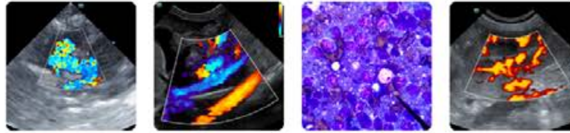


DATE

5/12/26

PATIENT

Chino Anderson

SPECIES

Canine

BREED

Spitz x

SEX

Neutered Male

AGE

1/1/16

WEIGHT

15 lbs

INTERPRETED BY

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

HOSPITAL NAME

Chadwell Animal Hospital

REFERRING VET

Dr. Schaupp

INVOICE

75085

PRESENTING CLINICAL SIGNS

Patient History: Hematuria, recent labs reveal kidney dz with much loss of protein. Hx of severe anxiety and pica. PE : many teeth missing, medial luxating patella right stifle G II

Current Medications: Azodyl - 2 caps PO QD (recently dispensed), Naraquin - 1 cap PO QD (recent), K/D diet Gabapentin for anxiety - 50 mg QD, Trazadone for anxiety 50 mg 1/4 tab PO PRN up to BID
Labwork Results: Attached, reported as: Creatinine 2.2, BUN 88, SDMA 19, Phos 8.2, Albumin 1.7, Hct - 50%, platelets 57K (suspected due to clumping). UPCR >3.94. UA - quiet sediment except for elevated RBCs. Radiograph (lat abd) - no radiopaque or mineralization seen in bladder or kidneys.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

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 prostate is somewhat prominent, measuring 1.19 cm in height in the sagittal view.

The left kidney has a normal shape and size (5.03 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 (5.0 cm) with a small mineralization. Overall echogenicity is slightly hyperechoic 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.52 cm at the cranial pole and 0.42 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 0.53 cm at the cranial pole and 0.51 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 (1.44 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 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. There is a moderate amount of non-organized echogenic debris. Some debris appears adhered to the gallbladder wall. Galblladder wall measures at 0.1 cm in thickness. The cystic and common bile ducts are normal/not visible.

Gastrointestinal
The stomach contains minimal luminal contents. It measures at a normal thickness of 0.24 cm 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 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. Duodenum wall measures 0.41 cm. Jejunum wall measures 0.33 cm. 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. Descending colon wall appears slightly prominent with intact wall layering, measuring at 0.19 cm.

Pancreas
The pancreas is normal and isoechoic to surrounding 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. No significant lymphadenopathy. There is mildly reactive mesentery in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Age related changes visualized associated with both kidneys.

- Prominent prostate – This is likely normal for a patient neutered after puberty. Correlate with age of neutering. If the patient was neutered prior to puberty, a fine needle aspirate may be warranted.

- 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.

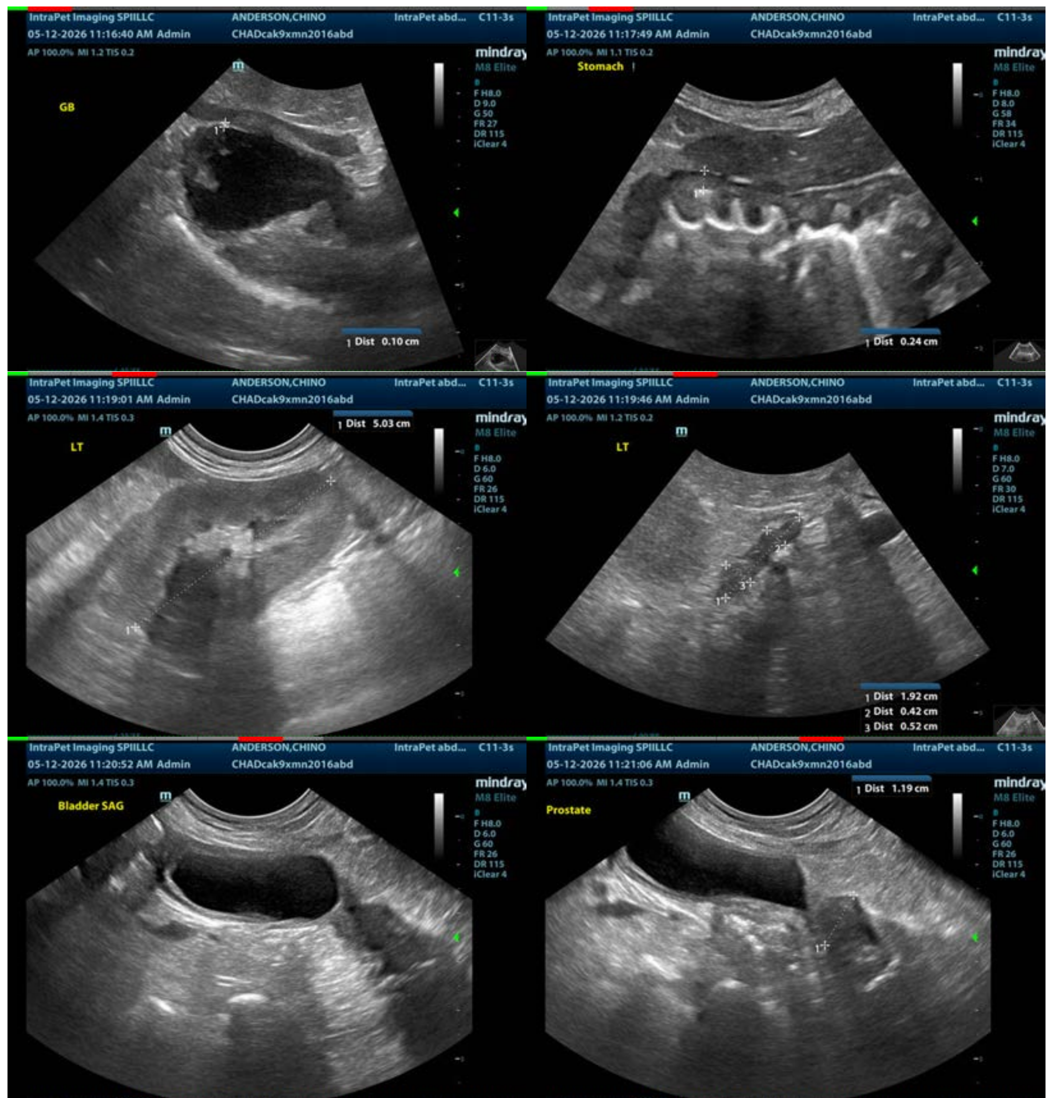
- Mildly prominent/thickened descending colon wall – Findings could be consistent with mild colitis.

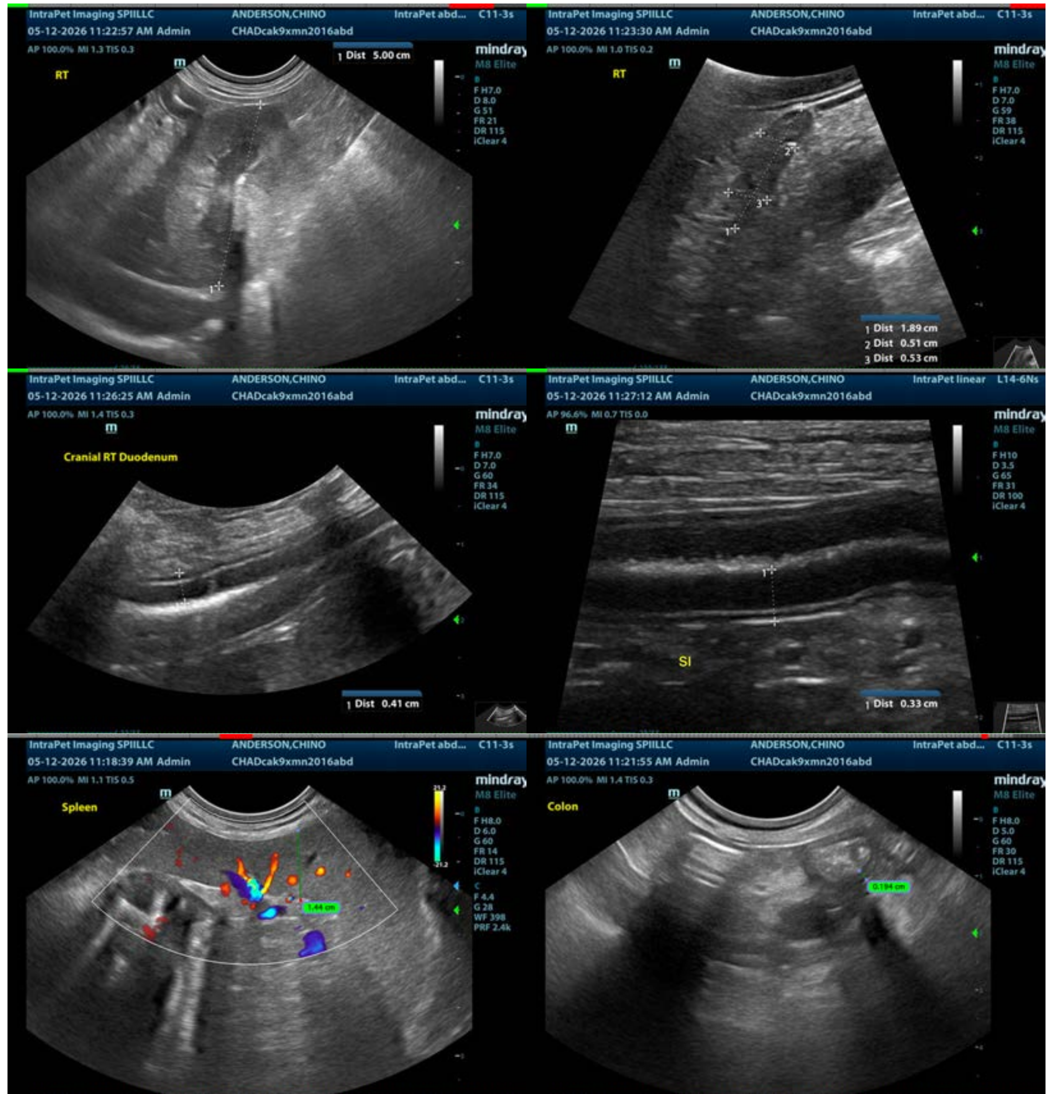
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed on today's scan are relatively mild as compared to the biochemical changes. Recommend a blood pressure and a urine culture to further evaluate. Further evaluation for a protein losing enteropathy/glomerulonephritis is likely warranted. This could include vector borne disease testing, thoracic

radiographs, etc., looking for evidence of any concurrent/complicating disease processes. Recommend reevaluation of urine protein to creatinine ratio on a pooled sample collected over the day (three separate samples collected at home and brought into the clinic) to establish your baseline prior to initiating medical therapy.

Albumin levels are low. This is likely secondary to the proteinuria, but there could be concurrent loss from other locations. Consider pre- and post-prandial bile acids to assess for any liver dysfunction, and possibly a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to evaluate for possible concurrent gastrointestinal disease.





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.

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