



## PATIENT

Zoey Meehan

## SPECIES

Canine

## BREED

Labrador Mix

## SEX

Spayed Female

## AGE

4 Years

## WEIGHT

106 pounds

## INTERPRETED BY

R. McKenzie Daniel,  
DVM, DABVP

## IMAGING PERFORMED BY

Emilia Monachino

## HOSPITAL NAME

Finger Lakes Animal  
Hospital- Vetcor

## REFERRING VET

Dr. Denise Kurtz

## INVOICE

12197

## DATE

11/11/25

## PRESENTING CLINICAL SIGNS

Jan 2024 episode of pancreatitis and developed chronic diarrhea. Has chronic obesity, arthritis and recurrent perivulvar dermatitis. On prescription low fat diet and chronic tylosin. 10/14/25 Wellness exam - decreased mobility, labwork performed to assess prior to starting NSAID therapy. Mild azotemia and bacterial cystitis found. Treated with 10 day course of Cefpodoxime. Recheck on 10/29 showed resolution of bacterial cystitis but azotemia still evident. Proteinuria confirmed with elevated UPC. Patient is up to date on lyme and leptospirosis vaccination. Recently exhibiting pollakiuria at home. Transitioned to Hills Multi-organ diet and initiated therapy with Welactin, Enalapril and Clopidogrel. Concern for glomerulonephritis.

Abnormal PE/Chem/CBC/UA Results: 10/14/25 - 4dx neg x 4; CBC - WNL; T4 1.9 - WNL; Chemistry - Glucose 123 (63 - 114); SDMA 13 (0 - 14) ; CREA 1.9 (0.5 - 1.5); BUN 66 (9 - 31); ALK P 393 (5 - 160); Potassium 3.9 (4.0 - 5.4); Na:K Ratio 38 (28 - 37); no hemolysis, no lipemia, remainder of panel WNL; Spec cPL 326 (0 - 200); fecal negative; UA - Specific Gravity 1.014 (1.030 - 1.098), pH 5.5 (6.0 - 7.5), marked pyuria, marked rods + cocci bacteria present on sediment, no RBCs. 10/29/25 recheck - CBC - WNL; Chemistry - CREA 1.7 (0.5 - 1.5), BUN 68 (9 - 31); rest of panel is WNL/NSF. UA - 1.015, 2+ proteinuria, pyuria and bacteriuria resolved. UPC = 1.8. 11/11/25 Average BP= 180/89 but patient is extremely fearful and did not receive enalapril today. UA with reflex urine culture submitted today.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

No evidence of pathology in the area of the uterine remnant.

The visualized medial iliac lymph nodes were sonographically normal without inflammatory or neoplastic criteria.

The kidneys exhibited adequate size with asymmetrical margination. Marked to variable thickened hyperechoic cortex with marked indistinct corticomedullary border demarcation and reduced medullary volume. Increased concurrent medullary echogenicity and bilateral mild pyelectasia was present with probable cortical infarcts and minor to focal medullary mineral. The left kidney measured 7.0 cm in length. The right kidney measured 6.9 cm in length.

### Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.49 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.56 cm width at the caudal pole.

### Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

## Liver

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The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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## Gastrointestinal

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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Normal visible colon wall layers were present with semi formed fecal matter in lumen.

## Pancreas

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The pancreas was normal in size and mild capsule asymmetry with isoechoic mildly heterogeneous remodeled parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

## Free Abdomen

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A solitary mid abdomen mildly prominent mesenteric lymph node was present (considered incidental). The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation or neoplastic criteria and maintaining a normal width: length ratio (<0.5).

## ULTRASONOGRAPHIC FINDINGS

## IMAGING PERFORMED BY

Emilia Monachino

- Bilateral chronic nephropathy exhibiting asymmetrical margination, markedly thickened cortex, probable cortical infarcts and mild pyelectasia.
- Normal bilateral adrenal glands.
- Sonographically normal urinary bladder and visible proximal urethra.
- Mild pancreatic remodeling.
- Sonographically normal liver and gallbladder- consistent with mild benign hepatopathy.

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The bilateral kidneys exhibited significant chronic changes not overtly representative of current azotemia. Bilateral chronic nonspecific nephritis i.e. glomerulonephritis, pyelonephritis, interstitial nephritis or other with potential combined renal dysplasia given the patient's age possible. No evidence of renal neoplastic criteria. Correlation with pending urinary work up with serial monitoring of UPC and systemic BP with PLN therapy indicated if evidence of persistent proteinuria with concurrent azotemia. UTI protocol is indicated if positive urine culture and sensitivity. Renal biopsy is required for a definitive diagnosis. Essential CKD therapy with monitoring is indicated. A GI panel to include PLI, TLI, cobalamin and folate to correlate with historical gastrointestinal signs and potential concurrent chronic pancreatitis is recommended. Suspect guarded long term renal prognosis given renal presentation.

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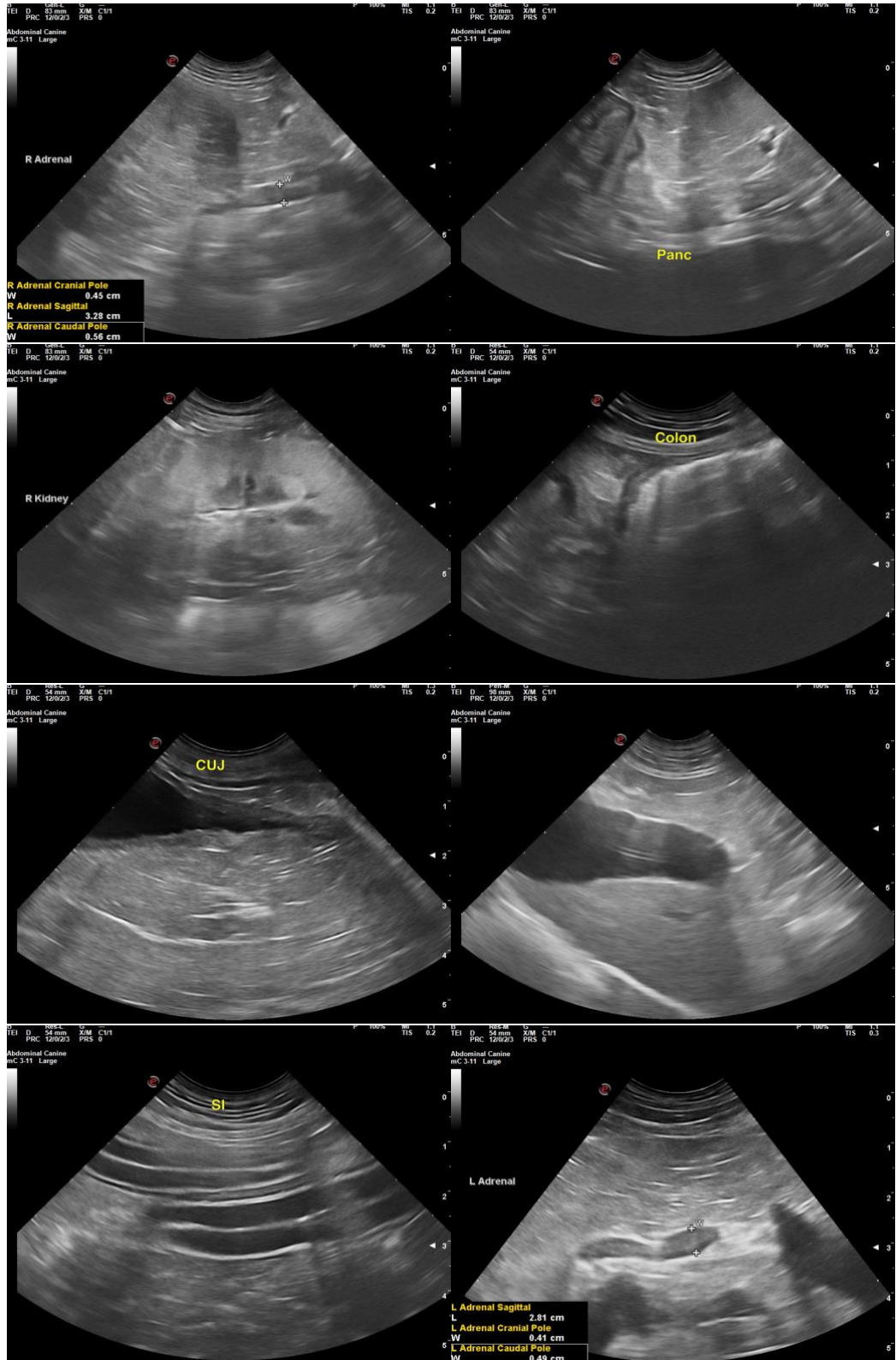
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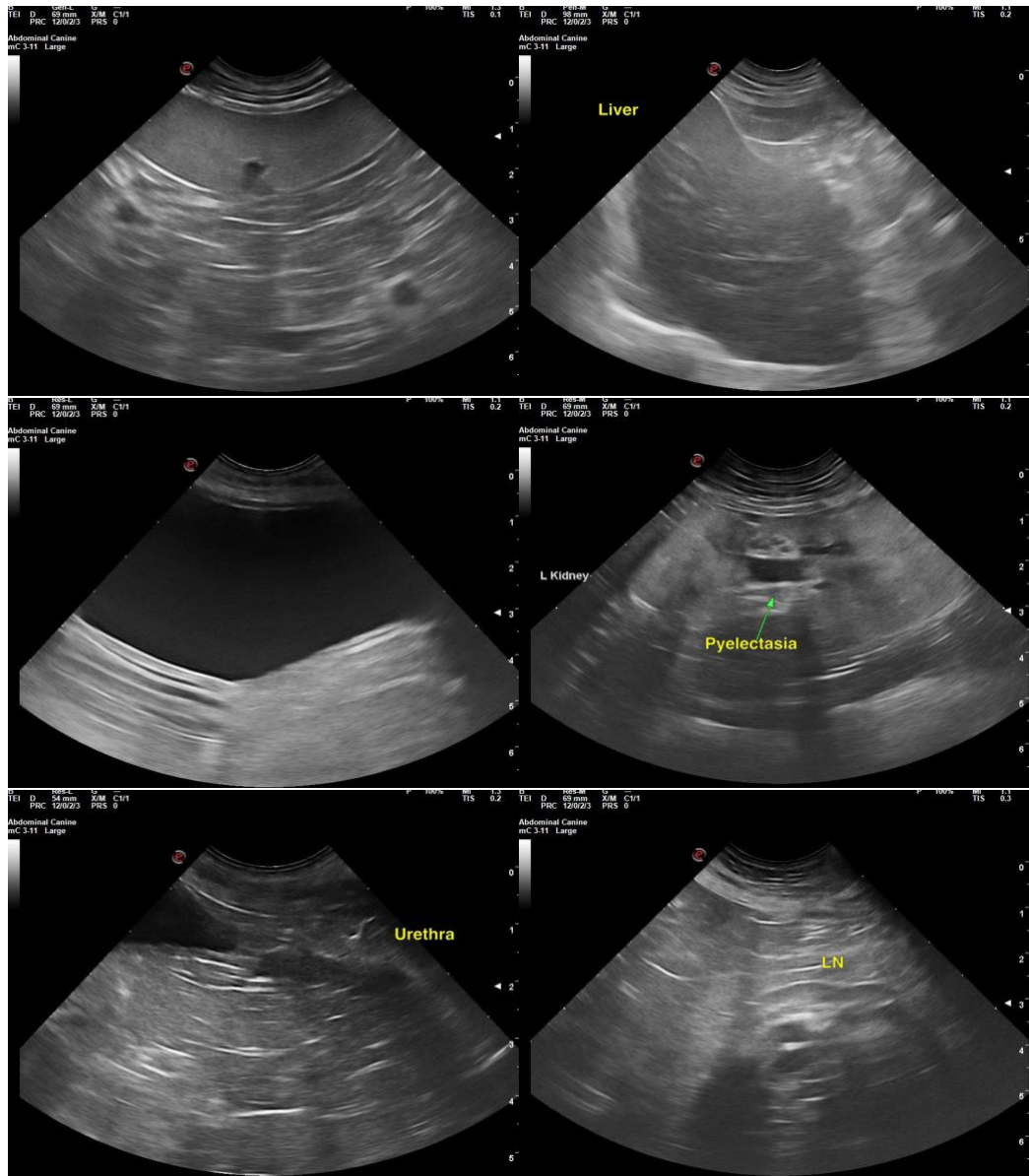
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

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