



PATIENT

Tio Colon

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

7 years

WEIGHT

37.4 lbs

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons),
DACVECC

IMAGING PERFORMED BY

Dr. Gabriel Ferrer

HOSPITAL NAME

Pulse Pet Ultrasound
Services

REFERRING VET

Dr. Mayra Fonseca

INVOICE

11056

DATE

1/8/2026

PRESENTING CLINICAL SIGNS

Presented as a referral for an abdominal ultrasound to evaluate azotemia, anemia, anorexia and lethargy. Pt presented to rDVM on Jan 5th, 3 days after picking up from New Year's boarding for lethargy and anorexia. Pt has not been vomiting or having diarrhea. Pt has been fed for years home cooked diet. When pt was with O no known exposure to toxins. Pt was vaccinated on Oct 2025. Pt was hospitalized when noticed Azotemia. PT is on IV fluids to 45mL/h, cerenia 1 mg/kg IV SID, famotidine 1 mg/kg, phosphate binder 7 scoops BID. Possibly adding benazepril, Unasyn, mirtazapine.

Abnormal PE/Chem/CBC/UA Results: PE: QAR Bloodwork: -CBC: RBC 3.58, HCT 20.8, HGB 7.5, retic 2.5,plt 114 -CHEM: CRE >13.6, BUN >130, Phosph >16.1, CA 4.7, ALKP 20 -U/A: leu 500, pro 30, glu 50, bld 25, USG: 1.012 BP 185mmHg.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. Renal cortex is hyperechoic bilaterally. There is mild pyelectasia bilaterally. There is very mild pelvic dilation in the left kidney with no visible ureteral dilation. Left kidney measures 6.16 cm in length, and the right kidney measures 5.57 cm in length.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Left kidney measures 2.2 cm in length, 0.51 cm at the caudal pole and 0.43 cm at the cranial pole. Right adrenal measures 2.1 cm in length, 0.57 cm at the caudal pole and 0.62 cm at the cranial pole.

Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing debris present. There is no surrounding free fluid or signs of active inflammation.

Gastrointestinal



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The stomach wall is diffusely significantly thickened with loss of wall layering, measuring up to 1.4 cm in thickness.

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

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Pancreas

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The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

AGE

ULTRASONOGRAPHIC FINDINGS

7 years

- Thickened gastric wall with loss of wall layering.
- Hyperechoic renal cortices with mild pyelectasia.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

INTERPRETED BY

Kidneys show signs of nephritis. In light of the azotemia, an acute renal insult is likely. Progression of chronic renal disease (not yet ultrasonographically evident), toxin exposure, leptospirosis, bacterial pyelonephritis, other infectious insults, recently resolved ureterolithiasis, among other things are possible.

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Additional diagnostics to be considered include urine culture (even if no bacteria on UA), leptospirosis testing, and careful questioning for the possibility of exposure to renal toxins (NSAIDs, grapes/raisins, cream of tartar, tamarind, vitamin D, rodenticide, etc). Doppler blood pressure measurement is recommended to screen for hypertension which can be present in both acute and chronic renal disease and worsens renal function.

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Treatment with intravenous fluid therapy, GI support as needed including enteral nutrition and monitoring for improvement or resolution of azotemia every 24-48 hours is recommended. Antibiotics are reasonable while awaiting infectious disease testing.

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If azotemia fails to resolve with fluid therapy, permanent renal dysfunction is likely. Management for any patient with chronic renal dysfunction includes renal specific diet (protein and phosphorus limited), encouraging increased water intake with canned food and providing clean, running water source, and management of proteinuria and hypertension with ACE-inhibitor with addition of more anti-hypertensives as required. Monitoring of bloodwork, urinalysis and blood pressure every 3-6 months, or sooner if feeling unwell, is recommended.

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Gastric wall thickening may be secondary to uremic gastritis given severity of azotemia. The loss of wall layering and severity of thickening is concerning for infiltrative disease. Gastric wall FNA is recommended to rule out round cell infiltration. Ultimately, gastric biopsy may be necessary to further differentiate if round cell infiltration can be ruled out, I would recommend treating for gastric uremia including antacids (proton pump inhibitor, sucralfate, etc) and anti-nauseas as needed with

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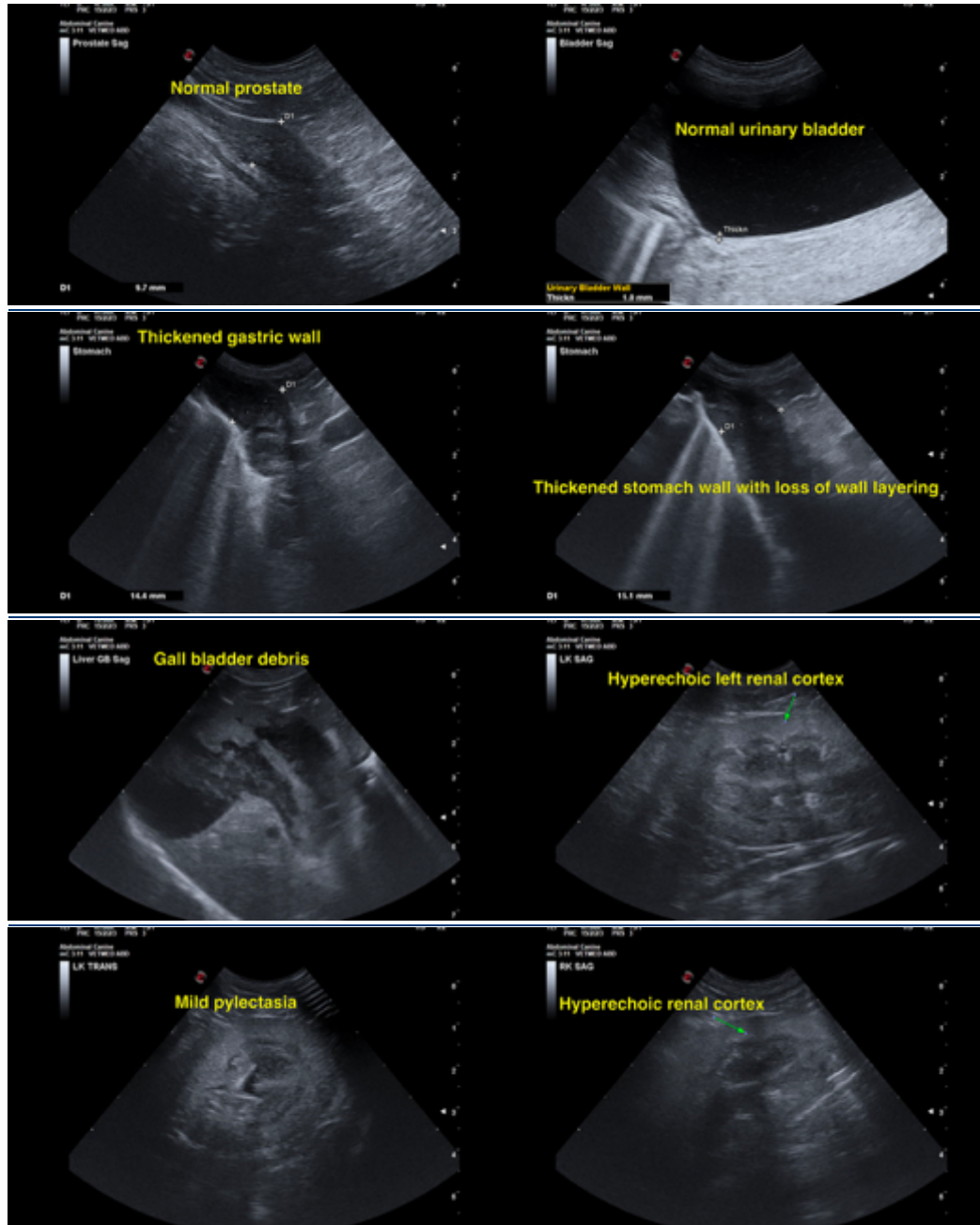
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consideration for gastric biopsy if there is no improvement and/or when renal values improve or normalize, and patient is a better candidate for anesthesia.



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



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can be of any further assistance please contact me.

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