



PATIENT

Layla Werner

SPECIES

Canine

BREED

Corgi Mix

SEX

Female Spayed

AGE

14.5 yrs

WEIGHT

36.8

INTERPRETED BY

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

IMAGING PERFORMED BY

A Murphy, CVT

HOSPITAL NAME

Wauwatosa VC

REFERRING VET

Dr. Mai

INVOICE

12941

DATE

12/12/25

PRESENTING CLINICAL SIGNS

History: presented today due to inability to keep food or water down with substantial vomiting. 7 days ago, the owner noticed she was eating normally but not drinking as much & vomiting once per day or EOD. over the past 7 days it has progressively worsened to daily vomiting and then multiple times per day. last night vomited yellow bile & water (no blood) 4-7 times, she will drink small amounts of water & vomit it back up within minutes. last night she ate about 1/3 of her normal meal (they have been breaking it up into smaller portions) and had a productive bowel movement that was normal.

Meds: she is currently on tramadol for pain, prednisone EOD for IBD, monthly B12 injections

Abnormal PE/Chem/CBC/UA Results: chronic elevated ALT (156) ALP (1865) & GGT (194)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder presented uniformly thickened urinary bladder wall isoechoic to the adjacent normal urinary bladder wall. The luminal margin of the thickened urinary bladder wall was mildly asymmetrical in contour. Urinary bladder wall thickness measured 0.63 cm width. Mineralization or echogenic foci within the thickened areas of urinary bladder wall was not present. The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal 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.

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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Mild pyelectasia and cortical cyst present in the left kidney. The left kidney measured 5.4 cm in length. The right kidney measured 5.3 cm in length.

Adrenal Glands

The left adrenal gland was overtly normal in size, position and shape measuring 0.56 cm width. The right adrenal gland was normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The right adrenal gland measured 0.63 cm width in the caudal pole.

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. Focal to intermittent, discrete, hyperechoic nodules most consistent with benign criteria, i.e. emerging myelolipomas. Concurrent, non-capsule deforming, non-homogeneous nodule measuring 1.6 cm in diameter.



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Liver

The liver exhibited generalized hepatomegaly primarily owing to moderately sized to caudally expanding non-homogeneous liver mass measuring ~9.0 cm in diameter. The gallbladder was distended in size with echogenic thickening of the gallbladder wall. There was biliary sludge that appeared to be non-mobile and organized. A stellate pattern to the organized biliary sludge was present. Evidence of pericholecystic omental inflammation and effusion was present.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The stomach was moderately distended with retained fluid and lumen gas.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Possible upper duodenal gas pocket vs shadowing lumen echo measuring ~1.5 cm in diameter. Mild segmental non-obstructive jejunal ileus.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Mild cystitis pattern
- Liver mass
- Immature gallbladder mucocele
- Non-disruptive splenic nodule with concurrent intermittent small probable myelolipomas
- Nonspecific gastroenteritis pattern exhibiting gastric and segmental intestinal ileus with suspect upper duodenal gas pocket, possible small upper duodenal foreign body thought less likely yet not excluded
- Bilateral chronic

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status and using 25-gauge needle, liver mass and splenic nodule FNA cytology warranted for further clarification. Gastric irritation or displacement secondary to the liver mass is possible. Continued gastrointestinal support if static or improving gastrointestinal signs would be appropriate. Given time frame between ultrasound study and interpretation and if persistent or progressive gastrointestinal signs sonographic reassessment of the gastrointestinal tract specifically upper duodenum for evidence of persistent or resolved duodenal gas pocket vs shadowing echo is recommended.



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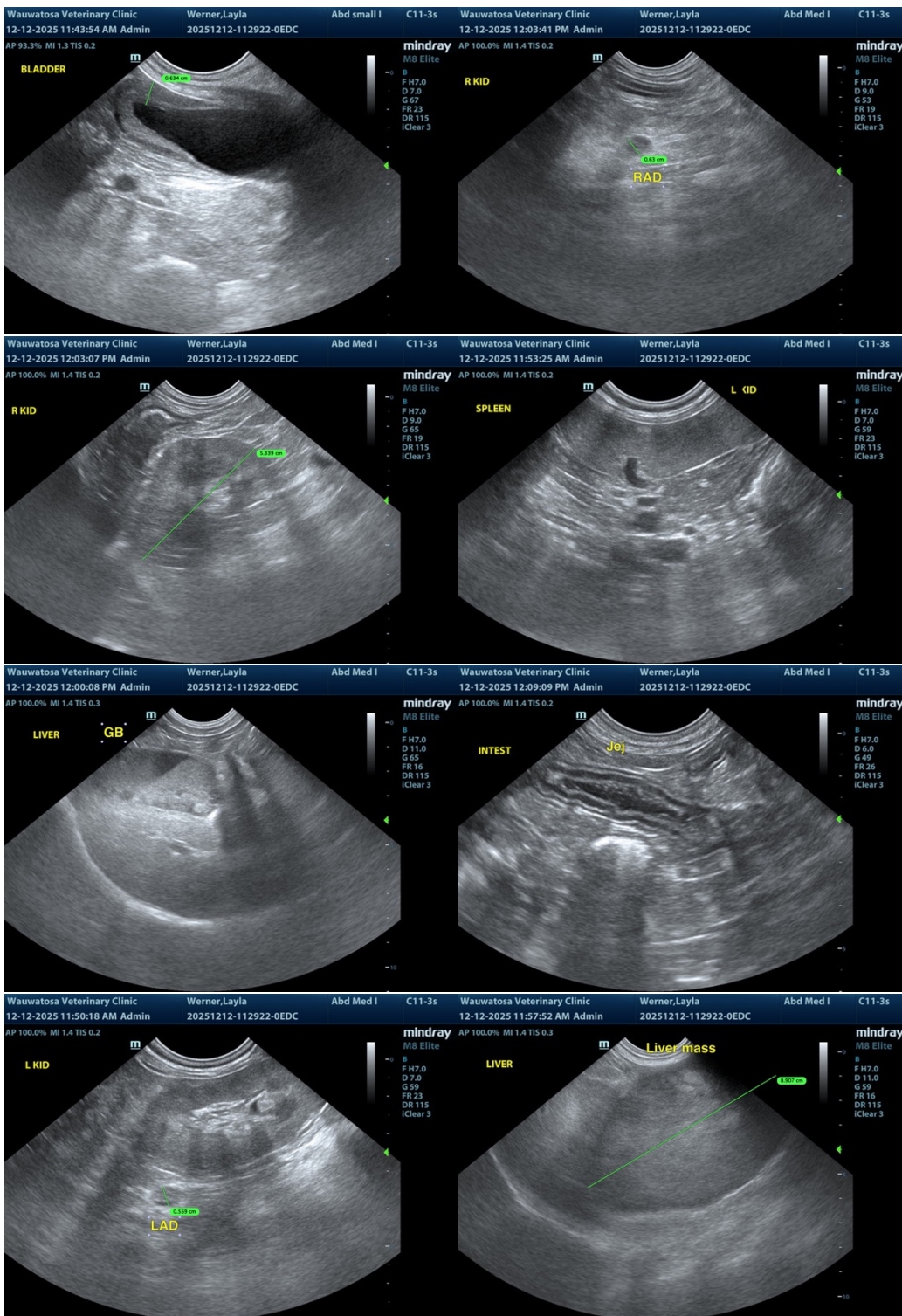
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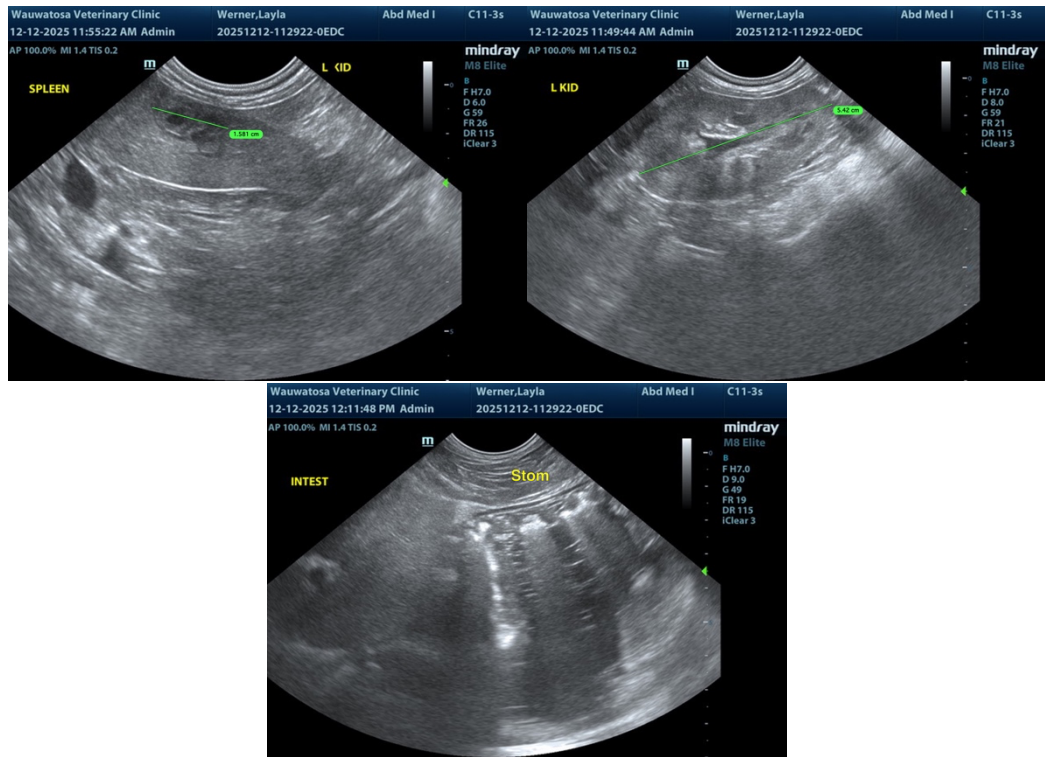
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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