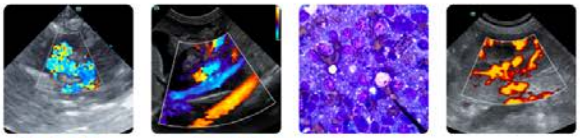


SonoPath www.animalsoundsnw.com info@animalsoundsnw.com 541.357.9423

PATIENT

Neenah Callahan

SPECIES

Canine

BREED

Labrador x

SEX

Spayed Female

AGE

8 Years

WEIGHT

54 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Hello Vet for Pets Wellness Center

REFERRING VET

Dr. Mullen

INVOICE

72839

DATE

2/10/26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Excessive urination, Proteinuria - r/o protein-losing nephropathy, neoplasia, urinary tract infection.

ABNORMAL Labwork Values: CBC: WNL CHEM Abnormal Findings: ALT 182 U/L HIGH 17 – 115, Cholesterol 424 mg/dL HIGH 131 – 346, WNL Renal values, *Creatinine 0.9 mg/dL 0.6 - 1.7*, *BUN 28 mg/dL 7 - 32*, Total T4 WNL, SDMA WNL, UA/UPC: Abnormal, Specific Gravity 1.030 WNL

Ketones TRACE HIGH NEGATIVE ***A Trace to 1+ (or rarely higher) result for ketones may be a false positive due to color interference (a common occurrence in veterinary samples). Findings should be interpreted in light of clinical signs, history, and other laboratory data.

Urine Protein 4+ HIGH NEGATIVE – TRACE. Protein:Creatinine Ratio 2.9 HIGH 0.0 - 0.2. UPC >2.0 is suggestive of glomerular disease

Current Medications: None

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.

The right kidney is normal is size (6.8 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (6.87 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The caudal pole of the right adrenal gland is normal in size (0.55 cm), shape and overall architecture, echogenicity and echotexture. The cranial pole is unable to be well visualized in these images. Visible surrounding vasculature appears normal.

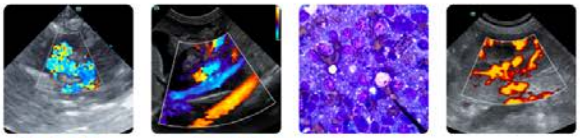
The left adrenal gland is normal in size (0.60 cm at cranial pole and 0.60 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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



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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.

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

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- This is a largely unremarkable/normal structural abdomen without a definitive ultrasonographically visible intraabdominal explanation for patient's reported proteinuria.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a urine culture could be considered.

A blood pressure is recommended.

Given the mildly increased ALT, bile acids could also be considered if patient's total bilirubin is not increased.

Comprehensive infectious disease evaluation, including testing for Leptospirosis, may be appropriate.

Otherwise, continued workup/evaluation for underlying causes of PU/PD that could also be contributing to the proteinuria is recommended, so that if an underlying cause can be diagnosed, treatment can be initiated.

In the meantime, and/or if another underlying treatable cause is not found and proteinuria is persistent, treatment recommendations to consider include enalapril (or benazepril if azotemic) +/- ARB, anti-thrombotic (low dose aspirin or clopidogrel), a renal diet if tolerated and fatty acid supplementation.

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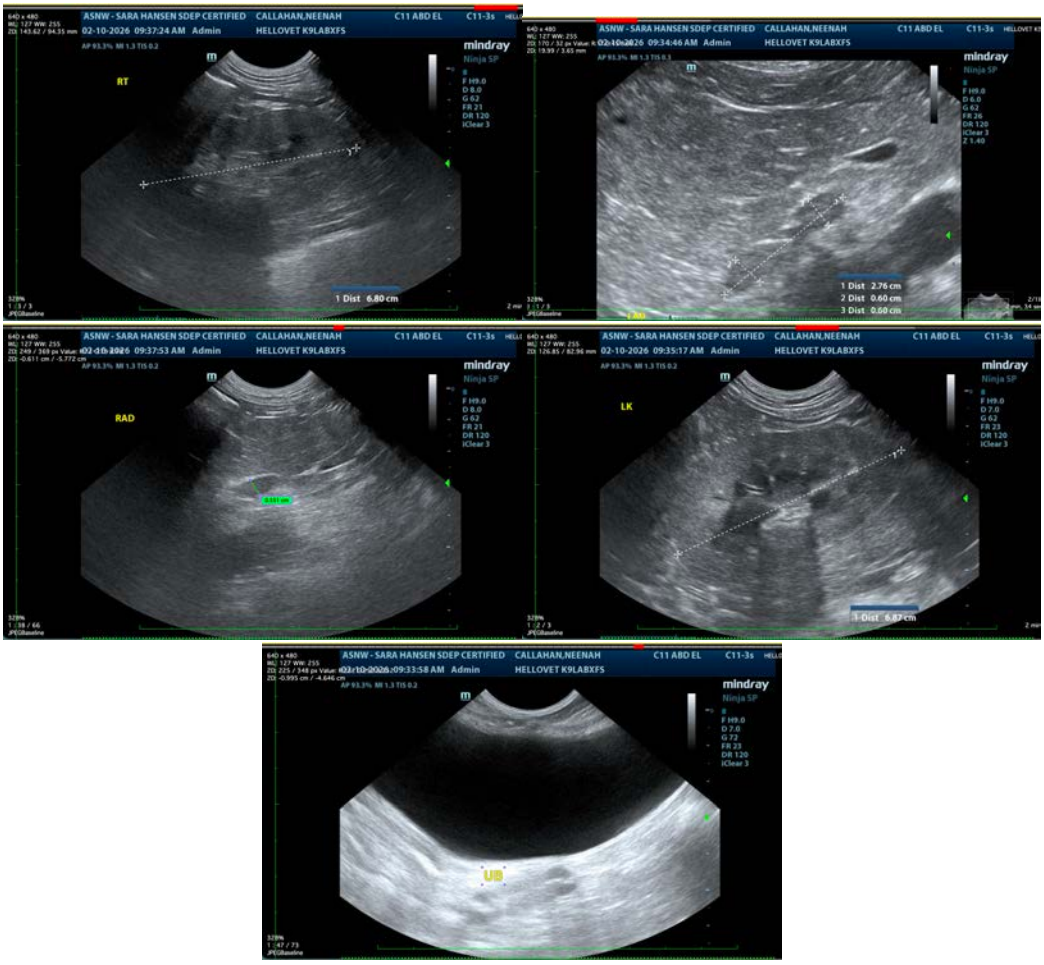
Begin FA supplementation slowly to prevent GI upset. If hypertension is present, additional therapy with amlodipine may be necessary to manage hypertension.



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