PATIENT

Chicka Taylor

SPECIES

Canine

BREED

Pitbull

SEX

FS

AGE

3 years

WEIGHT

53.4 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView Animal Hospital

REFERRING VET

Dr. Razia Sultana

INVOICE

10899

DATE

12/8/2025

PRESENTING CLINICAL SIGNS

Mild grade heart murmur and increased kidney values with decreased specific gravity Grade 1 murmur was auscultated, no other abnormalities on PE were noted.

Abnormal PE/Chem/CBC/UA Results: SDMA of 24 and Urine specific gravity: 1.016.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally normal in size (left measures 7.17 cm, and the right measures 7. 05 cm), irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. Moderate pyelectasia is present bilaterally. There is no mineral is observed.

Adrenal Glands

The right adrenal gland is normal in size (0.53 cm at cranial pole and 0.56 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.66 cm at cranial pole and 0.76 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

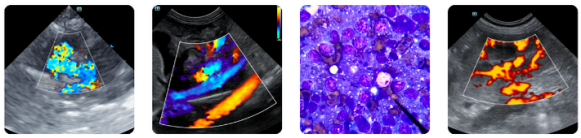
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.



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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted.

Free Abdomen

Adjacent to the left kidney, is a pocket of enhanced hyperechoic fat and some free fluid.

Medial iliac and mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- Moderate chronic kidney disease changes are noted bilaterally. Including chronic infarcts bilaterally and moderate bilateral pyelectasia.
- Concurrent, mild or potentially emerging acute pancreatitis, or potentially chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Moderately reactive medial lymph nodes, and mildly reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Pocket adjacent to the left kidney of free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a full urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

A blood pressure is recommended.

Recommendations regarding the subtle pancreas changes are largely dependent on clinical signs but could include a quantitative PLI.

Given the fairly recent spay, the free fluid adjacent to the left kidney in the area of the left ovary, could be a residual resolving post-op change, although, that seems a little bit unlikely this far out. So therefore, pathologic finding including hematoma, abscess, other, can't be definitively ruled out and should be interpreted in combination with patient's clinicals signs, laboratory changes, palpation i.e. pain in the area. Ultimately, sampling of the area, or potentially ultrasound monitoring.

In the meantime, beginning medical management of emerging chronic kidney disease may be appropriate, including managing hypertension and/or proteinuria, if present, electrolyte abnormalities

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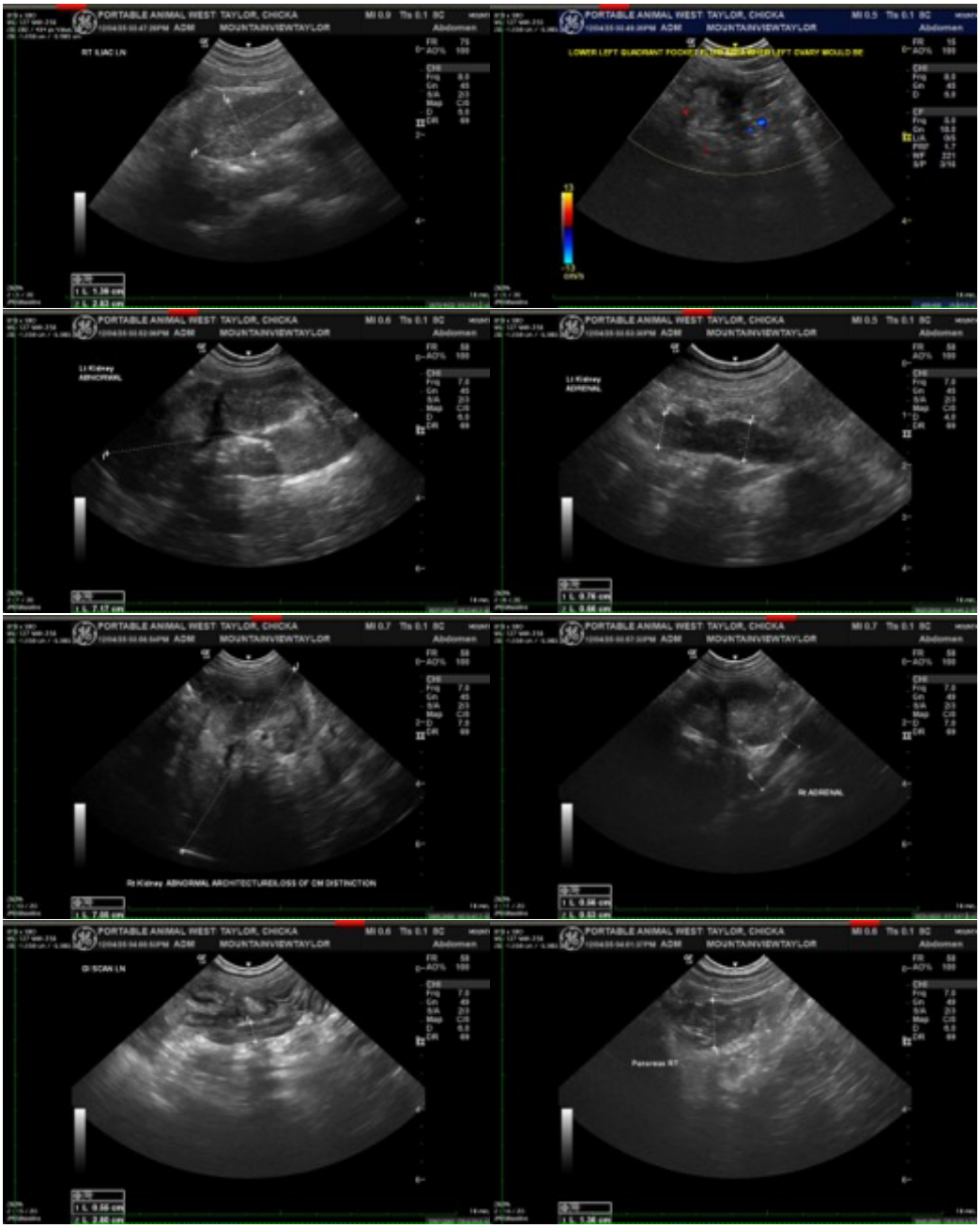
if necessary, gastrointestinal and/or other clinical signs if indicated, and potentially transition to a kidney diet.



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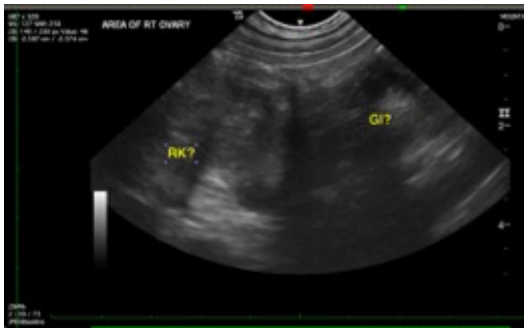

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com