



PATIENT

Chewie Chapman

SPECIES

Canine

BREED

Dachshund Mix

SEX

MN

AGE

10 years

WEIGHT

11.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Danielle Shemanski

HOSPITAL NAME

Western New York
Veterinary Services

REFERRING VET

Dr. Brenda Lefler

INVOICE

12054

DATE

6/2/2026

PRESENTING CLINICAL SIGNS

The patient presented on May 22nd at the RDVM due to shaking, decreased appetite, decreased defecation, and vomiting once. Patient history includes persistent fever and lethargy. PE at the RDVM included mild dehydration, fever (103.8), revealed hypoalbuminemia, acting painful during radiology positioning, but no pain during exam. Abdominal rads include possible renal/bladder mineral opacity and renomegaly on radiographs, requiring further evaluation of the urinary tract and abdomen. Diagnostics revealed hypoalbuminemia, urinary abnormalities, and possible renal/bladder mineral opacity with suspected renomegaly on radiographs.

MEDICATIONS: Carprofen 25 mg: 1/2 tab PO BID, Doxycycline 50 mg: 1 tab PO SID.

Abnormal PE/Chem/CBC/UA Results: 5/27/2026 UA: Blood /Hgb 4+ Ery/μL Unclassified crystals <1/HPF 5/22/2026 CBC RDW 22.2 % H WBC 18.40 K/μL H Neutrophils 15.17 K/μL H Blood chem: Creatinine 0.4 mg/dL L BUN 3 mg/dL L Albumin 1.8 g/dL AST 74 U/L H Radiology notes: Lat abd: Stool present in descending colon, possible mineralization in kidney, possible mineralization in bladder, gas in stomach, no signs of fluid in the abdomen.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears mildly diffusely thickened and irregular particularly in the apical region measuring at 0.47 cm. In the dependent portion of the urinary bladder there is shadowing, hyperechoic debris most consistent with sandy mineralized debris/small stones. The region of the trigone, ureteral papillae and visible urethra appear free of any mass lesions or calculi.

The prostate is normal in size (0.77 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (5.21 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is mineralized sandy debris/small stones visualized in the region of the pelvic and calyces. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.47 cm). Overall echogenicity is normal with adequate 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 0.49 cm at the cranial pole and 0.58 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 0.57 cm at the cranial and 0.46 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal



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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 (1.5 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. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively large/normal in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed. The significance of this is uncertain in the absence of liver enzyme elevations.

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 of the debris appears to be extending into the cystic duct. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with gas, fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. Full evaluation of the stomach is somewhat hindered by gas interference and some shadowing ingesta. No evidence of an obstruction is visualized.

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. The duodenum measured as normal (0.47 cm in wall thickness) and the jejunum measured as normal (0.3 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. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

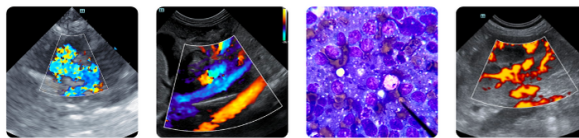
The area of the pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, 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.

ULTRASONOGRAPHIC FINDINGS

- Thickened irregular urinary bladder wall with mild mineralized/sandy debris/small stones.
- Sandy/mineralized debris visualized associated with the left kidney.



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- Subjectively hyperechoic liver. The diffuse hepatic changes are non-specific and can be seen with vacuolar hepatopathy, reactive change, nodular hyperplasia or, less likely, inflammatory/immune-mediated disease, infiltrative neoplasia, or other hepatopathy.
- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is some mineralization and sandy debris visualized in the urinary bladder and the left kidney. This is likely associated with the hematuria reported. There is no overt evidence of pyelonephritis, although a urine culture and possible empirical treatment could be considered.

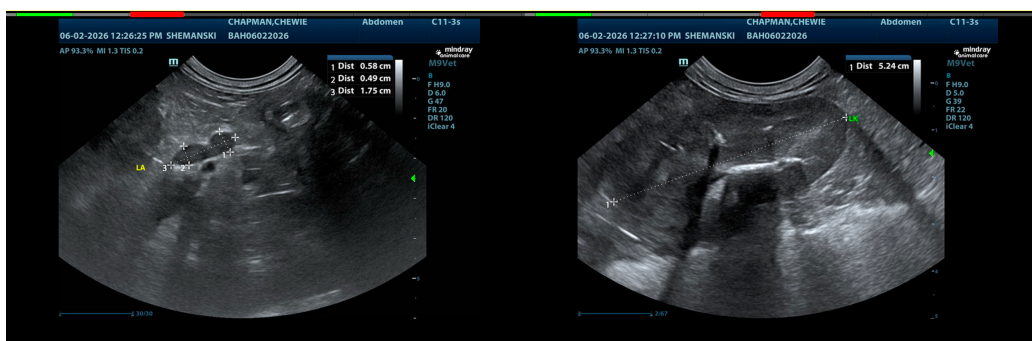
A definitive cause for the fever and low albumin is not visualized. Consider pre- and post-prandial bile acids to assess liver function, +/- a urine protein:creatinine ratio.

Finally, a GI Panel to Texas A&M for a qualitative PLI/TLI, cobalamin, and folate looking for evidence of underlying gastrointestinal disease. Use caution with the use of non-steroidal anti-inflammatories as renal disease and/or GI disease is possible, and this has the potential to be masking the fever. Additionally, consider the possibility that the fever was secondary to a pain response (back pain, passing a stone, etc. but the low albumin levels are concerning.

No significant lesions are visualized associated with the GI tract. The stomach was somewhat hard to visualize due to some intraluminal gas. A small unseen focal GI lesion cannot be ruled out.

If symptoms are persistent and an identifying cause is not identified, consider repeat imaging in the future looking for the development of new lesions or the progression of today's lesions.

Consider three view thoracic radiographs looking for any evidence of pneumonia or similar as a source for the fever reported.





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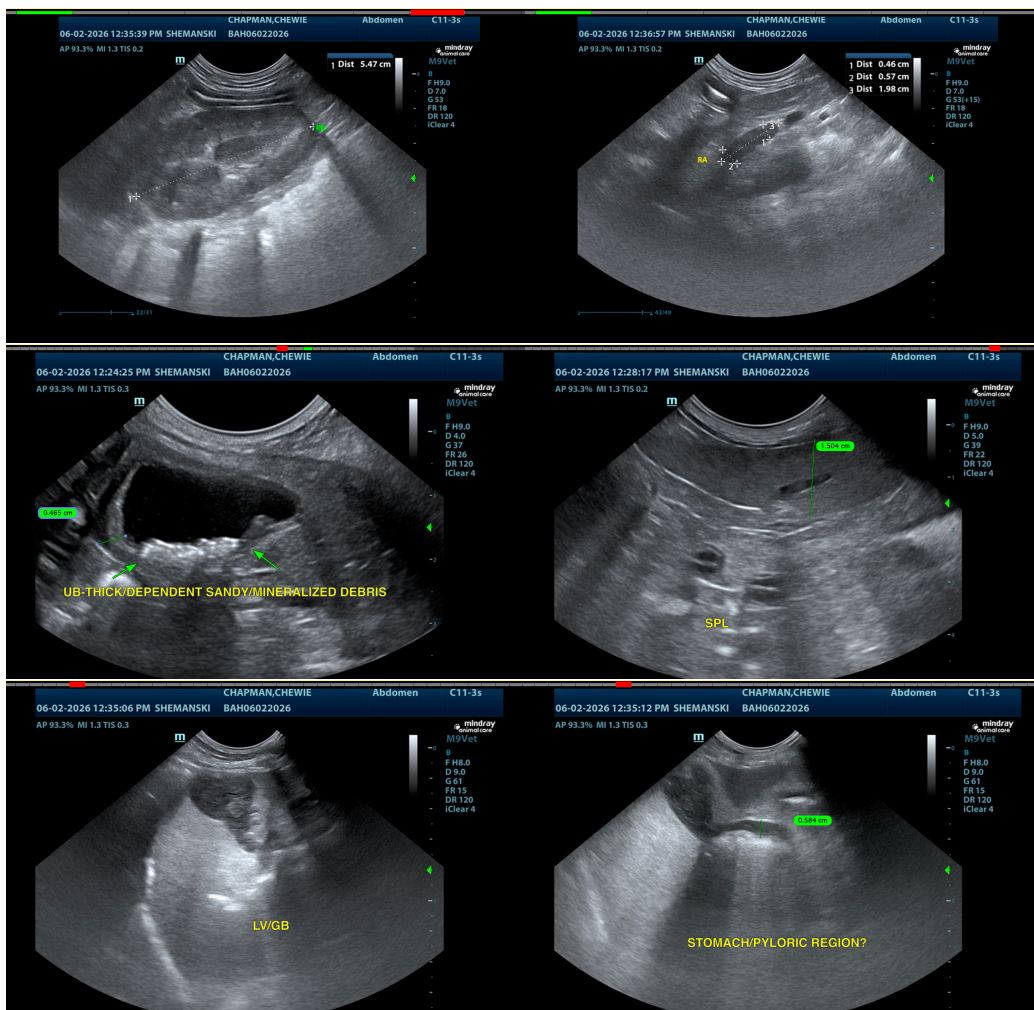
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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