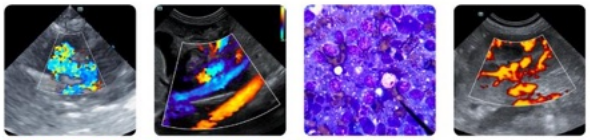


PATIENT

Aryra Robertson

SPECIES

Canine

BREED

Pomeranian

SEX

Female, spayed

AGE

7 Yrs.

WEIGHT

2.1 kg.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY

Dr. Belan

HOSPITAL NAME

Petzoic Animal Clinic

REFERRING VET

Dr. Nielsen

INVOICE

13403

DATE

12/2/25

PRESENTING CLINICAL SIGNS

History: Precious diagnosed with chronic renal disease IRIS stage 2 but has had an acute episode 2-3 days ago with severe elevation of renal enzymes Anorexic lethargic and weight loss. Abnormal PE/Chem/CBC/UA Results: Severe elevation renal enzymes no anemia 3+ protein in urine no urine culture but on antibiotics.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is distended. A scant amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone is normal.

The left kidney is normal in size (3.60 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is isoechoic relative to the spleen and diffusely thickened with moderate loss of corticomedullary distinction. The corticomedullary junction is mineralized. Mild pyelectasia is present (0.25 cm in the longitudinal plane. There is no evidence of infarcts or hydroureter.

The right kidney is normal to borderline small in size (2.95 cm in length) with a slightly irregular shape. The cortex is isoechoic relative to the spleen and diffusely thickened with moderate loss of corticomedullary distinction. The corticomedullary junction is mineralized. Trace pyelectasia is present. There is a questionable cortical infarct at the caudal pole. There is no evidence of hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.44 cm at cranial pole) (0.45 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.50 cm at cranial pole) (0.34 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

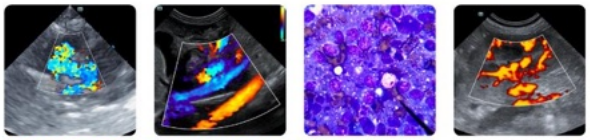
The spleen is normal in size (0.66 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal



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The gastric lumen is minimally fluid distended. Gastric wall thickness is difficult to determine due to rugal folds but appears normal to borderline thickened with retention of the normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely prominent with slightly irregular peripheral contours. The parenchyma is hypoechoic to heterogeneous and edematous in appearance. The pancreatic duct is not overtly dilated. Surrounding mesentery is hyperechoic.

Lymph nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

The mesentery throughout the abdomen is hyperechoic. A moderate amount of free fluid is present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The bilateral renal changes are most consistent with chronic interstitial nephrosis/nephritis with mineralization of the corticomedullary junction. The bilateral pyelectasia may be secondary to parenchymal remodeling, pyelonephritis, PU/PD (if applicable), fluid therapy or some combination thereof. Given the patient's clinical history and sonographic changes, acute-on-chronic renal failure is suspected.
- The pancreatic changes are suggestive of pancreatitis/pancreatic edema with adjacent peritonitis.

Secondary Findings:

- The gallbladder changes could be consistent with cholestasis, fasting or an emerging mucocele. Equivocal gastric wall thickening. This may be a normal variant for this patient or may be secondary to gastritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urine culture and sensitivity is recommended, preferably on a pre-antibiotic sample.

Also consider a UPC if proteinuria is present in the absence of infection.

A baseline blood pressure measurement should also be considered.

If the clinical suspicion is high for Leptospirosis, consider further testing (i.e., blood and urine PCR, serology).

A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended

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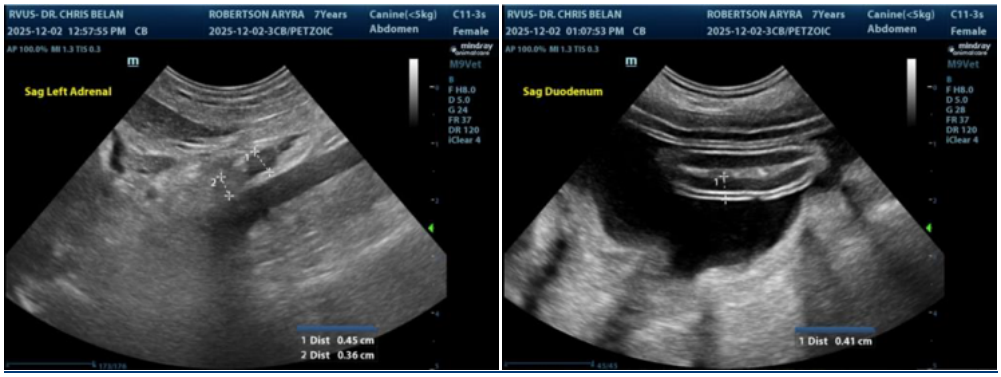
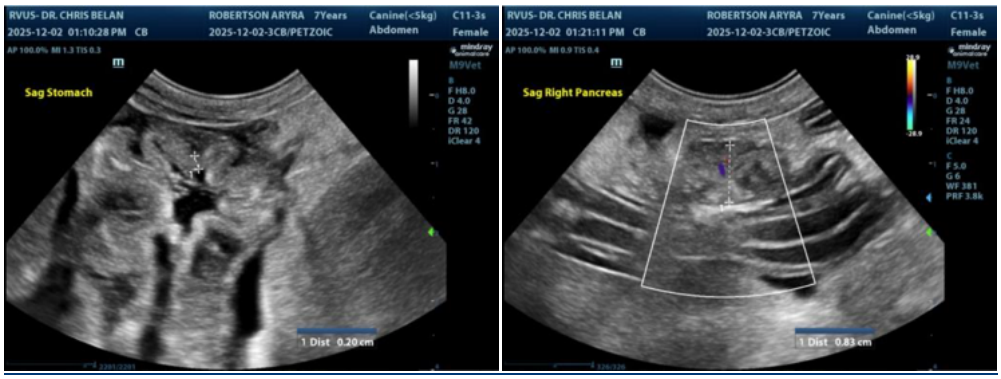
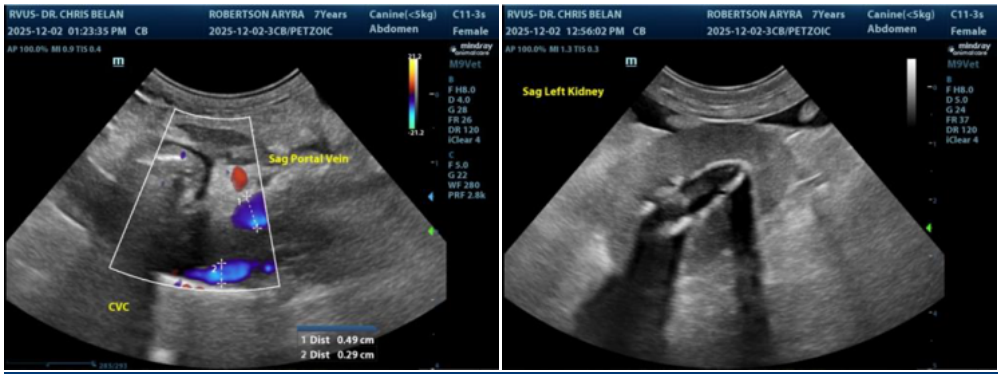
Three-view thoracic radiographs are recommended to assess cardiopulmonary status, particularly if aggressive IV fluid diuresis is to be initiated.

IV fluid diuresis and supportive care are recommended with serial monitoring of the patient's renal values to assess progression of the azotemia.







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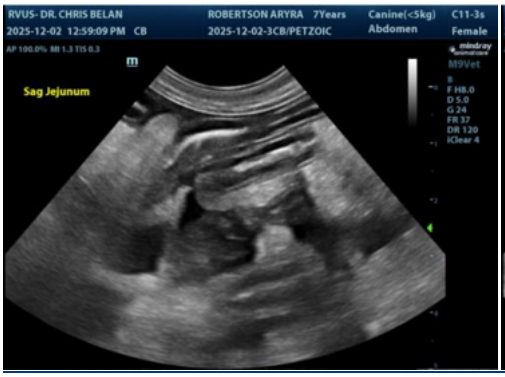

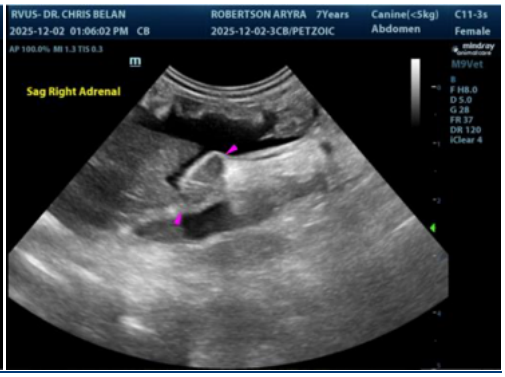

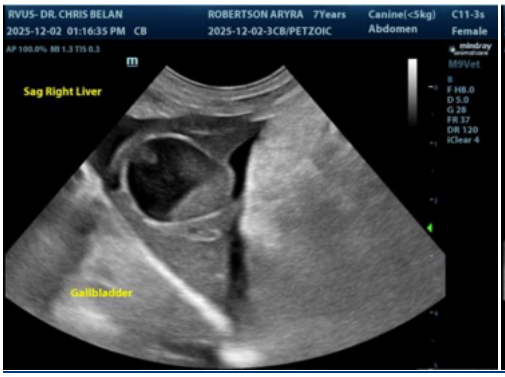

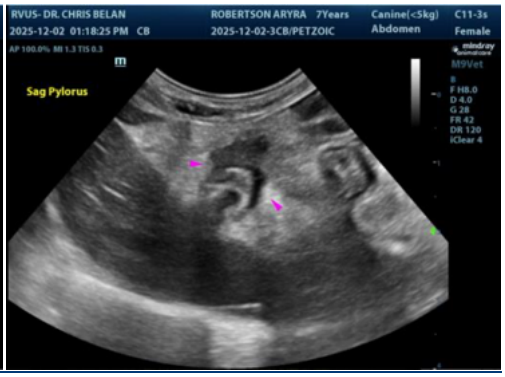

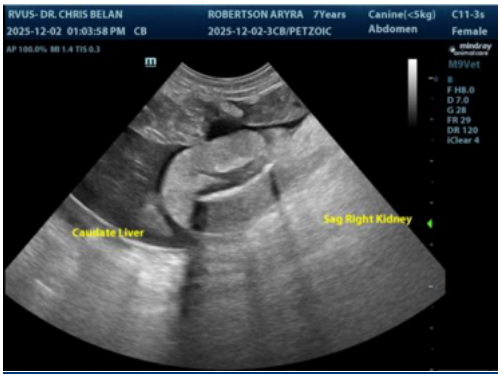

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com