



PATIENT

Daisy Odell

SPECIES

Canine

BREED

Goldendoodle

SEX

Spayed Female

AGE

6 Years

WEIGHT

65 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Jack Reese

HOSPITAL NAME

Willow Run Veterinary
Clinic

REFERRING VET

Dr. Anna Leppien DVM

INVOICE

13616

DATE

02/06/26

PRESENTING CLINICAL SIGNS

- urinary issues started a month ago after o came back from a trip - wasn't acting like herself, having accidents all over the house, decreased appetite
- -- was treated at prev vet for a UTI (amoxicillin x 7 days; now currently on Clavamox and rx diet), wouldn't eat food
- -- appetite continued to worsen, now past 3 days isn't eating at all, ate small morsel of boiled chicken 2 days ago
- V+ bile twice past 2 days
- Seems lethargic at home, will go for walk but energy level is down
- Did eat some chicken last night after getting Entyce

PE: a little quiet, mm pink/moist, no petechia/bruising Rads:mild splenomegaly, no bladder stones
CBC: Neut - 2.82, Lymph - 13.02, Eos - 0.02, PLT - 49 (few clumps on smear) Chem: SDMA - 27, BUN - 30, Creat - 1.5, Ca - 15.5, ALT - 139, ALP - 214, GGT - 24 (CBC/Chem on 1/16 at prev vet: Lymph - 3.88, Neut - 2.86, PLT - 56; normal renal values, Ca - 11.7)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder presented uniformly thickened wall isoechoic to the adjacent normal urinary bladder wall primarily visualized the cranial / apical urinary bladder. The luminal margin of the thickened urinary bladder wall was mildly asymmetrical in contour. 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 3.0 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. No evidence of distal aortic thrombus.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex. Bilateral kidneys revealed mild pinpoint medullary mineral. The left kidney measured 6.4 cm in length. The right kidney measured 6.3 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 0.53 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 0.41 cm width at 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



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noted. A soft tissue echo was present in the splenic hilus vasculature consistent with nonobstructive splenic vein thrombus measuring approximately 1.3 cm.

Liver & Gallbladder

The liver revealed hepatomegaly with mild ventrocaudal lobar swelling and maintained generalized homogenous parenchyma echogenicity exhibiting mild 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 thin walls and primarily anechoic luminal content. 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 with no signs of ileus, obstruction 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 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

Mid abdomen mesenteric root lymph nodes were present. The lymph nodes presented mildly enlarged with symmetrical contour and homogenous parenchyma and maintaining a normal width: length ratio (<0.5). An example of the lymph nodes measured 3.1 cm x 0.82 cm.

ULTRASONOGRAPHIC FINDINGS

- Nonspecific hepatopathy with mild ventrocaudal lobar swelling and maintained homogenous parenchyma.
- Nonenlarged noncongested spleen with small splenic vein thrombus.
- Sonographically normal gastrointestinal tract.
- Bilateral focal to mild renal medullary mineral.
- Mild cystitis pattern.
- Focal to intermittent mild mesenteric lymphadenopathy- suggestive of reactive hyperplasia or possible lymphadenitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Correlation with urinalysis with renal staging to include screening culture/sensitivity and UPC level is recommended. Extensive coagulation profile is suggested given splenic vein thrombus.



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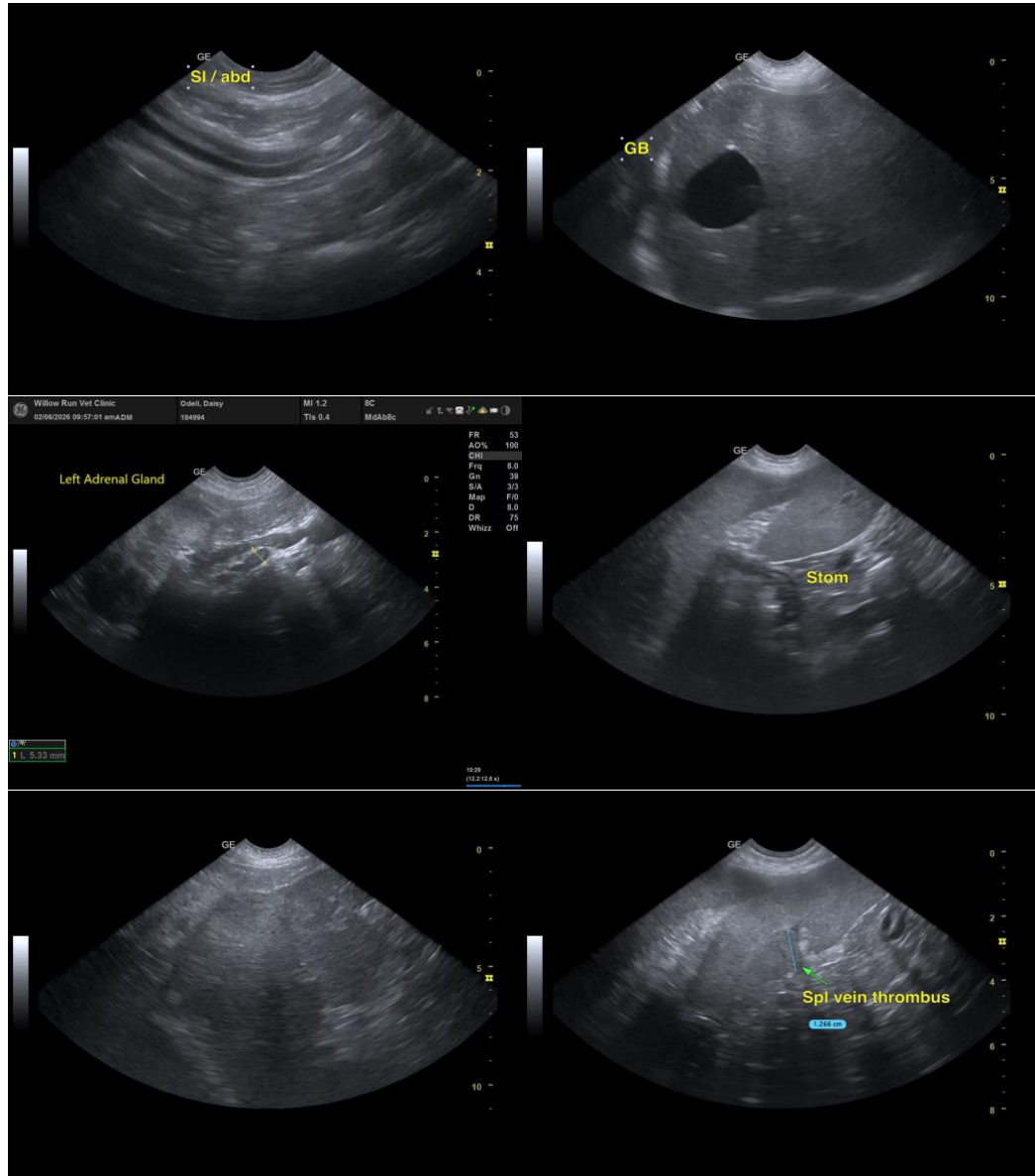
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If normal clotting status and adequate platelet count, hepatic +/- splenic FNA cytology using a 25-gauge needle is recommended to assess for occult disease. CBC pathology review +/- infectious disease serology is suggested.

A GI panel to include PLI/TLI/Cobalamin/Folate and cortisol level are recommended. Pending additional diagnostics, gastrointestinal support with sonographic monitoring of the splenic thrombus and lymph nodes for evidence of progression is recommended.





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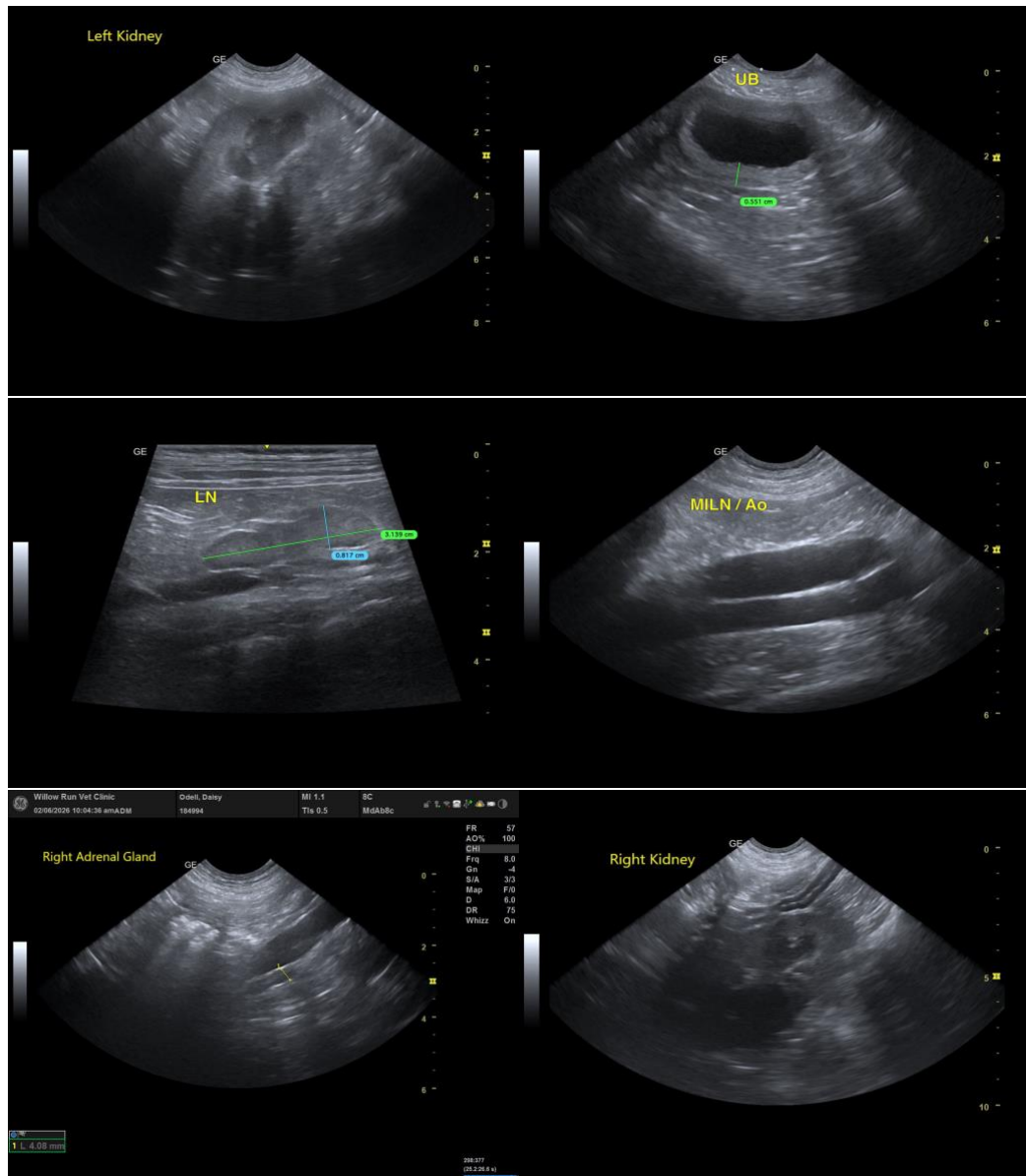
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com