

PATIENT

Jelly Sanchez

SPECIES

Canine

BREED

Toy Poodle

SEX

Spayed Female

AGE

12 Years 3 Months

WEIGHT

11.3 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Julissa Díaz DVM

HOSPITAL NAME

Centro Veterinario del
Norte

REFERRING VET

Rhemuel Varcancel
DVM

INVOICE

15542

DATE

04/28/26

PRESENTING CLINICAL SIGNS

The pet has been exhibiting loss of appetite and abdominal pain for the past 3 weeks. Blood tests were performed on April 13th on primary Vet. CBC, Chemistry: Elevated ALKP (1823) & ALT (172). 4DX: all negative. CPL: abnormal. Was hospitalized for a day. Convenia was administered on Saturday, April 25th. Previous Ultrasound was performed on 11-19-2024 due to chronic pancreatitis and chronic elevation on ALKP. The pet is being brought in for an abdominal ultrasound recheck, which was recommended by its primary veterinarian due to chronic elevation of ALKP and ALT enzymes.

The pet has been on a hydrolyzed diet and is currently eating only canned low-fat gastrointestinal food. It has not experienced vomiting or diarrhea.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder presented uniformly thickened wall isoechoic to the adjacent normal urinary bladder wall primarily visualized the cranial / apical urinary bladder. The luminal margin of the thickened urinary bladder wall was mildly asymmetrical in contour. Mild particulate urine sediment was present with no visualized current lumen mineral or calculi. The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal 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.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the right kidney. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomodullary symmetry and definition expected for the age of the patient. Nonobstructive right kidney renoliths were present with no evidence of right kidney hydronephrosis. The right kidney measured 4.8 cm in length.

The left kidney was normal in size with asymmetrical margination. Moderate hydronephrosis with echogenic fluid component and loss of overall discernable medullary parenchyma. Intact to asymmetrical nonhomogenous left renal cortex. Left kidney renoliths were visualized and visualized left hydroureter extending distally with concurrent ureteroliths. Mild left retroperitoneal inflammation and scant effusion was present. The left kidney measured 4.1 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 0.38 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 0.42 cm width at the caudal pole.

Spleen

The spleen presented normal in size and contour with primarily homogenous parenchyma. A solitary noncapsule deforming nonhomogenous hypoechoic cranial splenic nodule was present measuring 0.89 cm in diameter.

Liver & Gallbladder



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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 normal walls without evidence of edema or inflammation. The gallbladder lumen was primarily occupied by congealed to mildly organized nonmineralized debris. 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. 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 contour with heterogeneous mildly hyperechoic parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Mild cystitis pattern with urine sediment- no visualized current evidence of cystic calculi/mineral.
- Obstructive left ureterolithiasis with secondary left kidney nephrosis and suspect pyelonephritis.
- Static right kidney chronic changes with nonobstructive renolithiasis.
- Static hepatopathy- subjective benign.
- Noninflamed gallbladder mucocele.
- Static nonhomogenous remodeled pancreas.
- Previously noted static to mildly progressive cranial splenic nodule.
- Normal bilateral adrenal glands.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urine culture and sensitivity on sterile urine sample is recommended. If available, a referral for interventional procedure regarding the left ureter/kidney is recommended. The hepatopathy and cranial splenic nodule likely suggest benign criteria given similar sonographic presentation compared to the previous study.

Further assessment may include (assuming normal clotting status and using a 25-gauge needle) hepatic parenchyma and splenic nodule FNA cytology. Hepatosupportive medications including Denamarin and ursodiol are recommended with serial monitoring for evidence of progressive hepatopathy,



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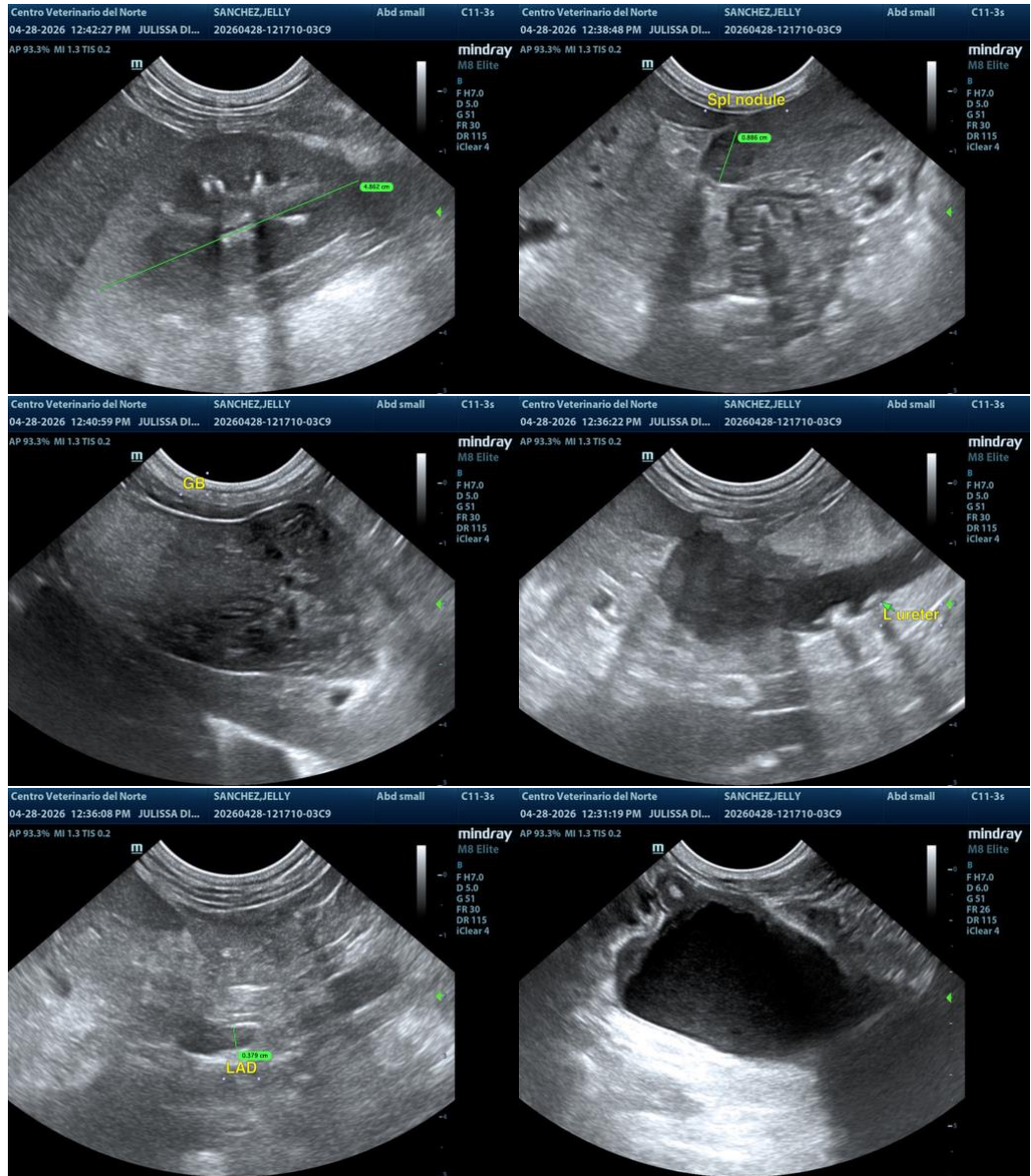
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cholestasis or cranial abdomen/subxiphoid discomfort on palpation. If noted, prophylactic cholecystectomy may be indicated.





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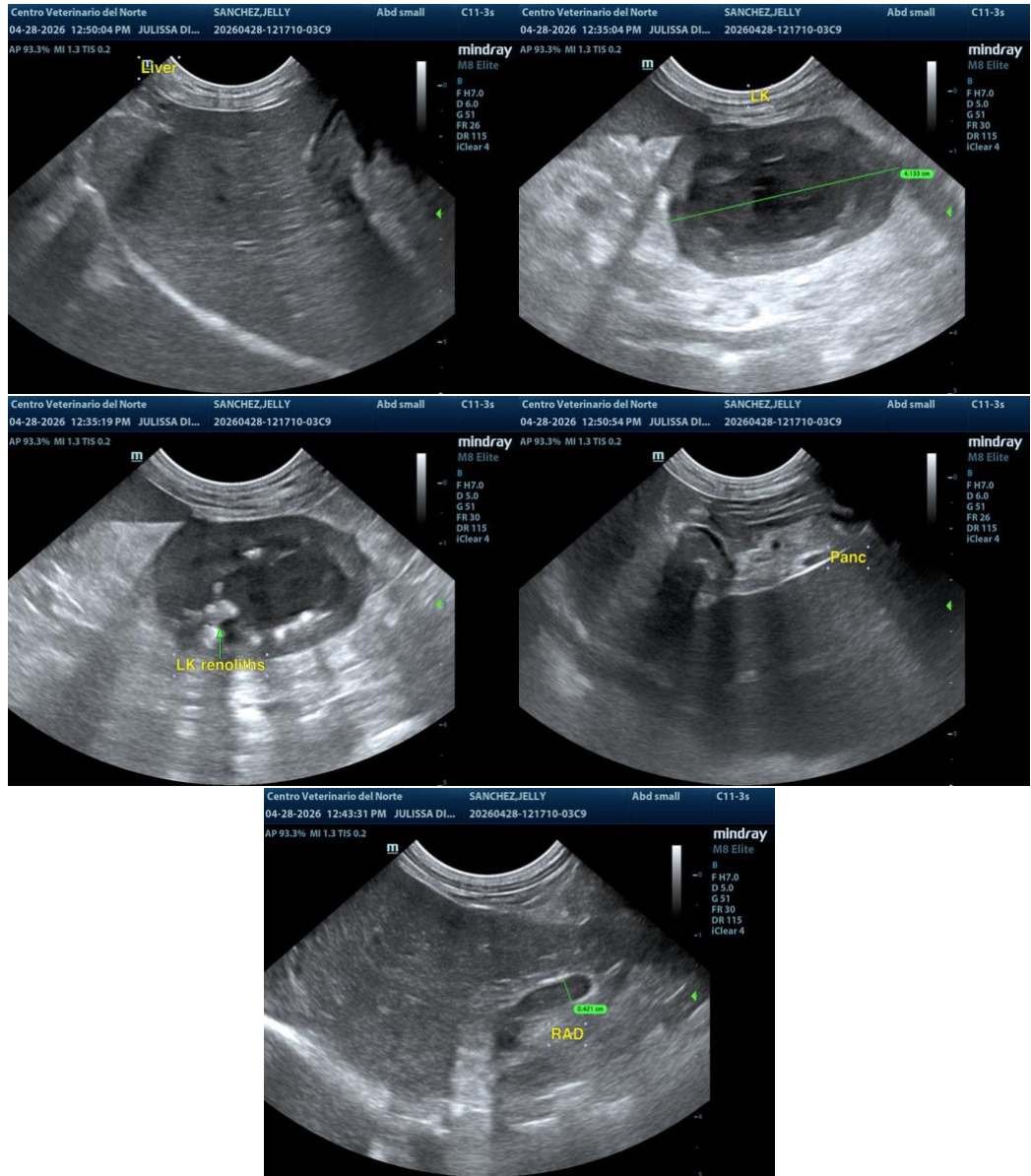
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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