

PATIENT

Sophie Ward

SPECIES

Canine

BREED

Chihuahua Mix

SEX

Spayed Female

AGE

9 Years

WEIGHT

8.2

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Cassidy Stone

HOSPITAL NAME

Petroglyph Animal
Hospital

REFERRING VET

Dr. Cassidy Stone

INVOICE

14909

DATE

04/07/26

PRESENTING CLINICAL SIGNS

Lethargic starting Wed with progressive inappetence for 3 days

Abnormal PE/Chem/CBC/UA Results: Worsening elevations of liver enzymes) ALP 4162, ALT 808) Azotemia (creat 4.7) Kidney stones and bladder stones noted on radiographs

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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 left kidney is large as a result of marked pyelectasia, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. Marked pyelectasia is present measuring 0.95 cm in the transverse view with several mineral densities including a 0.62 cm nephrolith noted within the renal pelvis at the entrance to the proximal ureter. The left kidney measured 4.7 cm in length.

The right kidney is normal in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. The right kidney measured 3.8 cm in length. Punctate nonobstructive nephroliths are also noted in the right kidney with mild pyelectasia.

Adrenal Glands

The left adrenal gland is unable to be well visualized in these images.

Right adrenal gland is normal in size (0.63 cm at caudal pole. The cranial pole is unable to be well visualized in these images. See other), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

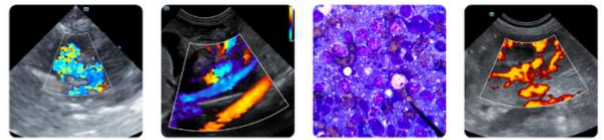
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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.

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



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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.

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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.

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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. See other.

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Free Abdomen

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

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There is no apparent pathologic lymphadenopathy noted in these images.

Other

In the right cranial abdomen in several views, there appears a 0.8 cm by 1.2 cm homogenous iso- to hypoechoic brown density that could represent a right caudal liver nodule versus a lymph node, or a mildly enlarged cranial pole to the right adrenal gland versus pancreatic nodule versus other.

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ULTRASONOGRAPHIC FINDINGS

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- Bilateral chronic kidney disease changes with marked pyelectasia noted in the left kidney, presumably secondary to at least partial obstruction from intrapelvic nephroliths. No ureteral dilation or definitive obstruction is visible in these images at this time, but it can't be ruled out. Similarly, ascending infection contributing to the pyelectasia bilaterally is a possibility.

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- Possible mild right adrenomegaly versus other right cranial density i.e. lymph node versus other as described above.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

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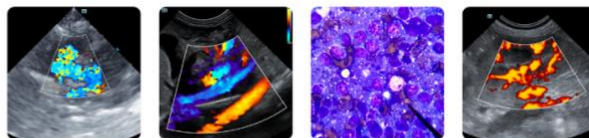
Bile acids are recommended if patient's total bilirubin is not increased.

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Testing for leptospirosis is recommended.

In the meantime, supportive/symptomatic medical management of clinical signs, as well as management of an empirical pyelonephritis and acute on chronic kidney insult as a result of obstruction from a left nephrolith is recommended while very closely monitoring for improvement. If improvement is not very rapidly noted, more aggressive intervention up to and including removal or



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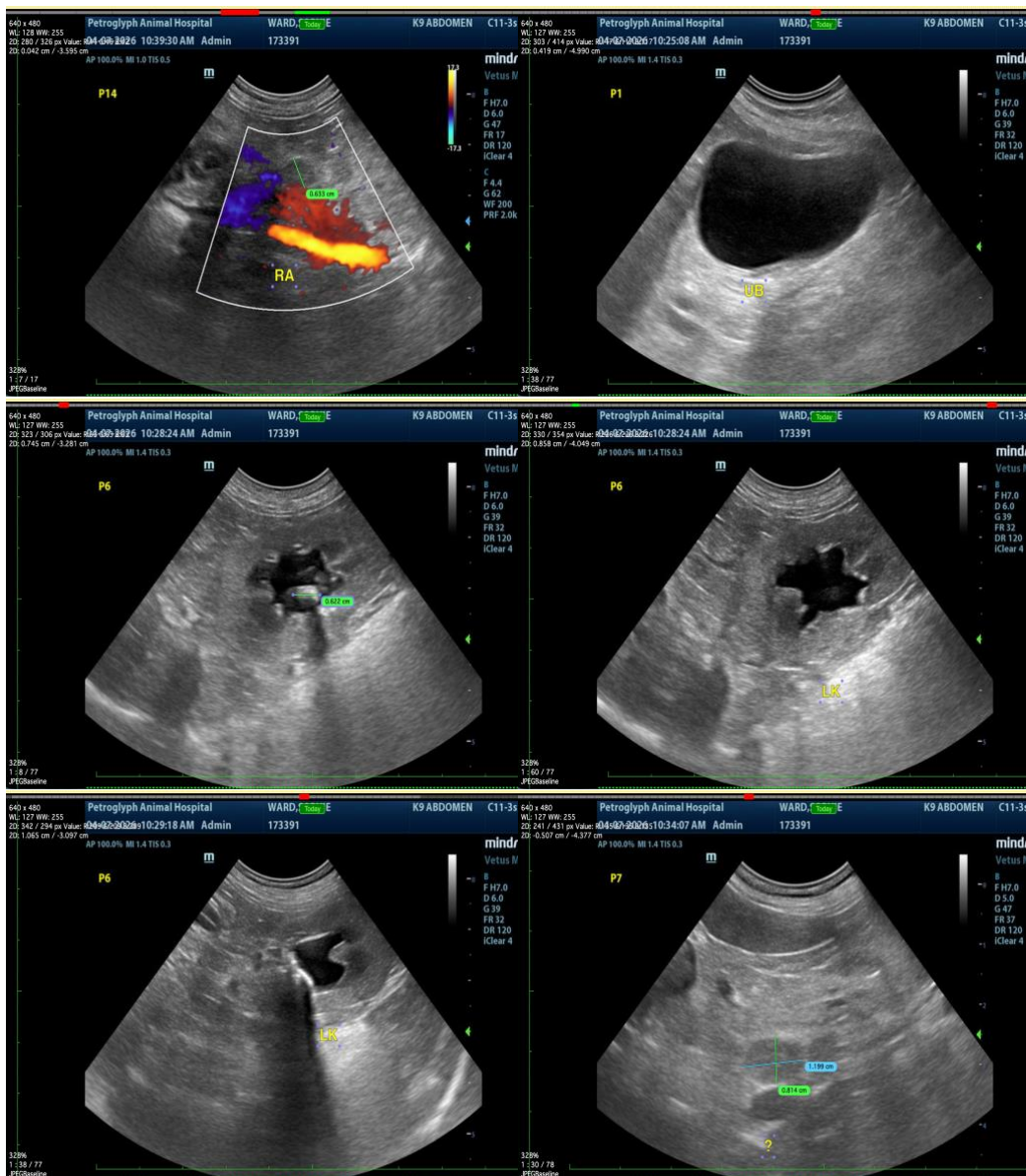
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bypassing the suspected left obstruction may be indicated to preserve remaining kidney function on the left side if present. Advanced imaging such as abdominal contrast radiography could be considered, especially given the concurrent right cranial abdominal density.

Ultimately the liver enzymes are of unknown relation to the suspected left obstructive nephrolith, but further workup and treatment of a hepatopathy up to and including possible liver biopsy may ultimately be indicated.





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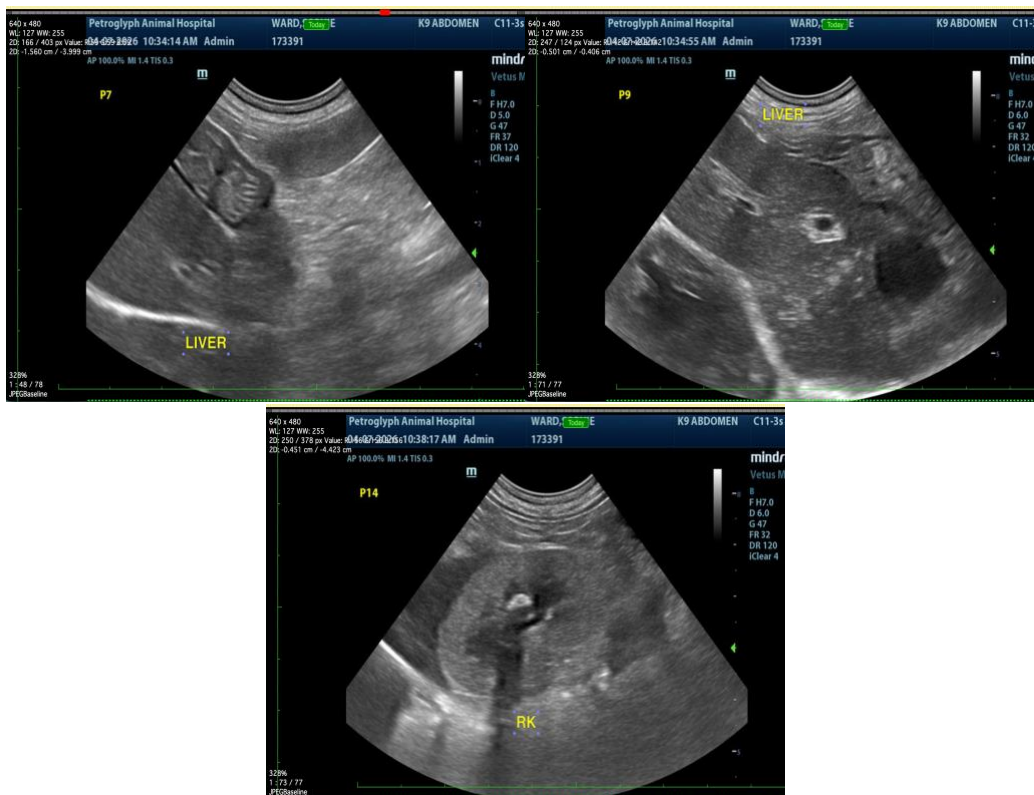
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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