



PATIENT

Eva Curry

SPECIES

Canine

BREED

Schnauzer

SEX

Female

AGE

13 years

WEIGHT

11.31 kgs

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)

IMAGING PERFORMED BY

Craig Seyler

HOSPITAL NAME

Wilvet South

REFERRING VET

Craig Seyler

INVOICE

12873

DATE

12/3/25

PRESENTING CLINICAL SIGNS

History: Eva is a 13yo SF Standard Schnauzer. She presented to her RDVM for vomiting yesterday. The lab work was sent out and today was found to be: CRE 3.0, BUN 193 (H), Phos 9.7 (H), Ca 12.7 (H), Cl 104 (L), ALT 186 (H), ALP 739 (H), Lipase 1171 (H). UA - USG 1.016, pH 5.5, protein 2+, no bacteria or RBC/WBC seen. Inactive sediment. She is known to have chronic renal dysfunction and has been managed by a specialist facility in Vegas.

She had lab work run on November 19th, 2025: CBC - Hct 39%, mchc slightly low. mcv upper normal. Chem - BUN 85, CRE 1.3, CA 12.1, ALT 188, ALP 726. UA - USG 1.018, inactive sediment, prot 2+ Given the relative increase in BUN compared to CRE I asked if Eva has any history of GI disease. She said no chronic GI issues.

Labs run today: EPOC - pO2 55 (H), pH 7.35 (L), Ca 1.23 (normal, 1.13-1.42). Bun >120, CRE 3.24. - BP taken today: 148/69 MAP 130

Meds: currently on telmisartan for hypertension from her renal disease.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment, urine mineral or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The area of the aortic trifurcation was free of pathology.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Intermittent small cortical cysts, areas of medullary mineral and mild pyelectasia. Chronic changes in pyelectasia slightly more prominent in the right kidney compared to the left. The left kidney measured 6.7 cm in length. The right kidney measured 6.0 cm in length.

Adrenal Glands

The left adrenal gland was borderline prominent in size with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.62 cm width at the caudal pole. The right adrenal gland was borderline prominent in size with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.59 cm width at the caudal pole.

Spleen

The spleen exhibited possible borderline enlargement in size with the spleen extending to approximate level of the urinary bladder. The spleen presented 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



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

Liver

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was mildly distended in size with evidence of wall edema. Gallbladder debris were primarily occupying the peripheral to mid gallbladder lumen with possible areas of entrapped peripheral lumen hypoechoic mucus. No evidence of pericholecystic inflammation. The common bile duct was not visualized.

Gastrointestinal

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. Subtle, hyperechoic mucosal speckling was present. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was normal in size and indistinct capsule compared to adjacent omentum. Heterogeneous, mildly remodeled parenchyma with no evidence of omental inflammation.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Chronic nephropathy exhibiting cortical cysts, medullary mineral and mild pyelectasia – renal changes more prominent in right kidney
- Hepatopathy
- Subjective mild splenomegaly
- Immature gallbladder mucocele
- Bilateral borderline prominent adrenal glands
- Remodeled pancreas
- Normal gastrointestinal tract with subtle, nonspecific intestinal mucosal speckling

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recheck renal staging to include screening C/S and UPC is recommended. The hepatosplenic presentation is most suggestive of benign criteria. Assuming normal clotting status and using 25-gauge needle hepatosplenic FNA cytology could be considered for further clarification. Suspect mild chronic pancreatitis and probable mild nonspecific enteritis without evidence of mechanical/metabolic gastrointestinal ileus. Hepato-gastrointestinal support and renal support indicated. The borderline prominent adrenal glands are likely incidental or patient variant given current clinical presentation.



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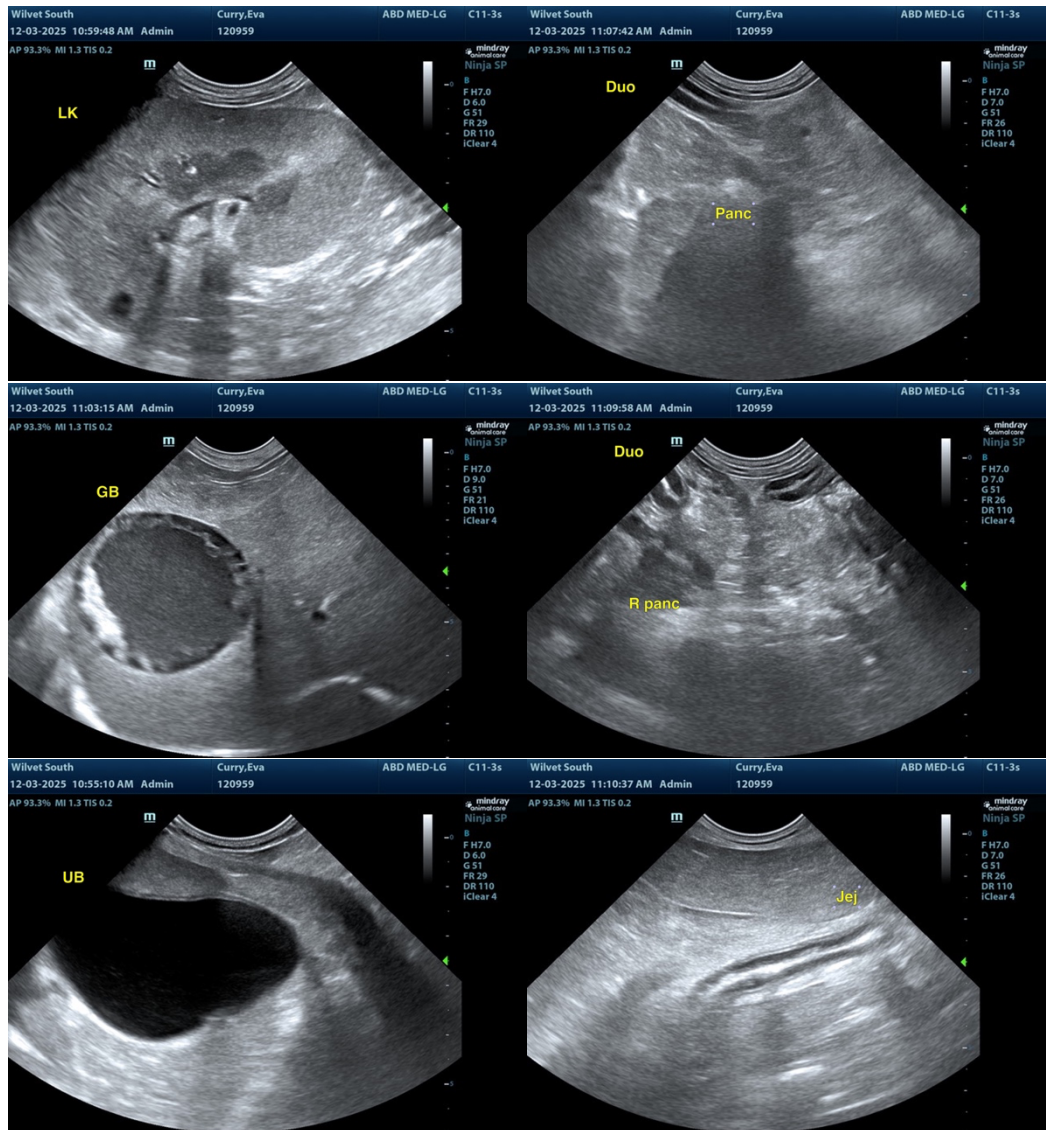
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Adrenal screening could be considered if clinical signs consistent with adrenal disease are non-reported or arise.





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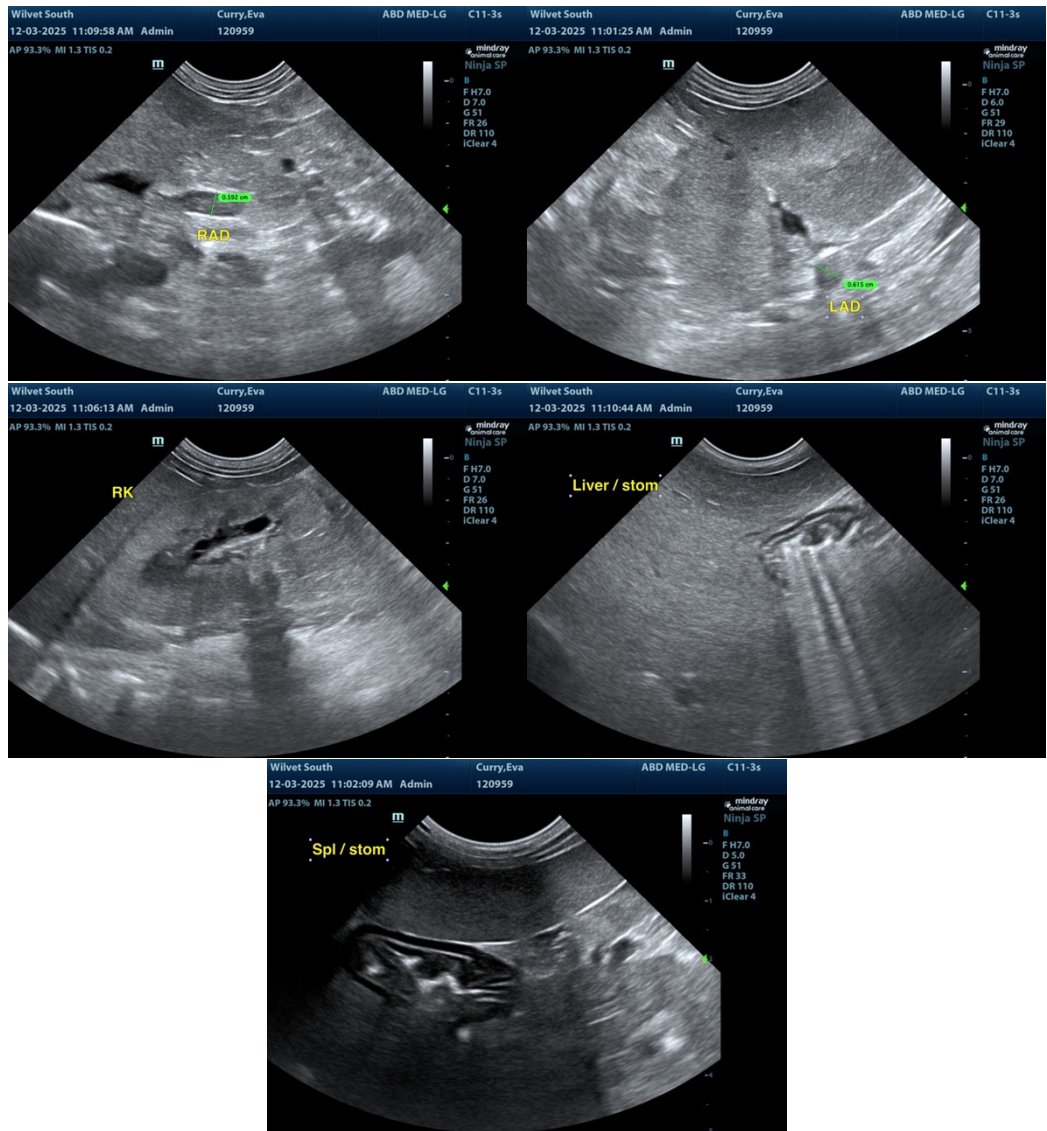
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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