PATIENT

Kodah Pizarro

SPECIES

Canine

BREED

Pomeranian Mix

SEX

Neutered Male

AGE

7

WEIGHT

28 lbs

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Pamela Harrigan, RDCS, Cert Vet Sonog (IVUSS)

HOSPITAL NAME

Jennifer Hart, DVM

REFERRING VET

Rhode Island AMC

INVOICE

22601

DATE

2-23-26

PRESENTING CLINICAL SIGNS

- Dec. 9, 2025: ALP 695 SDMA 21.3, crea 1.5. Dec. 22: vomiting, diarrhea - Cerenia/SQ fluids. UA - USG 1.018, pH 5, UPC 2.6.
- Started renal diet. Blood pressure showed hypertension - started on Enalapril.
  BW after Enalapril: BUN 52, crea 1.6.
- No clinical signs. Good appetite, normal stools, normal activity level.
- Sedated with torb /Dexdomitor for study

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately-distended. The wall is normal in thickness with a smooth mucosal surface. Several, small, cystic calculi are observed within the lumen. The region of the trigone and the proximal urethra, visible to a depth of 4 cm, are normal.

The prostate is normal in size (1.12 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.62 cm in length) a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The right kidney is normal in size (4.74 cm in length) a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

Adrenal Glands

The left adrenal gland is normal in size (0.44 cm at cranial pole) (0.59 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 region of the right adrenal gland is evaluated. No obvious pathology is observed in this region.

Spleen

The spleen is subjectivelynormal in size (1.63 cm in width at the level of the hilus) with slightly irregular peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small-to-moderate amount of gravity-dependent, echogenic to mineralized debris/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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Gastrointestinal
The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a 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 obvious evidence of an obstructive pattern.

Pancreas
The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph Nodes
A few prominent jejunal lymph nodes are visualized (one measuring 4.23 x 0.55 cm).

Free Abdomen
There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral nonspecific chronic renal changes with dystrophic mineralization. These findings, in conjunction with the proteinuria, are consistent with a protein-losing nephropathy. Most protein-losing nephropathy are idiopathic. However, they could be secondary to infectious, inflammatory, immune-mediated, or neoplastic disease. An underlying cause should be sought, if possible.

Secondary Findings

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.
- Gallbladder debris/sand, non-mucocele
- Small, cystic calculi
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the presence of a protein-losing nephropathy, consider the following:

1. Angiotensin II receptor blocker (e.g., telmisartan)
2. Antithrombotic (e.g., clopidogrel at 2.5 mg/kg PO q 24 hours)
3. Omega-3 fatty acids (65 mg/kg of DHA and EPA combined daily)
4. Prescription renal diet
5. Hypertension management
6. Routine monitoring of UPC, blood pressure and bloodwork (CBC, chemistry panel) to assess for progressive disease

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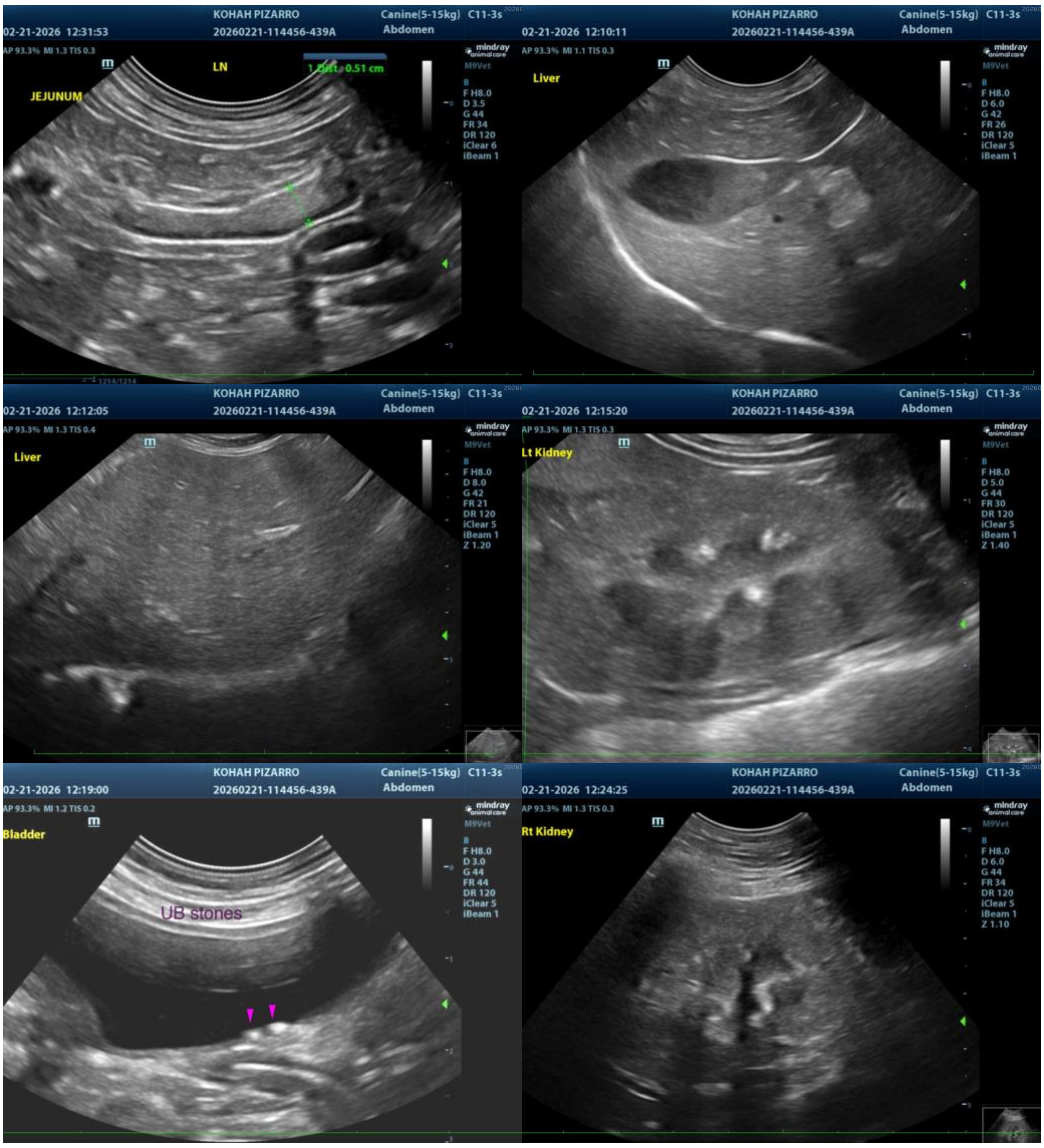
- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.
- Regarding the cystic calculi, consider stone removal, analysis, and culture, alternatively, an attempt at medical dissolution can be considered.



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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