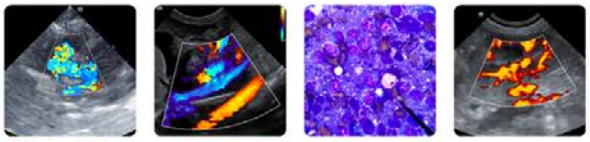




**PATIENT**

Yoshi Groff

**SPECIES**

Canine

**BREED**

Yorkshire Terrier

**SEX**

Intact Male

**AGE**

6 Months

**WEIGHT**

1.4 kg

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Renee Trionfetti, VMD

**HOSPITAL NAME**

Blue Pearling Wyomissing

**REFERRING VET**

VCA Sinking Springs

**INVOICE**

74987

**DATE**

5/6/26

## PRESENTING CLINICAL SIGNS

AUS to further evaluate azotemia with a history of vomiting (Cr 2.7, SDMA 48.9, BUN 92, USG 1.008-1.011). Multiple vomiting episodes (chronic). Bloodwork was normal in Jan 2026 then increased renal values as of April 2026. Normal bile acids, ACTH stim ruled out Addison's and negative Lepto. Urine culture on free-catch shows e.coli (r/o contaminant vs true infection).
Sedated for ultrasound and cystocentesis: Butorphanol 0.35 mg/kg IV + Alfaxalone 1.4 mg/kg IV. Tolerated well and with good effects.

Abnormal PE/Chem/CBC/UA Results: April 2026: - CBC: Hct 49%, MCHC 29 L, MCV 75-n, Plts 454-n, Monos 968 H, Lymph 5687 H, Eos 1L, remainder NSF - Chem: Cr 2.7 H, SDMA 48.9 H, BUN 92H, Alb 3.5-n, Na 161 H, Mg 2.8 H, Ca 13 H, Phos 7.5 H, normal LES - T4: 2.2-n - Lepto PCR Blood & Urine: Neg x 2 - ACTH stim: not Addisone (Pre- 2.3, Post- 13.4) - BA: Pre- 23.5 H (< 13), Post- 17.6 (< 25) - UC: E.coli on free-catch - UA (free-catch): USG 1.008, pH 6.5, trace bld, WBC 0-1/hpf, Coccobacilli > 100 - repeat UA (free-catch): USG 1.011, pH 6.0, WBC 2-3/hpf, Bact rods 26-50/hpf

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a mild amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The area of the prostate is examined without evident prostatic pathology.

In the area of the left kidney is an approximately 1.1 cm in length ovoid structure characterized by an echogenic rim and mildly fluid dilated center, presumably left kidney tissue.

The right kidney is small, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. No overt neoplasia or mineral is observed. Mild pyelectasia is noted measuring 0.26 cm in the transverse view.

### *Adrenal Glands*

The right adrenal gland is normal in size (0.42 cm at cranial pole and 0.28 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

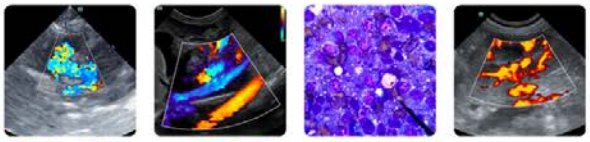
The left adrenal gland is normal in size (0.32 cm at cranial pole and 0.32 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### *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.

Both testicles are visualized without evident testicular pathology.

## ULTRASONOGRAPHIC FINDINGS

- Severe renal dysplasia – This appearance of the kidneys in a young dog is most concerning for congenital renal dysplasia or juvenile nephropathy. Other differentials include glomerular or interstitial nephritis, leptospirosis, chronic pyelonephritis, ethylene glycol toxicosis, etc.
- Mild amount of echogenic urinary bladder debris.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If possible, a cystocentesis sample for sterile urinalysis and culture is recommended.

A blood pressure is recommended if not recently evaluated.

In the meantime, beginning and/or continuing medical management for chronic kidney disease is recommended, including supportive/symptomatic medical management of clinical signs, fluid therapy if hydration status warrants it, management of any concurrent hypertension, proteinuria, electrolyte abnormalities, etc. if indicated, and if tolerated, transition to a kidney friendly diet could be considered.

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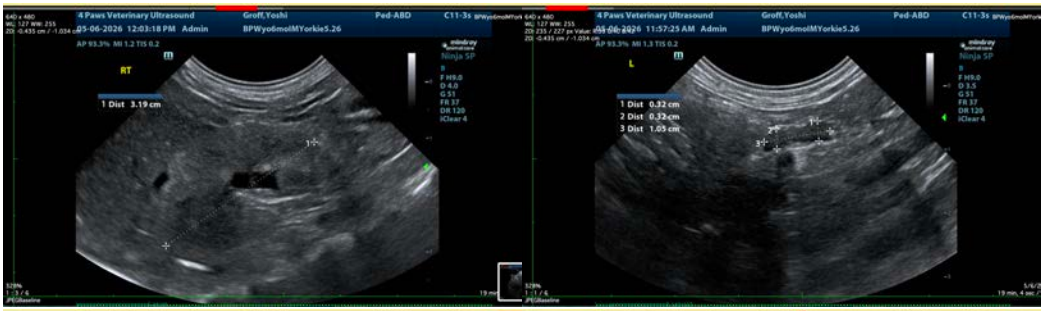


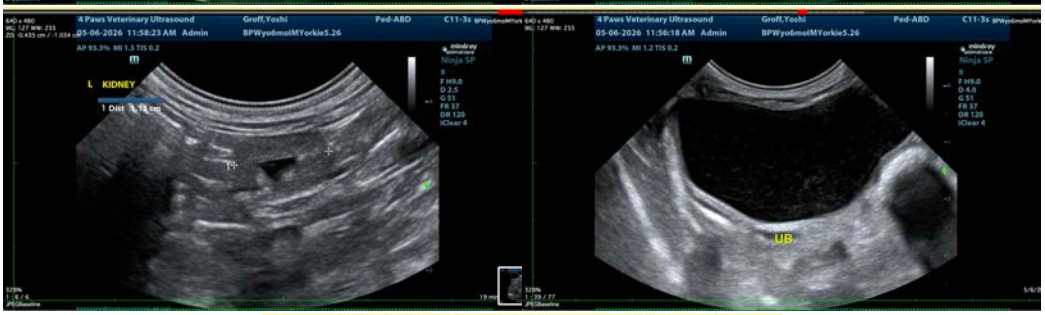


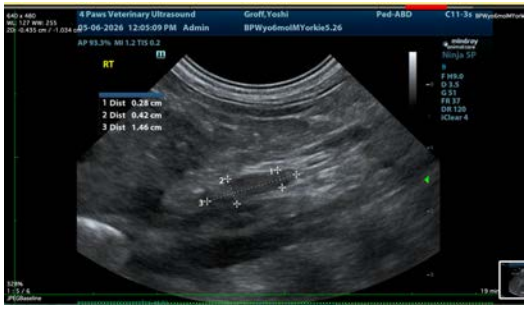


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**Beth Johnson**, DVM, DACVIM
info@sonopath.com