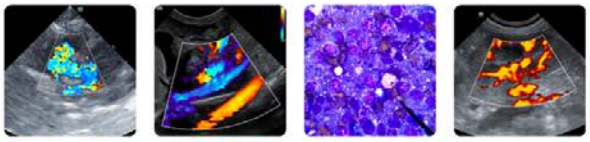


PATIENT

Lilo Nichols

SPECIES

Canine

BREED

Boston Terrier

SEX

Spayed Female

AGE

12 Years

WEIGHT

18 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jack Reese

HOSPITAL NAME

Willow Run Veterinary Clinic

REFERRING VET

Jessica Latham, VMD

INVOICE

74018

DATE

3/25/26

PRESENTING CLINICAL SIGNS

Several month history of progressive weight loss. PU/PD. Hematuria, mild proteinuria. Imaging recommended to help r/o bladder neoplasia, other causes of lower urinary symptoms to aide in management of suspected kidney disease in addition to ruling out other causes for unexpected weight loss.

Abnormal PE/Chem/CBC/UA Results: Free catch urine sample: Isosthenuria (1.013) Hematuria (3+) Proteinuria (2+) UPC 1.0 IDEXX SDMA 18 (0 - 14 µg/dL) BUN 72 (7 - 27 mg/dL) ALT 139 (10 - 125 U/L) Urine culture pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears normal with no evidence of wall thickening. The region of the trigone has no evidence of overt masses or calculi. The urethra is not clearly visualized.

The left kidney has a normal shape and size (5.16 cm). The cortex is increased in echogenicity, with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There are numerous small cortical cysts visualized. 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 (4.86 cm). The cortex is increased in echogenicity, with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There are numerous small cortical cysts visualized. 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 large, measuring 0.70 cm at the cranial pole and 0.81 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.

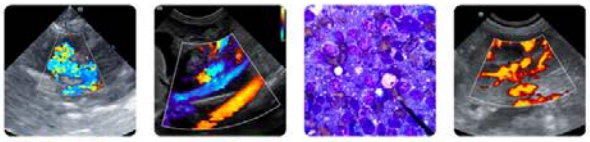
The right adrenal gland is large, measuring 1.01 cm at the cranial pole and 0.77 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (1.28 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

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



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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains moderate fluid/shadowing ingesta. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum 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. Duodenum wall measures 0.36 cm. Jejunum wall measures 0.40 cm. Visualized peristalsis appears appropriate. The small intestine subjectively appears mildly thickened with some areas exhibiting mild mucosal speckling.

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 prominent and mottled compared to the surrounding isoechoic mesentery. 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. 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.

PRIMARY FINDINGS

- Bilateral adrenomegaly – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.
- Bilateral renal changes most consistent with chronic renal disease.
- Prominent, mottled pancreas most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.
- Mildly prominent/thickened small intestine with areas exhibiting mild mucosal speckling – Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.

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SECONDARY FINDINGS

- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

- Fluid/ingesta distended stomach – Correlate with feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying or a partial outflow tract obstruction (none observed).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

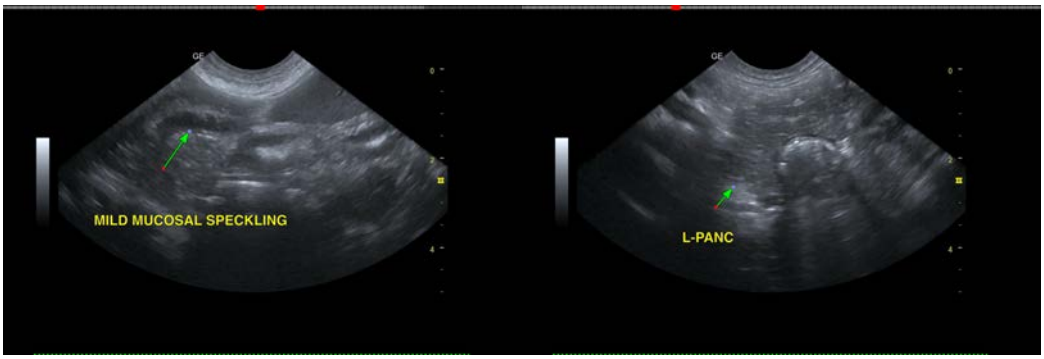
Both adrenals are large, and the liver is large and subjectively heterogeneous. These changes could be consistent with pituitary dependent Cushing's if appropriate symptoms are present. You could consider adrenal function testing if clinically appropriate.

Both kidneys have changes consistent with chronic renal disease. Recommend a blood pressure, urinalysis and culture as a baseline +/- urine protein to creatinine ratio.

No focal lesions were visualized associated with the urinary bladder. The urethra is not clearly visualized. Correlate with a digital rectal exam to see if you can palpate any thickening or irregularity in the region of the urethra.

The pancreas is prominent in both limbs, but overt inflammation is not observed. Correlate with PLI level. If this is significantly elevated, recommend treatment for chronic pancreatitis.

There is some mild mucosal speckling visualized associated with the small intestine. This could contribute to weight loss, particularly if there is a history of soft stool, GI signs, etc. Initially you could start with a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate. If the B12 is low, this could be an indicator of underlying gastrointestinal disease and further evaluation may be warranted (combination hydrolyzed protein/ultra low-fat diet, probiotic therapy, etc.).



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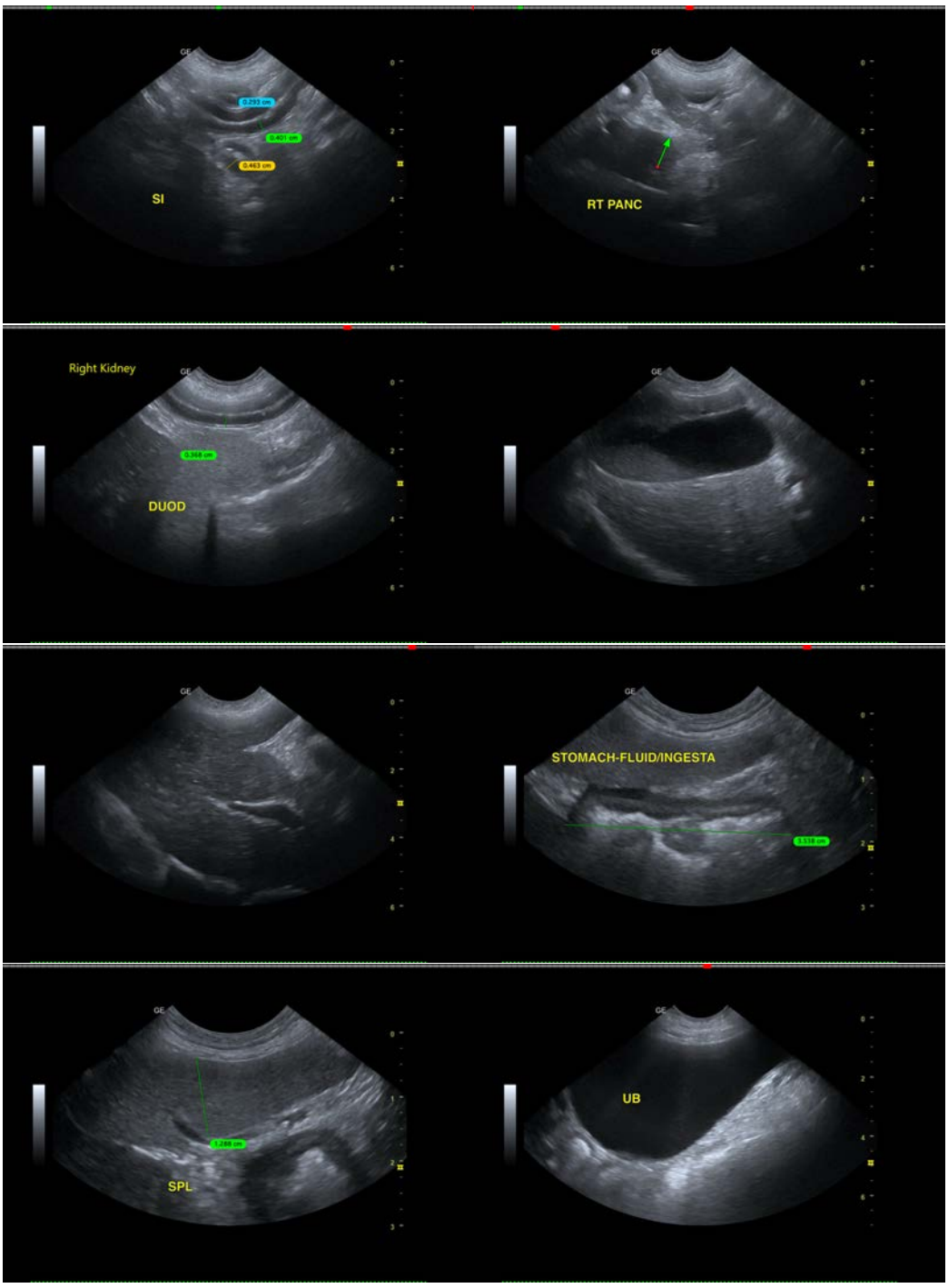

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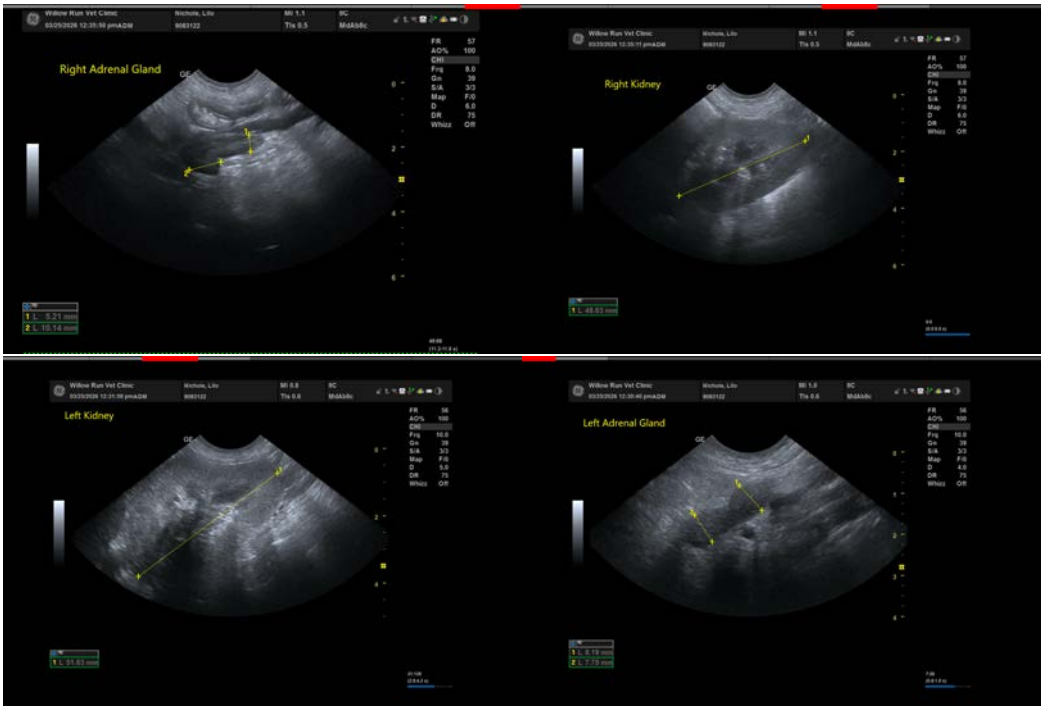

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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