PATIENT

Sager Molly Macgee

SPECIES

Canine

BREED

Mini Australian Shepherd

SEX

Spayed Female

AGE

5 years

WEIGHT

34.8 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView Animal Hospital

REFERRING VET

Dr. Pablo Mendoza

INVOICE

10983

DATE

12/18/2025

PRESENTING CLINICAL SIGNS

Chief Concern / Reason for Ultrasound: Stage 1-2 kidney disease, stable, uncontrolled Proteinuria, r/o Renal proteinuria Glomerular proteinuria Glomerulonephritis Renal amyloidosis Pre-renal proteinuria Overload/overflow due to pre-glomerular proteinuria Systemic hypertension Post-renal proteinuria Inflammation or infection in the upper or lower urinary tract (or reproductive tract in voided specimens, Neoplasia . Relevant Medical History and Physical Exam Findings: P is doing okay per O, no clinical signs that can be concerning, may intermittent decreased appetite.

Abnormal PE/Chem/CBC/UA Results: Recent Diagnostics: Relevant Laboratory Results / Abnormalities: CLP on 12/15/2025: Mild elevation of SDMA, BUN and Creatinine values are high normal. otherwise unremarkable. High Proteinuria:1.1 Low USG:10.14 Current medications (include full name, dosage, and frequency): Enalapril Tablets 10mg:Please give 1.5 tablet(s) by mouth every 12 hours. Recently switched P to: Telmisartan 20mg tablet- 1/2 tab by mouth SID Hill's Kidney diet.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.87 cm). The cortex is of increased echogenicity with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.74 cm). The cortex is of increased echogenicity with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.75 cm at the cranial pole and 0.47 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.46 cm at the cranial pole and 0.62 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (1.64 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a very small hypoechoic nodule visualized in the parenchyma measuring 0.27 cm.

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The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild gas and fluid. The majority of the gastric wall appears normal measuring at 029 cm, with intact wall layering. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. In the region of the cardia there is evidence of focal gastric wall thickening, primarily appearing to involve the mucosal layer. Layering appears largely intact but is reduced in detail. Some measurements are up to 0.99 cm in thickness with significant mucosal folding in the region.

The visualized areas of duodenum (0.59 cm), jejunum (0.41 cm) and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed

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.

Pancreas

The pancreas is hyperechoic and mottled in both limbs. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. A mesenteric lymph node is visualized measuring 0.53 cm.The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

Other

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

- Small, hypoechoic nodule in the spleen. There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

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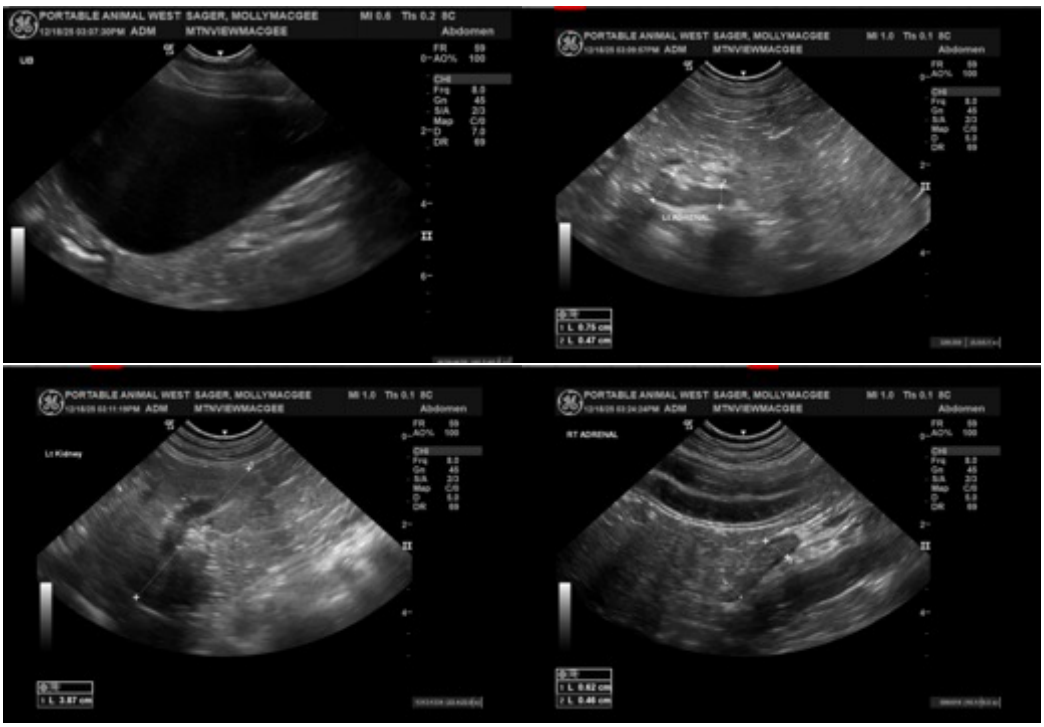
- Mildly hyperechoic, mottled pancreas. Findings are most consistent with chronic pancreatic remodeling. Correlate with PLI level. Chronic mild pancreatitis is possible.
- Gastric wall thickening in the cardia region of the stomach. Findings could be consistent with hyperplasia/gastritis or early neoplastic change or imaging artifact (prominent mucosal folding.)
- Mildly thickened small intestine. Findings are most consistent with mild inflammatory change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys have changes consistent with chronic renal disease. This could be congenital or acquired secondary to renal injury earlier in life. Recommend a blood pressure and a urine culture as a baseline (if not already done) and continued evaluation/treatment for proteinuria.

The stomach wall appears slightly thickened and irregular in the cardia region, adjacent to the esophageal inlet. The significance of this is uncertain, particularly in the absence of current gastrointestinal symptoms (would expect vomiting, regurgitation, inappetence, etc.) These changes can be seen sometimes with protein pump inhibitors. If this patient is on this medication, it should be discontinued and re-evaluated. Options moving forward would include repeat evaluation in 6 – 8 weeks or upper GI endoscopy with the intent to further evaluate and potentially obtain biopsies from the region.

If an underlying enteropathy is strongly suspected, you could consider a GI Panel to Texas A&M for a qualitative PLI/TLI, cobalamin, and folate to further evaluate and if values are supportive of a chronic enteropathy, further evaluation may be warranted.



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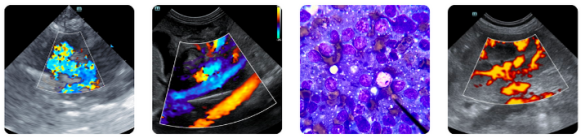

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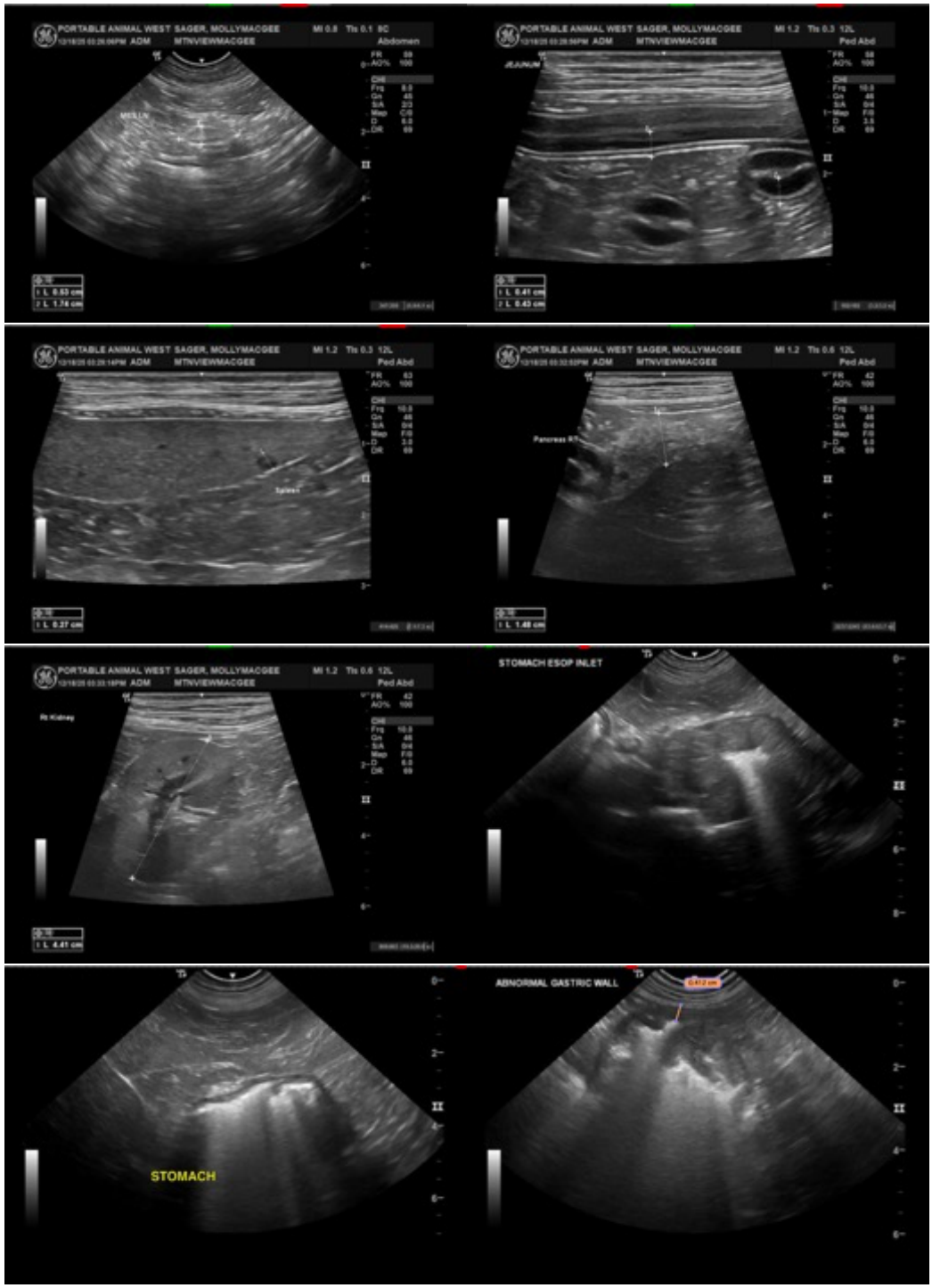

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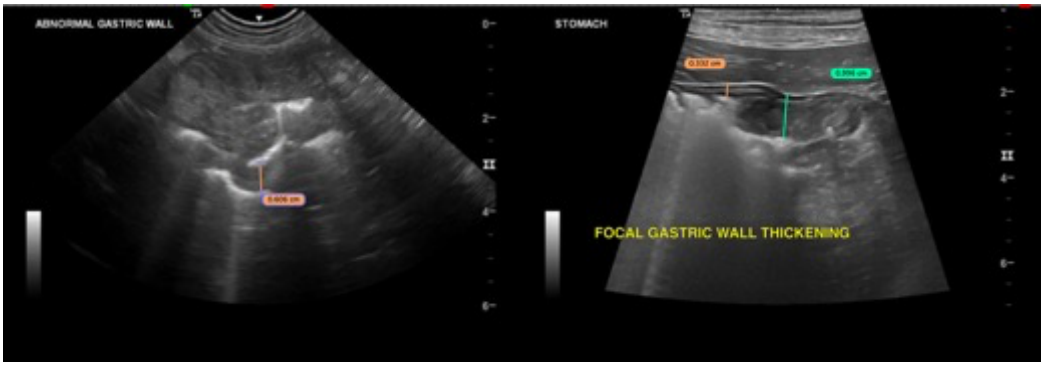

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com