



PATIENT

Libby Brown

SPECIES

Canine

BREED

Yorkie

SEX

Spayed Female

AGE

9 Years

WEIGHT

7.31 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kristin Evans

HOSPITAL NAME

Emergency Animal
Hospital of Crystal
Falls

REFERRING VET

Samantha Butrico,
DMV

INVOICE

75687

DATE

6/4/26

PRESENTING CLINICAL SIGNS

Presenting complaint/duration: 4-5 days ago P started becoming lethargic, not playing. She did vomit 1-2X during that time. O went on an overnight trip to Lubbock that P accompanied them on, she was lethargic during the trip. She did not want to eat before the trip. This morning vomited 5-6X, had diarrhea.

Abnormal PE/Chem/CBC/UA Results: Creat 4.9, BUN >130 mg/dl, hyperphosphatemia >16.1

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 irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted. Acoustic shadowing from mineral along the medullary rim area is noted bilaterally with no visible evidence of obstruction. Multiple cortical cysts are present bilaterally. Left kidney is normal in size at 3.9 cm. Right kidney is normal in size at 4.2 cm.

Adrenal Glands

The adrenal glands are unable to be well visualized.

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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.



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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.

Pancreas

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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.

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Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

WEIGHT

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- Moderate chronic kidney disease changes with non-obstructive mineral and cortical cysts bilaterally. The medullary rim sign is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

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- Gastritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.
- Mild gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Given patient's history, further differentiating/managing any prerenal component to patient's reported azotemia is recommended. Therefore, if not recently evaluated, a 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 ratio is recommended.

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A blood pressure is recommended if not recently evaluated.

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A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.



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In the meantime, supportive/symptomatic medical management of clinical signs, rehydration, etc. is recommended while monitoring azotemia for improvement to help determine what, if any, further gastrointestinal workup may be warranted, as well as what potential management for emerging of longer term chronic kidney disease may be indicated.



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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