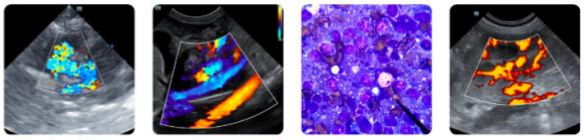

PATIENT

Sadie Plourde

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

8 Years

WEIGHT

6.3 kg

INTERPRETED BY

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS

IMAGING PERFORMED BY

Dr. Sarah Barthelemy

HOSPITAL NAME

Fish Creek Pet Hospital

REFERRING VET

Dr. Whale

INVOICE

15341

DATE

04/22/26

PRESENTING CLINICAL SIGNS

Progressive weight loss, intermittent hyporexia, acute lethargy

Abnormal PE/Chem/CBC/UA Results: Hypoalbuminemia at 19 Azotemia (creat approx 400) Proteinuria - UPCR and culture pending USG 1.016

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra to a depth of 2.0 cm presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized, and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some mild age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex. Slight pyelectasia was present in the right kidney measured 0.39 cm. The left kidney measured 4.21 cm in length. The right kidney measured 4.66 cm in length. Blood flow to the kidneys appeared to be adequate. Slight microcystic changes and cortical striations were noted bilaterally.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.43 cm width at the cranial pole and 0.50 cm width at the caudal pole. The right adrenal gland measured 0.44 cm width at the caudal pole and 0.32 cm width at the cranial pole.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

The **gastric** wall revealed mild hypertrophy and mucosal remodeling. The gastric lumen was empty. The small intestine and colon were unremarkable.

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Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some minor parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

Free Abdomen

A trace amount of free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Renal pyelectasia owing to pelvic scarring, potential UTI, history of passage of calculi are all possible.
- Minor pancreatic remodeling.
- Mild gastric luminal remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the weight loss is unclear. Protein losing nephropathy is likely. If no significant proteinuria is present, then protein losing enteropathy is possible, yet structurally, the GI tract is unremarkable The lethargy and hyporexia may be owing to non-visceral causes such as orthopedic pain, CNS or thoracic disease. Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.

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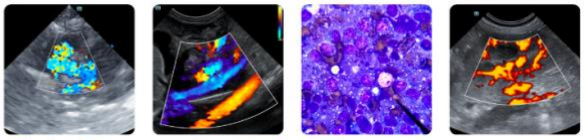

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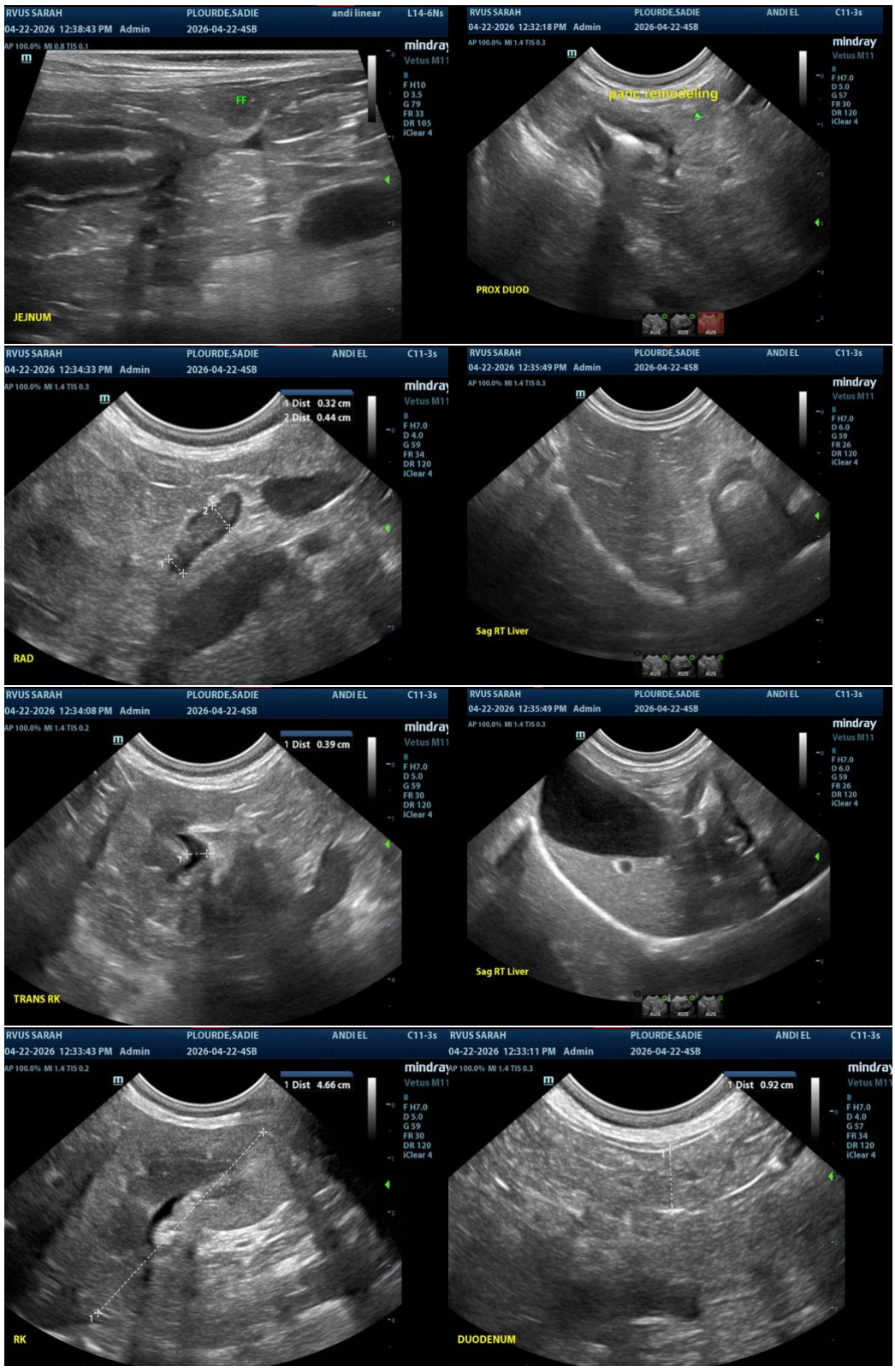

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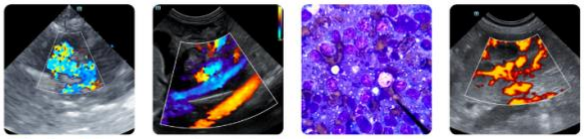

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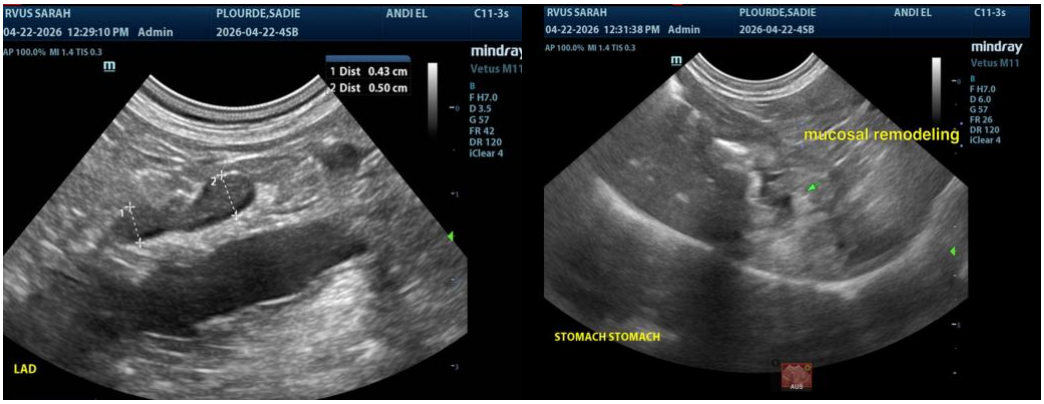

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS,

CEO, Owner, Founder -- SonoPath.com

info@SonoPath.com