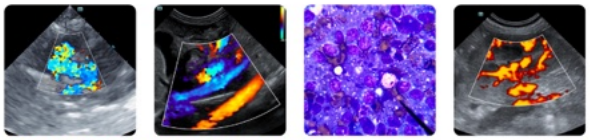


PATIENT

Maxie Cory

SPECIES

Canine

BREED

Wirehaired Terrier/Dachshund Mix

SEX

Spayed female

AGE

15 years

WEIGHT

8.7 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Ertunc

HOSPITAL NAME

Humboldt Veterinary Medical Group

REFERRING VET

Dr. Ertunc

INVOICE

68751

DATE

11/17/25

PRESENTING CLINICAL SIGNS

History: Presented 11/11 due to weight loss and PU/PD, progressed to anorexia and PU/PD, no V/D reported. Has been receiving SQ fluids and Cerenia. Ate well x 2 days following Entyce, then hyporexic again.
CBC: WBC= 5.7 K/µL (5.8-16.2), all other values WNL. Chem: IDEXX SDMA =30 µg/dL (0-14), Creatinine = 2.8 mg/dL (0.5-1.5), BUN = 63 mg/dL (9-31), Total Protein = 7.6 g/dL (5.5- 7.5), Globulin= 4.6 g/dL (2.4-4), all other values WNL. U/A: S.G.= 1.012, inactive sediment.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the proximal urethra and vesicoureteral junction. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.99 x 2.24 cm, and the thickness of the cortex is 0.40 cm, in the sagittal plane. The cortical is isoechogenic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is a mild pyelectasia of 5.86 mm, no nephroliths or hydronephrosis. Doppler color shows normal pattern.

The right kidney is normal in shape and size: 2.96 x 1.80 cm, and the thickness of the cortex is cm, in the sagittal plane. The cortical is isoechogenic compared to liver parenchyma. 1.39x1.59 mm cyst. The corticomedullary ratio is normal and the corticomedullary definition is preserved. Renal pelvis is mildly dilated: 4.21 mm, with no nephroliths or hydronephrosis.

Adrenal Glands

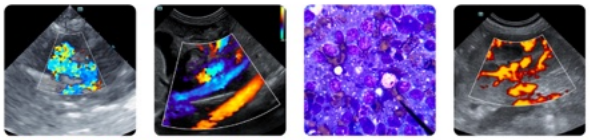
Both adrenal glands show normal shape and echogenicity. The left adrenal gland measures 0.46 cm at the cranial pole and 0.60 cm at the caudal pole. The right adrenal gland measures 0.51 cm at the cranial pole and 0.51 cm at the caudal pole.

Spleen

Splenic thickness is 1.06 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder lumen is normally distended. The wall is thin, and the contents show a moderate amount of organized biliary sludge near the gallbladder neck. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 2.23 mm and preserved wall layering. Pylorus: 3.63 mm.

Duodenum: 2.31 mm. Jejunum: 2.55–2.97 mm, with normal wall layering. The ileocecal junction is normally visualized. No signs of obstruction, ileus, or foreign material are identified.

Colon: transverse segment 1.25 mm, empty; descending segment 1.10 mm, containing a small amount of formed feces.

Pancreas

The pancreatic regions examined did not show any evident signs of inflammation.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes and ileocecal lymph nodes are not visualized, but the surrounding regions appeared unremarkable. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

- Left kidney: Mild pyelectasia (5.86 mm).
- Right kidney: Mild pyelectasia (4.21 mm); presence of a small renal cyst (1.39 × 1.59 mm).
- Gallbladder: Moderate amount of organized biliary sludge near the neck.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys maintain normal overall architecture, contour, and corticomedullary distinction. However, mild bilateral pyelectasia is present and the right kidney contains a small cortical cyst, an age-related incidental finding. No nephroliths, ureteroliths, or signs of obstructive hydronephrosis are identified, and renal perfusion appears normal on Doppler assessment. These ultrasound findings support chronic renal disease rather than an acute obstructive process.

Although mild bilateral pyelectasia is present, the ultrasound does not show the parenchymal changes typically associated with pyelonephritis (such as asymmetric renal enlargement, cortical heterogeneity, pelvic debris, or increased renal vascularity). In addition, the urinalysis reveals inactive sediment and there is no evidence of cystitis. Therefore, pyelonephritis is not considered the main diagnosis in this

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case based on the current findings (although a chronic subclinical infection cannot be entirely ruled out without urine culture).

The presence of moderate organized biliary sludge within the gallbladder neck is consistent with an age-related or functional biliary stasis and is not necessarily clinically relevant in the absence of cholecystitis or ductal dilation, both of which are absent.

Primary diagnosis

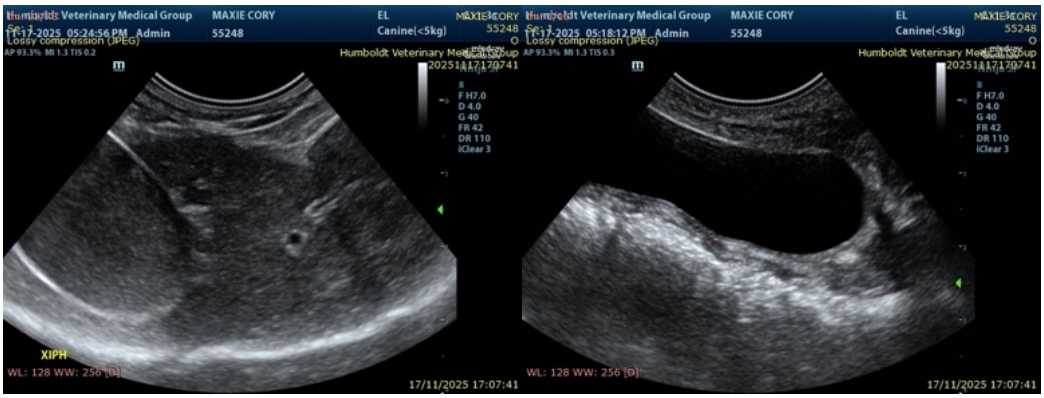
- Chronic kidney disease IRIS Stage 3 (based on creatinine 2.8 mg/dL, SDMA 30 µg/dL, and inadequate urine concentration), with mild compensatory pyelectasia.

Differential considerations

- Chronic tubulointerstitial nephritis (most likely underlying pathology in geriatric patients).
- Early or chronic pyelonephritis (less likely given inactive sediment and lack of pelvic debris but cannot be fully excluded in CKD patients).

Recommendations

- Urine culture (even with inactive sediment) if pyelonephritis remains a concern.
- Recommend IRIS staging workup if not already performed: blood pressure measurement, UPC ratio, repeat urinalysis, and assessment for proteinuria or hypertension.
- Continue renal-supportive therapy, hydration support, renal diet, and close monitoring of appetite and body weight.
- Monitor gallbladder sludge periodically.



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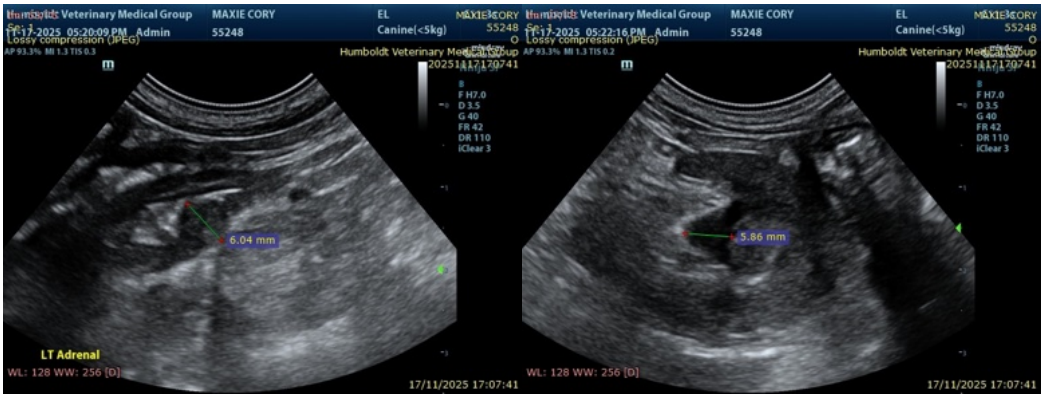

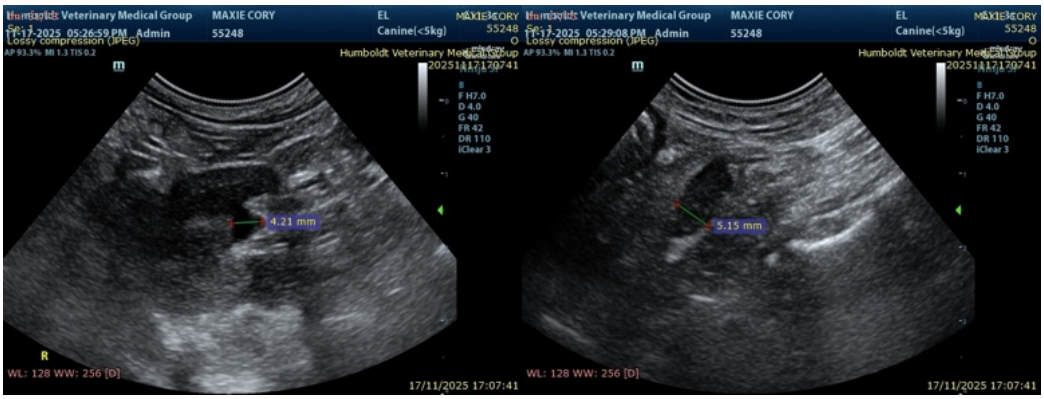

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com