

## PATIENT

Emma Mittler

## SPECIES

Canine

## BREED

Min Pin

## SEX

Spayed Female

## AGE

04/16/12

## WEIGHT

4.8 kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Loetitia Saint-Jacques,  
LVT

## HOSPITAL NAME

Incline Veterinary  
Hospital

## REFERRING VET

Dr. Sovyk

## INVOICE

16415

## DATE

05/22/26

## PRESENTING CLINICAL SIGNS

Recent GI upset on Monday with diarrhea; resolved by Tuesday. Currently on prescribed GI diet (biome); fully transitioned. Recent move (less than a week ago). Increased water consumption since move. History of kidney stone requiring surgical removal during knee surgery (couple years ago). Previous episodes of anorexia associated with kidney stones and nausea. Takes PetTabs vitamins daily. Ate dinner normally yesterday. Stool softer last night but normal this morning. No vomiting. No access to toxins, trash, or unsupervised outdoor time. Previously ate grass regularly; stopped ~1 week ago (no grass at new location). History of anxiety/agoraphobia (improved ~3 years ago) Working diagnosis. Acute gastroenteritis -resolved on a diet. Grade 2/6 systolic heart murmur - r/o mitral valve disease (age-appropriate degenerative change), physiological, others. - Acute anorexia (resolved with antiemetic) - r/o nausea secondary to mild pancreatitis, dietary indiscretion, stress from recent move, neoplasia, IBD, others - Mildly elevated CPL (266, reference 0-200) - r/o early/mild pancreatitis, dietary indiscretion, others. BP 116/74, 128/85, 153/102

Abnormal PE/Chem/CBC/UA Results: Heart murmur 2/6 MPV 8.1 8.7 - 13.2 fL LOW PDW 6.9 9.1 - 19.4 fL LOW QPL 266 0 - 200 U/L HIGH REPEATED CPL THIS MORNING 191

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and 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. No evidence of inflammatory or neoplastic change were noted.

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. Mild bilateral pyelectasia was present with right kidney cortical cyst. The left kidney measured 4.5 cm in length. The right kidney measured 4.3 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 0.49 cm width at the caudal pole.

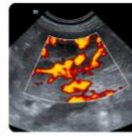
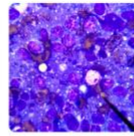
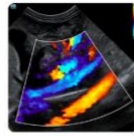
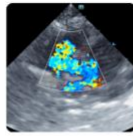
The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.5 cm width at the caudal pole.

### 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 noted.

### Liver & Gallbladder

The liver presented 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



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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. Intermittent discrete hypoechoic intraparenchymal nodules were present with an example measuring 0.7 cm in diameter.

The gallbladder was non distended in size with minor nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

**Gastrointestinal**

The stomach presented intact borderline prominent wall layering most notable in the pylorus and empty gastric lumen with mild lumen gas. No evidence of obstruction to pyloric outflow. The pylorus wall measured 0.55 cm wall width.

The small intestine presented with intact mildly prominent wall layering given the patient's body weight. Normal to minor altered wall layer ratio owing to propensity for minor prominent muscularis and submucosa intestine layers. The duodenum wall measured 0.44 cm wall width. The jejunum wall measured 0.42 cm wall width.

Normal visible colon wall layers were present with formed to semi formed fecal matter.

**Pancreas**

The pancreas presented normal in size and contour with mild non-homogenous hyperechoic pancreatic parenchyma compared to adjacent non-reactive omentum. without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

**Free Abdomen**

Intermittent normal to mildly prominent medial iliac and mesenteric nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). No evidence of overt or significant peritoneal effusion.

**ULTRASONOGRAPHIC FINDINGS**

- Gastroenterocolonopathy- potentially resolving.
- Mild chronic pancreatitis/fibrosis.
- Hepatomegaly with discrete hypoechoic intraparenchymal nodules- suggestive of benign criteria, i.e. vacuolar hepatopathy, cholestasis, inflammation, subtle hyperplasia, fibrosis, or hematopoiesis.
- Chronic renal changes with pyelectasia and right kidney cortical cyst.
- Normal adrenal glands.
- Intermittent, mild mesenteric/medial iliac lymphadenopathy- subjective benign.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Chronic pancreatitis may be suspected if cranial abdomen/subxiphoid discomfort on palpation in conjunction with elevated pancreatic lipase. Dietary indiscretion, inflammatory bowel, infectious disease, enterotoxin in conjunction with chronic pancreatitis, occult parasitism, less likely occult Addison's disease or emerging neoplasia are all potentials.



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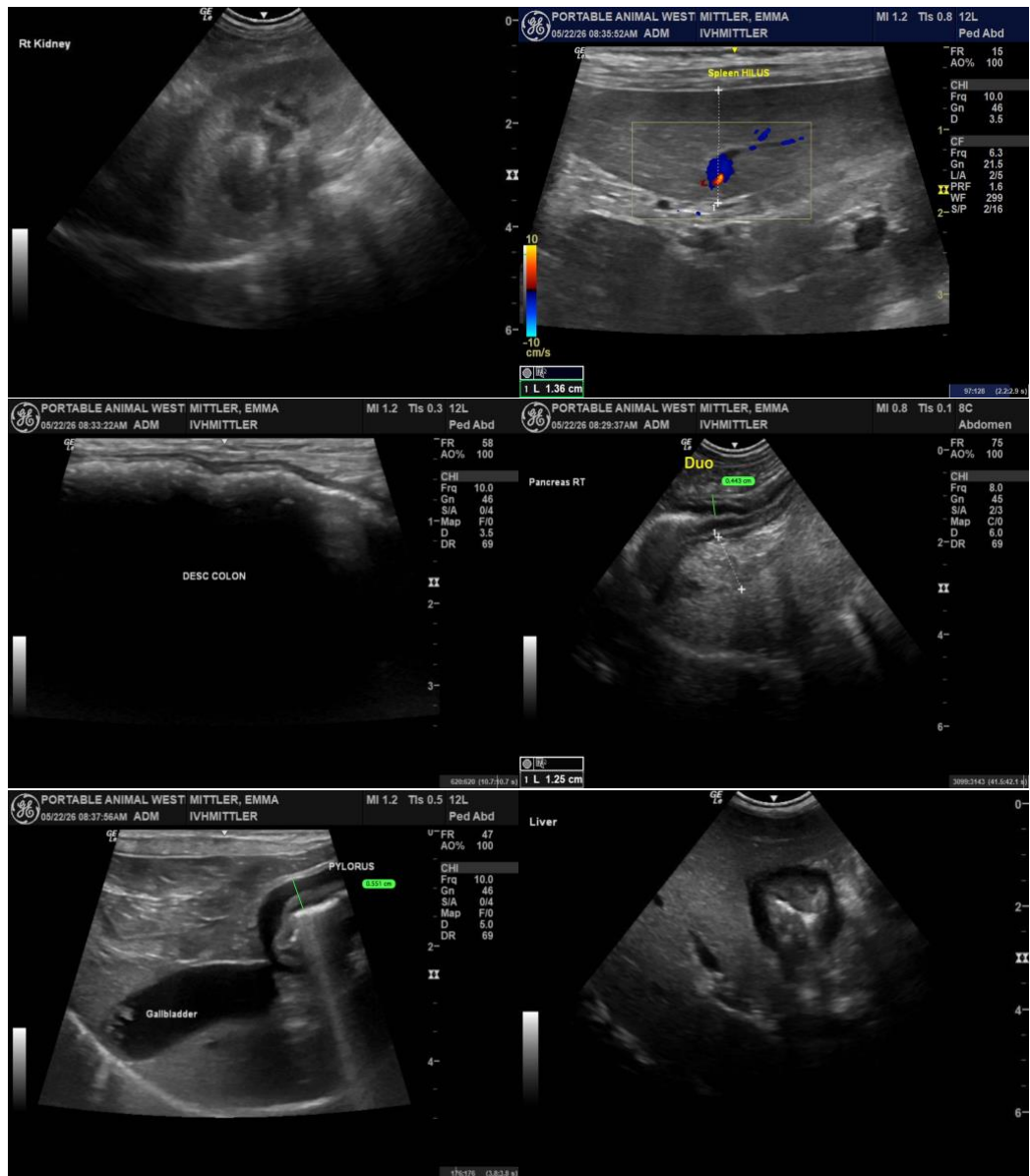
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A GI panel to include PLI/TLI/Cobalamin/Folate, fresh fecal analysis to assess for parasitic ova / Giardia and cortisol level are recommended. Empirically, a limited antigen or hydrolyzed diet trial with potential long term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Proviale or Visbiome), and as needed gastroprotectants is suggested with clinical monitoring. Note that recent research has shown that indiscriminate use of antibiotics may actually cause harm.

Correlation with urinary workup including urinalysis, culture/sensitivity +/- UPC level, if non-inflammatory proteinuria, given bilateral pyelectasia is recommended.





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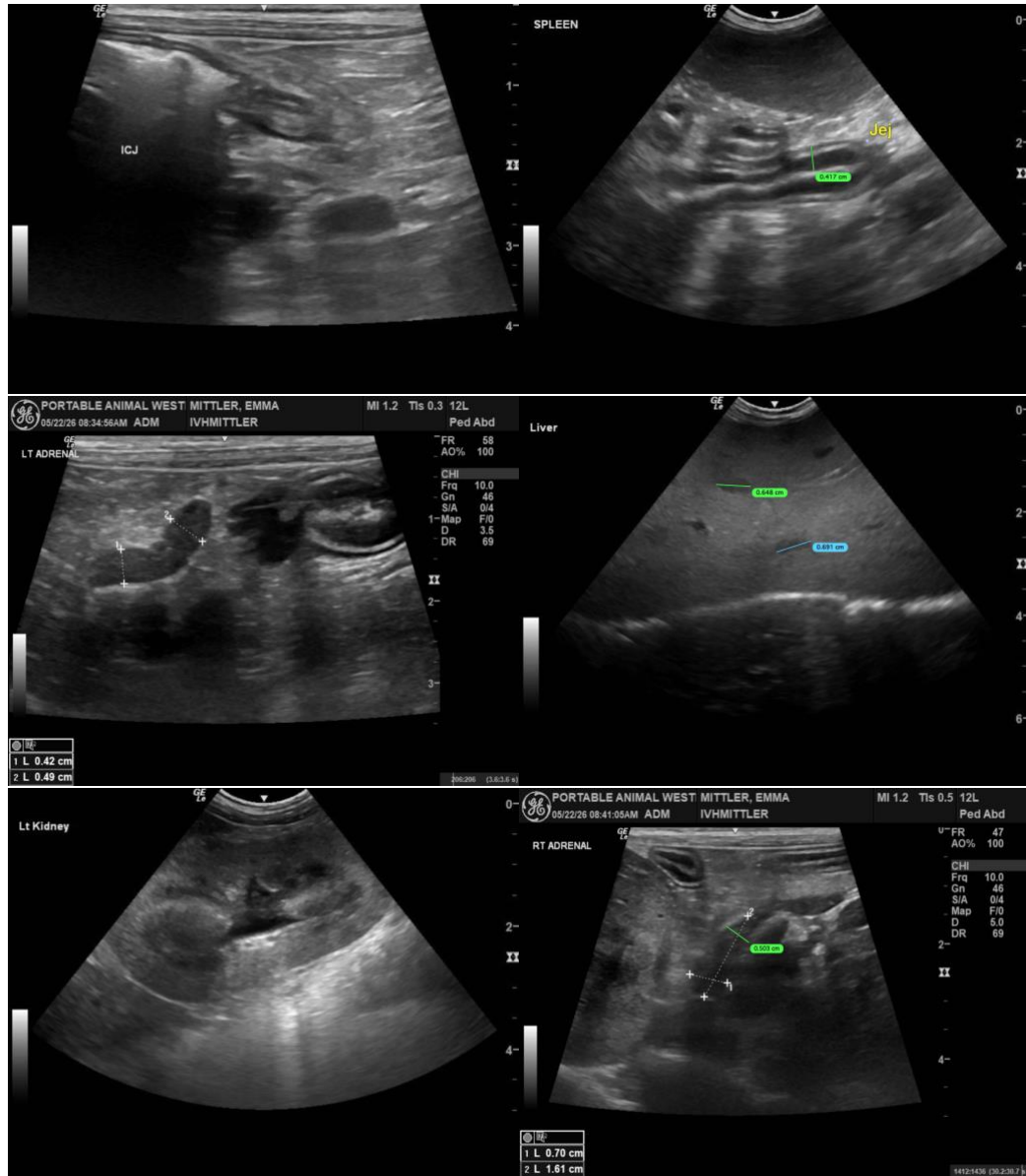
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)