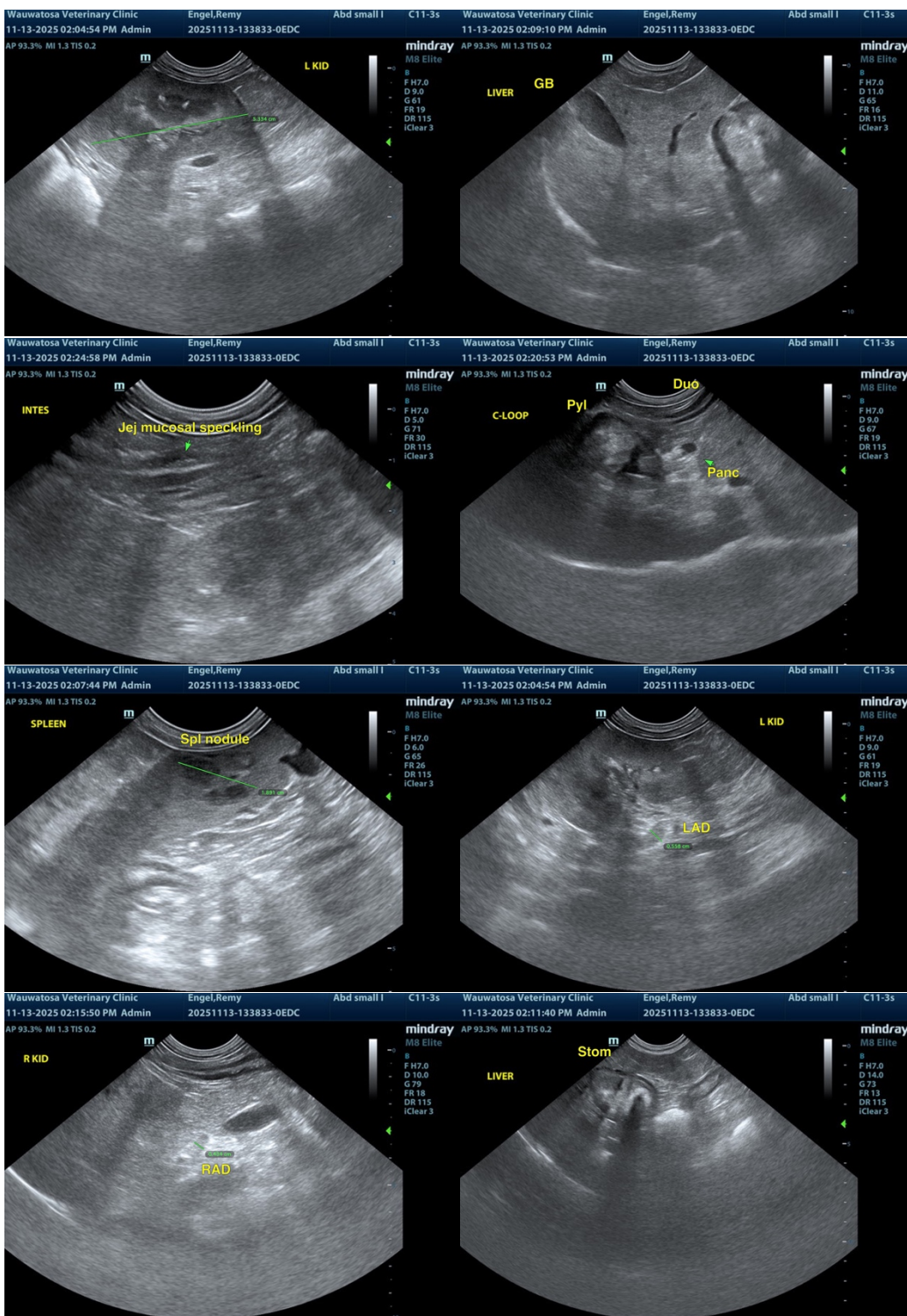
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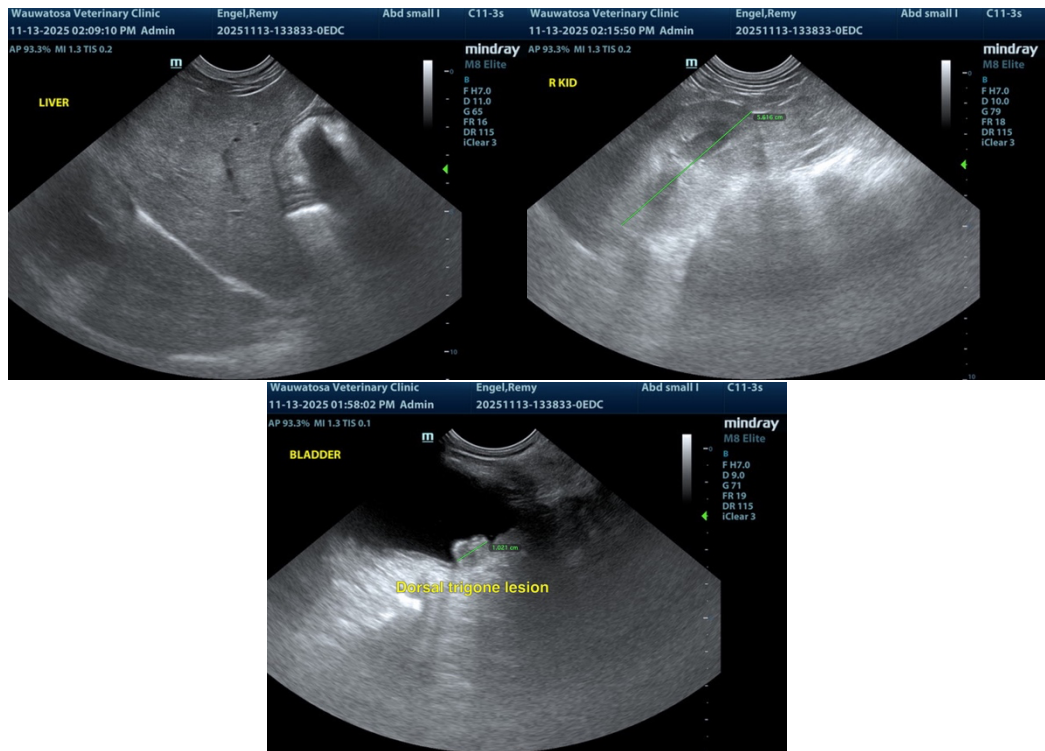
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com