



## PATIENT

Delilah Millard

## SPECIES

Canine

## BREED

Terrier Mix

## SEX

SF

## AGE

15 years

## WEIGHT

7.12 kgs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Renee Trionfetti,  
VMD

## HOSPITAL NAME

Blue Pearl  
Wyomissing

## REFERRING VET

Blue Pearl  
Wyomissing, ER

## INVOICE

10916

## DATE

5/27/26

## PRESENTING CLINICAL SIGNS

AUS to further evaluate vomiting/lethargy. A week ago diagnosed w/ bronchitis and enteritis. Responded to doxy and Metro. Last 24 hours started vomiting. Currently hospitalized in ER. BW shows abnormal cPL, mild leukocytosis with a neutrophilia, azotemia (r/o pre-renal vs renal), hyperphosphatemia, hyperglobulinemia, hyperglycemia, elevated LES (ALT/ALP) elevated GGT, hypokalemia, hypochloridemia.

Hosp tx: Cerenia, buprenorphine, IVF w/ KCl

Abnormal PE/Chem/CBC/UA Results: - Rads: Possible mild heart enlargement, no evidence of failure. Bronchial pattern - age vs bronchitis (rads are from a week ago) - PCV/TS: 43/9.4 - CPL: abnormal/positive - CBC: WBC 18.49 H (4.00 - 16.53 103/uL), NEU 17.58 H (2.88 - 11.72 103/uL), LYM 0.28 L (0.83 - 4.91 103/uL) - Chem - BUN > 140.0 H (9.0 - 29.0 mg/dl), Creatinine 4.6 H (0.4 - 1.4 mg/dl), Phosphorus > 15.0 H (1.9 - 5.0 mg/dl), Total Protein 7.9 H (5.5 - 7.6 g/dl), Albumin 3.7 (2.5 - 4.0 g/dl), Globulin 4.2 H (2.0 - 3.6 g/dl), Glucose 208 H (75 - 125 mg/dl), Cholesterol 361 H (120 - 310 mg/dl), ALT 280 H (0 - 120 U/l), ALP 265 H (0 - 140 U/l), GGT 15 H (0 - 14 U/l), Potassium 2.8 L (3.8 - 5.3 mEq/l), Chloride 94 L (102 - 120 mEq/l) Lepto/UA/4DX pending

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, and cystourethral junction exhibited normal thickness and tone. Mildly thickened visible proximal urethra was noted without evidence of urine retention or mural mineralization to a depth of 3.0 cm. The proximal urethral measured approximately 1.0 cm width. Primarily anechoic urine was present in the lumen. Nondependent, particulate, mild sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination were 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 bilateral was present. Mild medullary mineral to small renoliths were present. The left kidney measured 3.7 cm in length. The right kidney measured 3.8 cm in length.

### Adrenal Glands

The bilateral adrenal glands exhibited mild asymmetrical enlargement. Mild parenchyma heterogeneity and mild capsule asymmetry were present without suspicion for overt neoplasia. The left adrenal gland measured 2.5 cm length x 0.82 cm width in the caudal pole. The right adrenal gland measured 1.7 cm length x 0.72 cm width in the caudal pole.

### Spleen

The spleen was normal in size with primarily symmetrical contour and mild nonhomogeneous splenic parenchyma. A solitary, mild capsule deforming, hypoechoic, nonhomogeneous cranial medial splenic nodule was present, measuring 0.47 cm in diameter.



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## *Liver/ Gallbladder*

The liver presented generalized non-congested hepatomegaly with subjective normal contour. The liver parenchyma was nonuniform and hypoechoic to the spleen with a mild coarse echotexture and subjective mild parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. A discreet nonhomogeneous hyperechoic intraparenchymal nodule was noted in the ventral mid-liver, measuring 1.2 cm in diameter. The gallbladder was non-distended in size, containing primarily anechoic content with moderate, nondependent, variably congealed yet nonorganized gallbladder debris. The common bile duct was not definitively visualized.

## *Gastrointestinal*

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty without evidence of retained ingesta, fluid, 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. Segmental mild hyperechoic duodenojejunal mucosal speckling was noted.

Normal visible colon wall layers were present with soft fecal matter in lumen.

## *Pancreas*

The left and right pancreas were prominent in size with indistinct to asymmetrical capsule contour and heterogeneous, slightly hypoechoic parenchyma compared to adjacent non-reactive or inflamed omentum.

## *Free Abdomen*

No overt lymphadenopathy or peritoneal effusion was present.

## *Heart*

Rapid view of the heart revealed no evidence of pericardial masses or effusion in the visible window. Subjective normal left and right cardiac chamber dimension and adequate LV systolic function were noted.

## ULTRASONOGRAPHIC FINDINGS

- Chronic / chronic active pancreatitis pattern with remodeling
- Nonspecific gastroenterocolitis pattern exhibiting mild intestinal mucosal speckling and soft fecal matter in colon
- Enlarged nonhomogeneous liver with discreet intraparenchymal nodule
- Nonorganized gallbladder debris – not consistent with mature mucocele
- Mildly expansive splenic nodule
- Chronic renal changes exhibiting medullary mineral / small renoliths and mild pyelectasia
- Bilateral nonhomogeneous adrenomegaly
- Mild urine sediment with subjective mildly thickened proximal urethra
- Subjective normal cardiac structure / function



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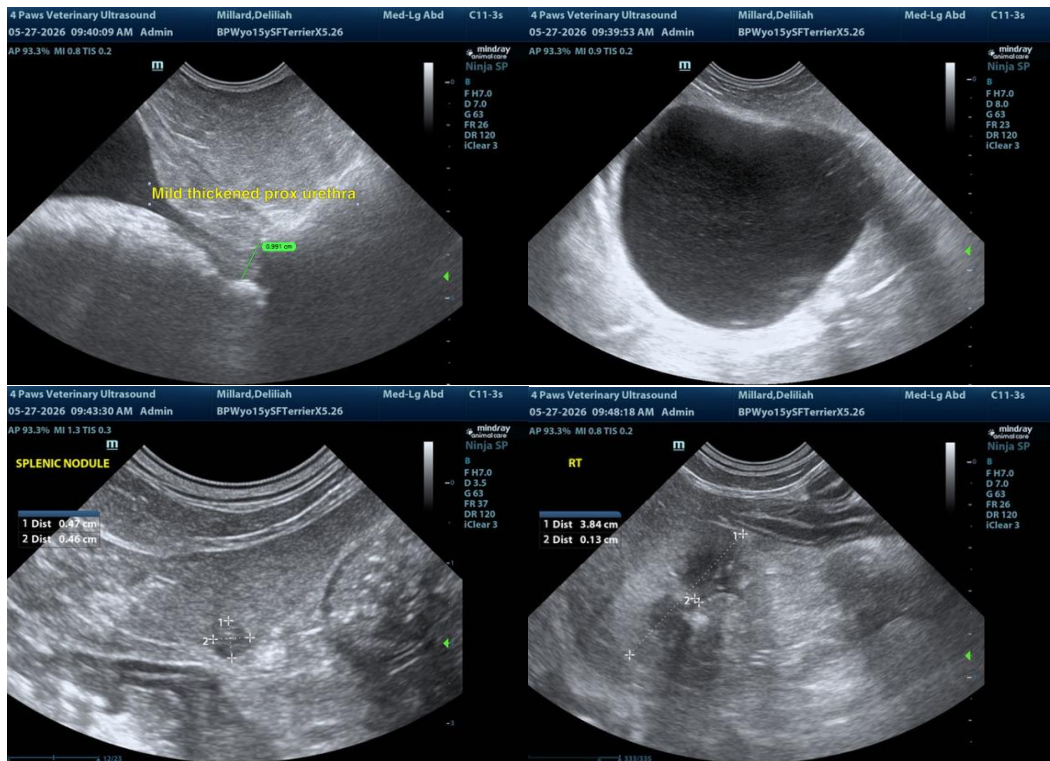
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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Continued gastrointestinal support and empirical therapy for nonspecific gastroenterocolitis and chronic / chronic active pancreatitis are indicated. Overall, the hepatopathy and discreet liver nodule are suggestive of likely benign criteria, i.e., metabolic, vacuolar, cholestatic, inflammatory hepatopathy or combination with suspect discreet nodular hyperplasia, lipogranuloma, with emerging to low-grade hepatic neoplasia thought less likely.

Potential etiologies for the splenic nodules may include benign processes such as nodular hyperplasia, extramedullary hematopoiesis, hematoma, infection, infarction, or neoplasia. Ultrasound-guided FNA of the liver and splenic nodule using 25-gauge needle and assuming normal coagulation parameters may be considered. Otherwise, hepatosupportive medications with sonographic monitoring of the liver and spleen for any changes in appearance, with initial recheck in 4 weeks, would be a more conservative approach. Adrenal workup is indicated if clinical signs consistent with Cushing's Syndrome are present.

The subjective mildly thickened proximal urethra may be an incidental and age-related variant. Monitoring for evidence of stranguria with sonographic monitoring if clinically indicated is recommended.





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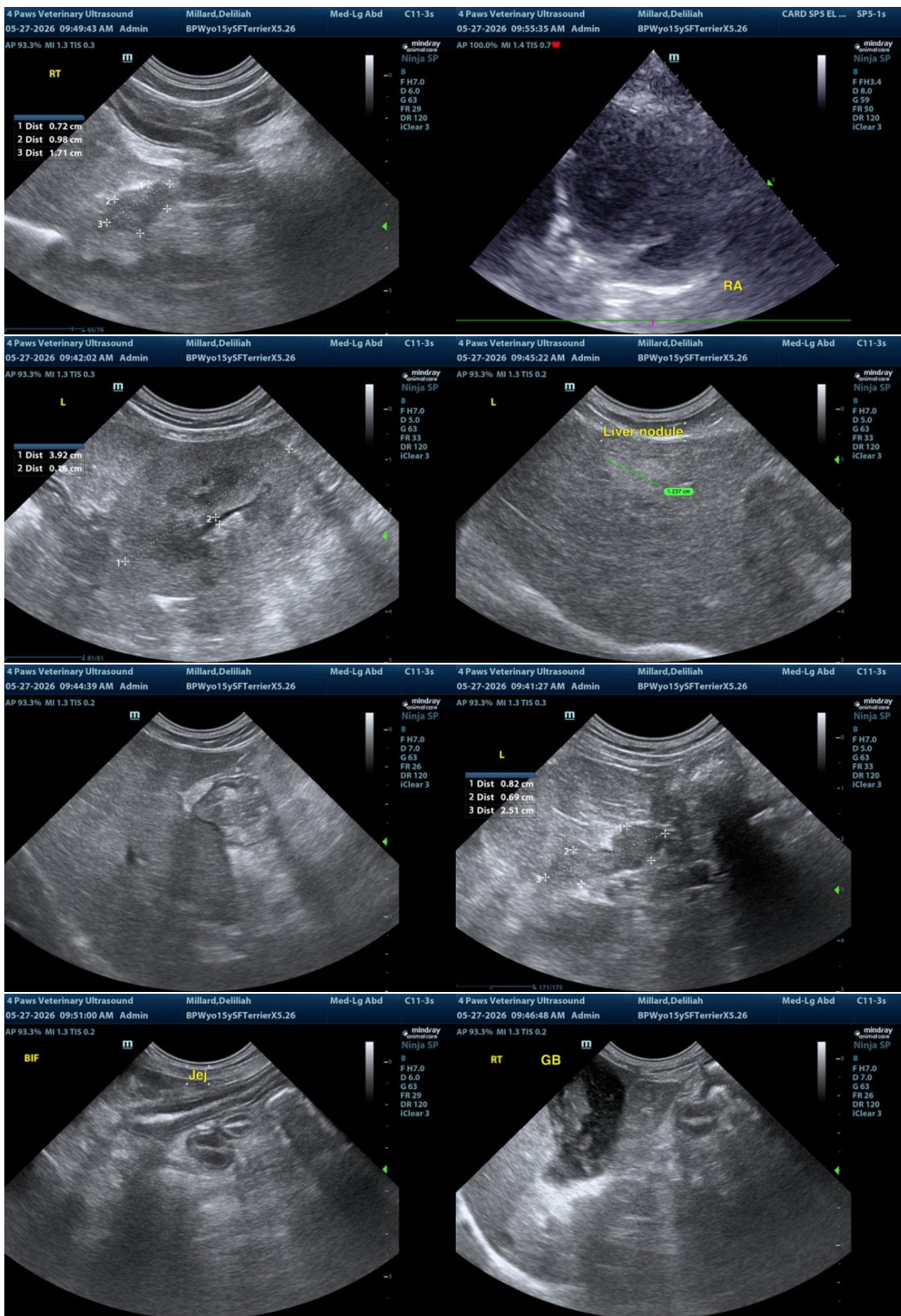
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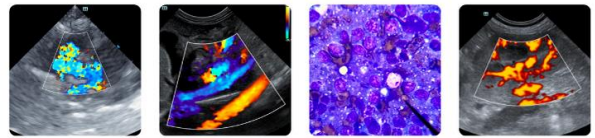
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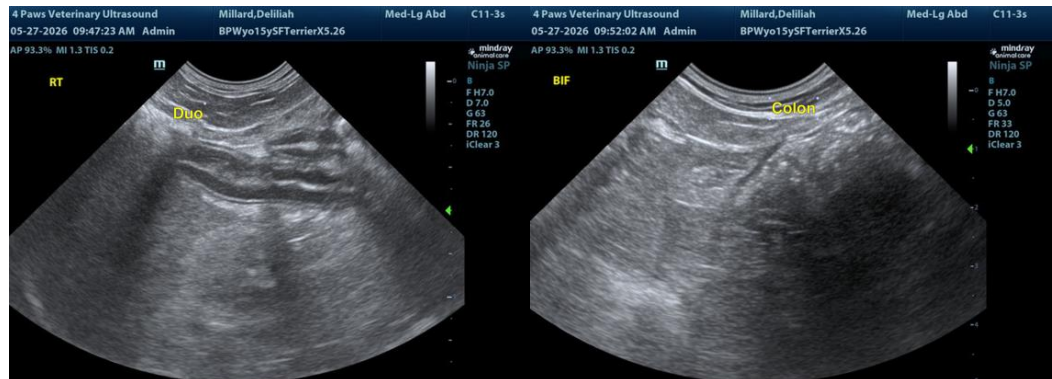
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)  
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