Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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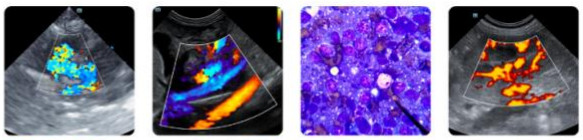

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Paisley Heiber

SPECIES

Canine

BREED

Yorkie

SEX

Female Spayed

AGE

12

WEIGHT

4.9

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Blue pearl MtP ER

REFERRING VET

Dr Graham

INVOICE

22548

DATE

2-12-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Paisley is a 12y/o FS Yorkshire Terrier presenting for v/d, lethargy, and anorexia.

O says starting Friday when other owner had surgery is when P's symptoms started. O said P started refusing food. O tried bland diet which P usually takes but P is refusing that as well. O says P is vomiting which is mostly bile. P's diarrhea is very soft and dark brown. Fecal ova & parasites- negative. P went to rDVM yesterday and tried outpatient care. P went home with propectilin, metronidazole 50mg, and had a Cerenia inj @12pm. O said P was still refusing food and O could only get meds in P. O says this morning P had a pile of vomit in her bed. O has 3 other dogs at home who are doing fine. P is not an eater of stuff and does not get into anything. No new treats or recent diet changes other than the bland diet.

Patient is normotensive. Urine culture is pending.

e/d decreased
no c/s
8/2025- cbc, chem, ua/ upc- SDMA, BUN, Creat, PHOS WNL, Cystatin B 227 ng/ml; UPC 5.0
Patient was diagnosed with proteinuria and was treated with Benazepril and fed Hill's k/d.
10/4/2025 His UPC improved to 4.6, but he was switched to Telmisartan 20 mg- 1/4 tab PO q24h

Abnormal lab-work values/Diagnostics:
- CBC: EOS 0.05 K/uL **L**, PLT-CRT 0.51% **H**
- CHem 17 w/ Lytes: CREA DNR, BUN >130 mg/dL **H**, PHOS >16.1 mg/dL **H**, Chloride 105 mmol/L **L**, TP 8.4 g/dL **H**, Glob 4.6 g/dL **H**
* 1:2 Dilution: CREA DNR, BUN >390 mg/dL **H**, PHOS > 48.3 mg/dL
* 1:3 Dilution: CREA 5.7 mg/dL BUN 171 mg/dL **H**, PHOS 15.7 mg/dL **H**
- PCV/TS:
* SG 1.010
* pH 5.0
* Urine Protein: trace
* GLU: negative
* KET: negative
* BLD: negative
* BILIRUBIN: negative
* Urobilingen: normal
* LEU esterase: negative
* RBC: <1/hpf
* WBC: <1/hpf
* Bacteria; Cocci: suspected
* Bacteria; rods: suspected
* Squamous Eipthelial Cells: none detected
* Non-Squamous Epithelial Cells: <1/hpf
* Hyaline Casts: none detected
* Non-Hyaline Casts: >1/LPF
* Calcium Oxolate Crystals: none detected
* Struvite Crystals: none detected
* Ammonium Biurate Crystals: none detected
* BILI Crystals: none detected
* unclassified crystals: none detected
- Resting Cortisol Single Slide: 6.50 u/pg

Current Medications: Cerenia, telmisartan, protonix, ampicillin, IVF

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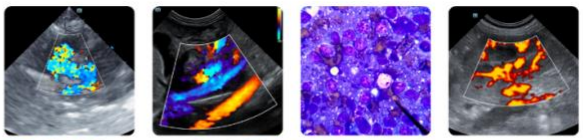

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Radiographic Findings

1. Fluid-filled GI tract is suggestive of functional ileus (e.g. as with gastroenterocolitis or pancreatitis). No evidence of GI foreign material or mechanical obstruction. Given the reported vomiting despite antiemetic therapy, abdominal ultrasound should be considered for further evaluation. Additionally recommend blood work if not already performed.
2. Diffuse bronchointerstitial pulmonary pattern may represent normal age-related changes, atelectasis, digital artifact or chronic lower airway disease (e.g. bronchitis). Correlate with clinical history.
3. No overt evidence of pulmonary metastasis or cardiovascular disease in the provided right lateral view.
Notes to Specialist (if any)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The left kidney is normal in size (4.47 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate to severe loss corticomedullary distinction. A few, tiny, cortical cysts are seen. Mild-to-moderate pyelectasia is present (0.30 cm in the transverse plane). Hyperechoic shadowing diverticular foci are visualized. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.14 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate to severe loss corticomedullary distinction. A few, tiny, cortical cysts are seen. Trace pyelectasia is present (0.13 cm in the longitudinal plane). Hyperechoic shadowing diverticular foci are visualized. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size at the cranial pole and enlarged at the caudal pole (0.50 cm at cranial pole) (0.78 cm at caudal pole). Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (1.07 cm at cranial pole) (0.75 cm at caudal pole) with swollen peripheral contours. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.93 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 curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A few polypoid-like lesions are arising from the mucosal surface. 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.

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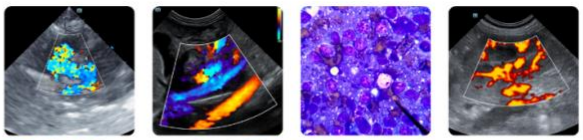

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Gastrointestinal
The gastric lumen is not distended. The gastric wall is normal to mildly-thickened (up to 0.52 cm) with retention of the normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern. There is evidence of mucosal speckling in some segments. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas
The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes
The abdominal lymph nodes are normal/not visible.

Free Abdomen
There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral nonspecific chronic renal changes with dystrophic mineralization and pyelectasia. The pyelectasia may be secondary to pyelonephritis, parenchymal remodeling, PU/PD (if applicable), fluid therapy (if applicable), or some combination thereof.
- The gallbladder changes are suggestive of a developing mucocele.
- The gastric wall changes are suggestive of gastritis, with a lower possibility of emerging neoplasia.

Secondary Findings

- Minor geriatric hepatic parenchymal changes
- The small intestinal mucosal speckling could be consistent with enteritis or may be a normal variant for this patient. Correlation with the patient's clinical history is recommended.
- Bilateral adrenomegaly
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Minor urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Leptospirosis testing (i.e., blood and urine PCR, serology) can be considered, particularly if clinical suspicion for disease is high.
- While awaiting urine culture and sensitivity results IV fluid diuresis and other symptomatic are recommended, with close monitoring of the patient's renal values to assess progression of azotemia.

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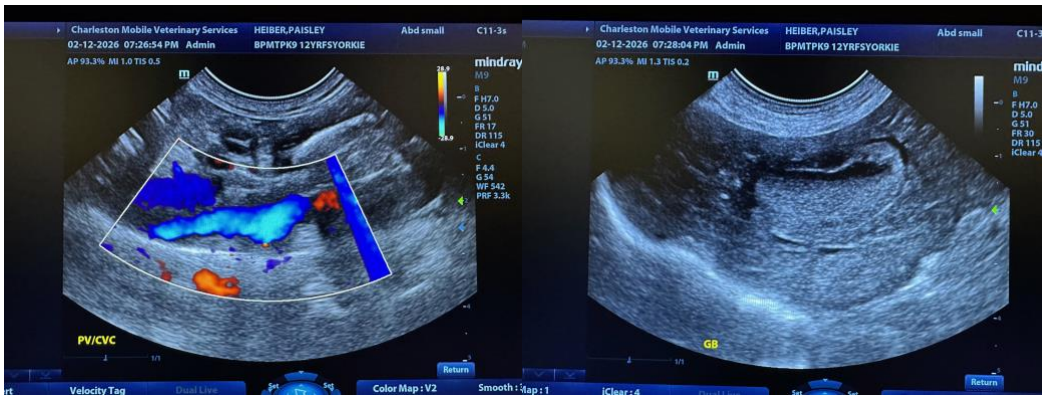
- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended once the patient's appetite has normalized. Serial sonographic monitoring (e.g., every 4-6 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.



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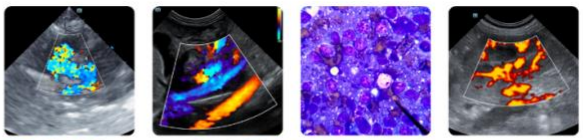

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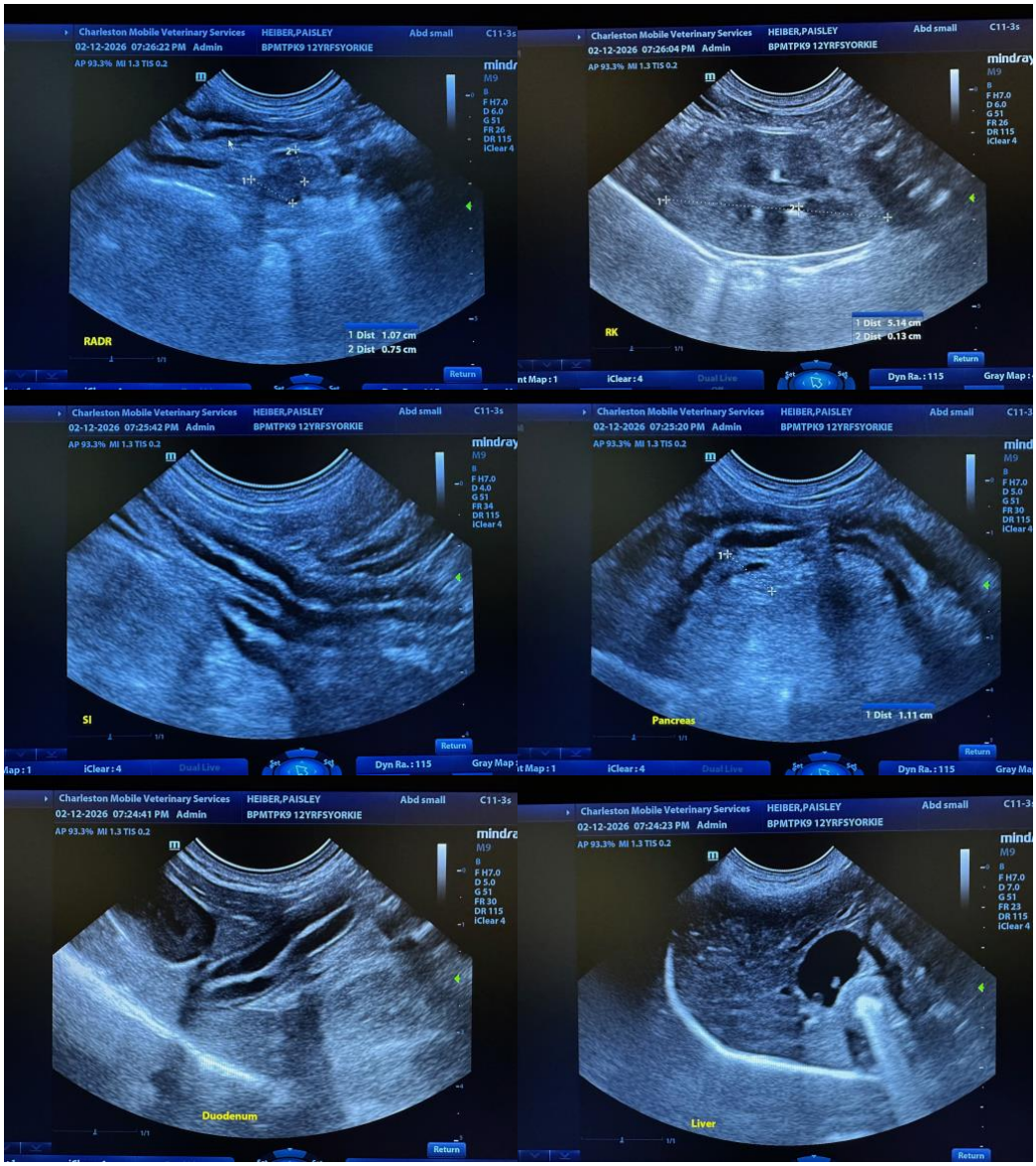

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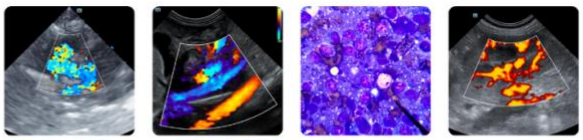

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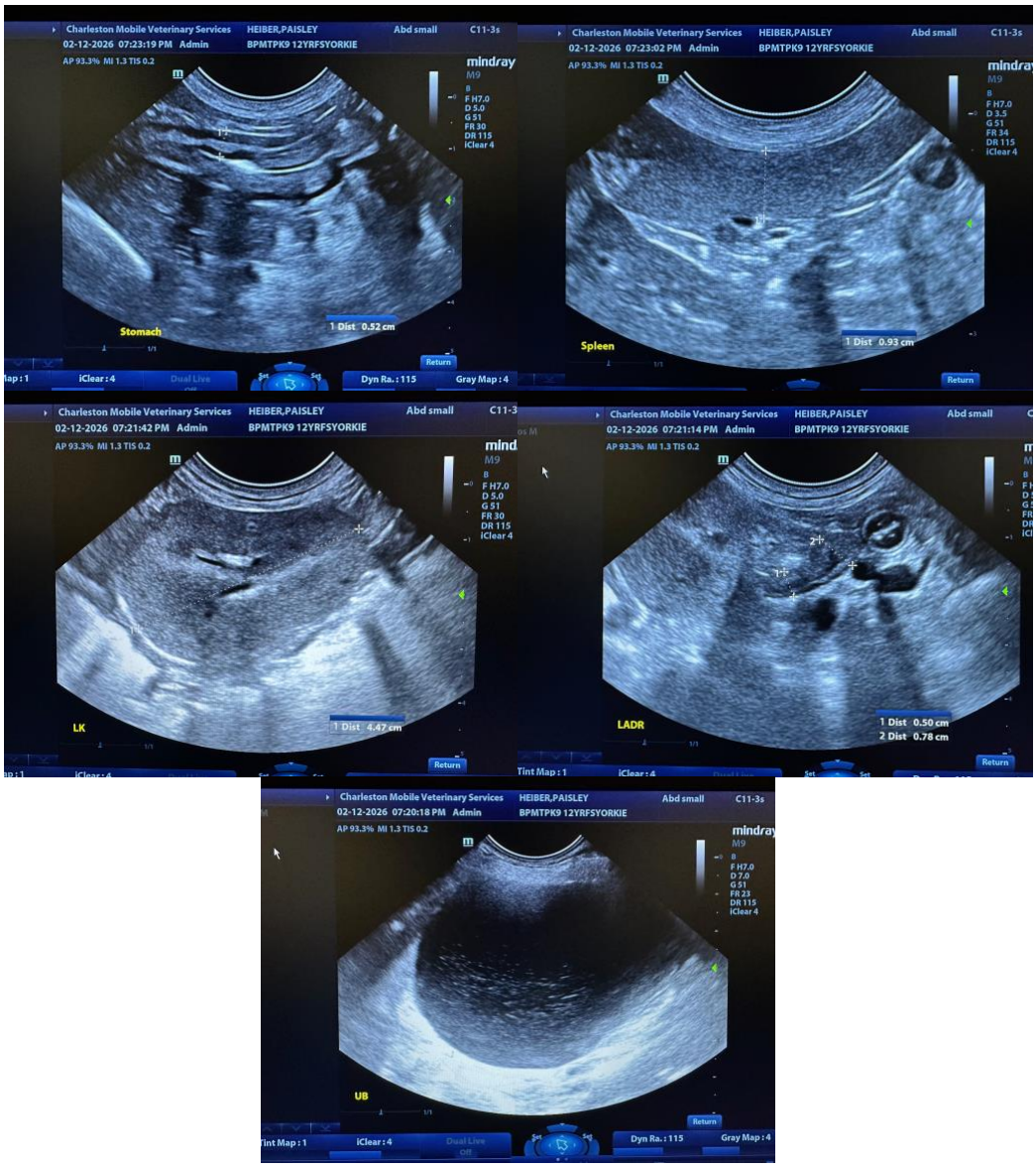

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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