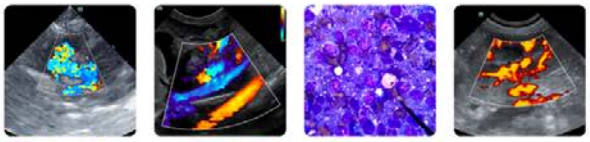


PATIENT

Bear Gustafson

SPECIES

Canine

BREED

Labradoodle

SEX

Neutered Male

AGE

10 Years

WEIGHT

26 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Heatherlynn McFarlane, DVM (Internal Med)

INVOICE

72723

DATE

2/4/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate suspected PLN. Weight loss was first noted Nov 2025 and was PU/PD (though was on steroids for skin allergies). BW performed showed elevated renal values (Creat 1.87, BUN 33) and a mildly low albumin (2.4). UA showed normal USG at 1.048, queit sediment, and proteinuria with UPC showed >1.6. Started on benazepril 15mg q12hr but azotemia and UPC continued to be progressive (Creat 3.12, BUN 63, UPC >2.06). 4Dx positive for anaplasma, ehrlichia (historical) but negative for Lyme. Leptospirosis Ab were negative as well. Due to progressive azotemia and UPC, tx with 20d course of doxycycline (just finished). Lost 5.4lbs since 8/2025.PMH: Heart murmur, stage B1

Meds: Benazepril 10mg q12hr (**increased 1/29/26). Gabapentin, Trazodone for vet visit

Abnormal PE/Chem/CBC/UA Results: 1/11/25 4Dx: Anaplasma, Ehrlichia pos (hx); HW/Lyme negative 1/29/25 CBC: WBC 5.75, Neut 4.44, Lymph 0.86, HCT 45.7%, PLT 239 Chem: TP 5.5, Alb 2.4), Glob 3.1, Cr1.87, BUN 33 H) norm LES, Chol 412 H, norm-lytes, Phos 4.1, Mg 1.6 Nov 2025 IH UA: USG 1.048, pH 7, BLD 250, Pro 500 H, inactive sed UPC >1.60 H Dec 2025 Leptospirosis Ab: Neg Renal Panel: Cr3.12 H, BUN 63 H, norm lytes Phos 4.9 H UPC: >2.06 H NIBP 188/115, 180/116, 189/117 1/28/26 Renal Panel: TP 4.4 (L), Alb 1.7 (L), Glob 2.7, Creat 1.7 (H), BUN 35 (H), SDMA 15.3 (H), Na 149, K 4.4, Cl 119, Ca 9.5 (corrected 11.3), Phos 4.4, UA (cystocentesis): USG 1.049, pH 7.5 (H), WBC none, RBC 2-3/HPF, Bacteria none, protein 4+ (H), glu/ketones negative, crystals/casts none UPC: 9 (H) NIBP (Doppler, #4, LFL): 174mmHg (average of 4)

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted. Non-obstructive mineral is noted within the left kidney cortex, primarily the caudal pole. Additionally, multiple chronic infarcts are present bilaterally. Left kidney is small-normal measuring 6.48 cm. Right kidney is normal in size at 6.31 cm.

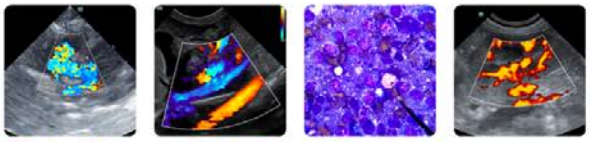
Adrenal Glands

The right adrenal gland is normal in size (0.83 cm at cranial pole and 0.60 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.46 cm at cranial pole and 0.61 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.



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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 mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is 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

- Moderate bilateral chronic kidney disease changes, including chronic infarcts bilaterally and non-obstructive mineral in the left kidney – An acute on chronic process can't be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already in place, medical management/treatment of the reported infectious disease/diseases is recommended followed by reassessment of azotemia, proteinuria, hypertension, etc., with ongoing medical management of emerging chronic kidney disease and protein losing nephropathy, hypertension, etc. as indicated.

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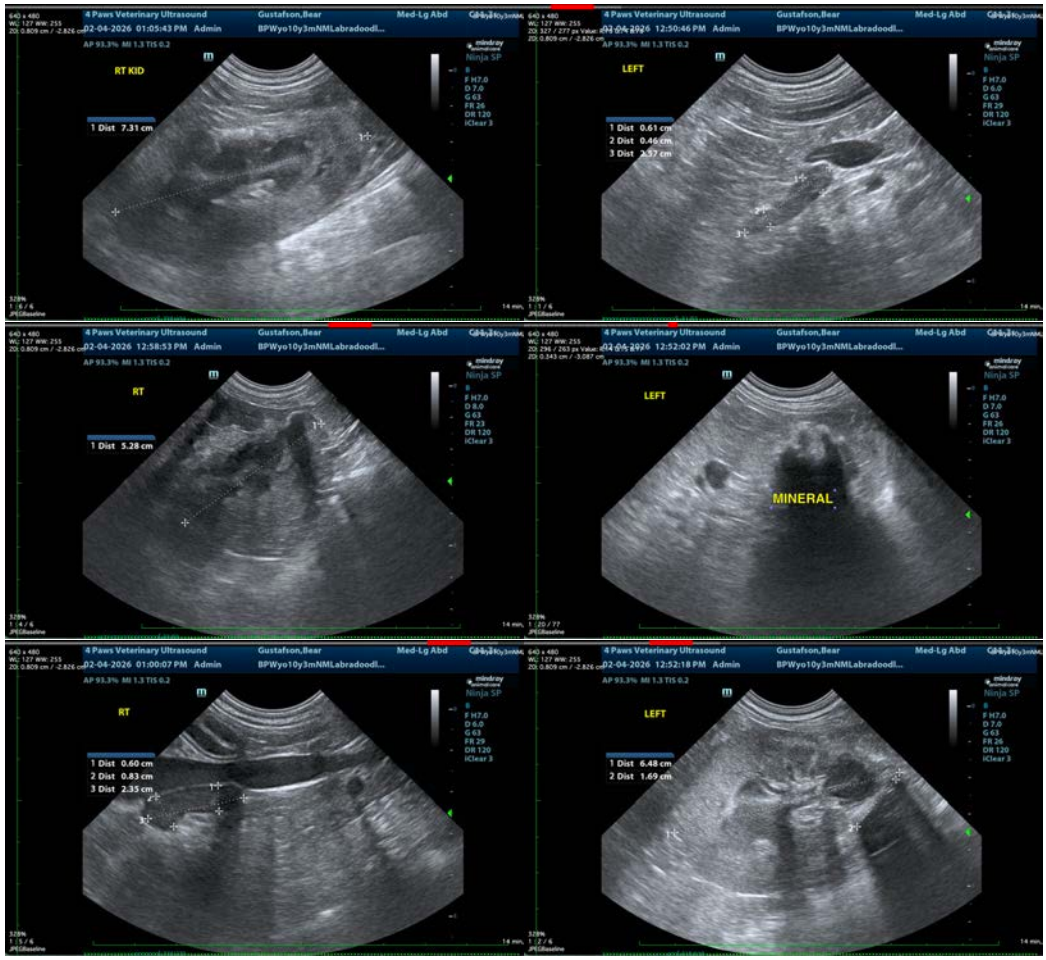

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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