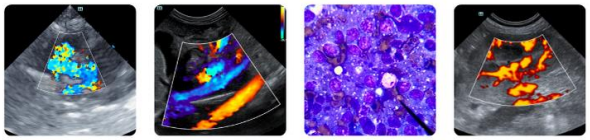


PATIENT

Effie Quintero

SPECIES

Canine

BREED

Chinese Crested Hairless

SEX

FS

AGE

14 years 9 months

WEIGHT

3.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sookhoo

HOSPITAL NAME

Calusa VC

REFERRING VET

Dr. Rodriguez

INVOICE

10772

DATE

4/8/26

PRESENTING CLINICAL SIGNS

Hospitalization for anorexia and lethargy. Presented to Calusa ER last night for decreased appetite, not wanting to drink like normal and being more lethargic. No vomiting, no diarrhea.

History of a heart murmur and on heart medications (Vetmedin 1.25mg BID, Benazapril 1.25mg PO SID, Spironolactone 25mg PO SID). History of having liver disease in 2023 (normal values currently), surgery on suspect R hip ~ 10 years ago with persistent lameness since.

Diagnostics performed last night revealed evidence of azotemia (SDMA 29 H, BUN 92 H, and Creat 2.0 H) and a UTI. Last night, patient was not been interested in food despite the addition of an appetite stimulant.

Abnormal PE/Chem/CBC/UA Results: BUN 92 mg/dL, Creat 2.0 mg/dL, SDMA 29, CPL 132

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was distended in size with normal tone. Normal urinary bladder wall was noted without evidence of inflammation or tumors. Primarily anechoic urine was present in the lumen. Particulate, mild nondependent sediment was present without evidence of mineral or calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted. The urethra exhibited normal structure and tone to a depth of 3.0 cm.

No evidence of pathology in the area of the aortic trifurcation.

Normal margination was present in the left kidney. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate to marked loss of corticomedullary border demarcation with variable echogenic corticomedullary echogenicity. The left kidney exhibited mild to moderate hydronephrosis without overt or visualized evidence of left ureter obstruction. The left kidney measured 2.9 cm in length.

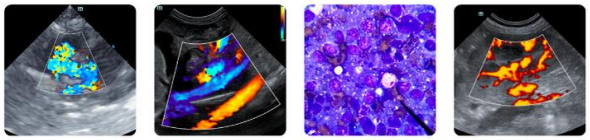
Normal margination was present in the right kidney. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of right kidney pelvic dilation was present. The right kidney measured 2.9 cm in length.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry were present without suspicion for overt neoplasia. The left adrenal gland measured 0.47 cm width at the caudal pole. The right adrenal gland measured 0.45 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 thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.



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Liver/ Gallbladder

The liver presented generalized hepatomegaly with congestive vasculature. Mild increased hepatic parenchyma echogenicity was present, exhibiting multiple, discreet, hypoechoic, intraparenchymal nodules, with an example measuring 0.71 cm diameter. The liver exhibited symmetrical yet swollen contour. The hepatic vasculature was dilated in appearance, most notable at the level of the hepatic vein / caudal vena cava junction, without evidence of thrombosis. The gallbladder was non-distended in size containing primarily anechoic content with mild to moderate, primarily gravity-dependent, nonorganized gallbladder debris. No evidence of gallbladder wall edema. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact, mildly prominent wall layering. The lumen of the stomach was empty without evidence of retained ingesta, fluid, or foreign material.

The small intestine presented intact, mildly thickened, given patient body weight, owing to propensity for mildly prominent intestinal mucosa. Segmental discreet hyperechoic mucosal speckling was present. The intestinal lumen was empty without mechanical / metabolic ileus to the level of the colon. The duodenum wall measured 0.37 cm width. The jejunum wall measured 0.33 cm width.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Distended bladder with mild urine sediment
- Bilateral chronic nephropathy exhibiting mild to moderate left kidney hydronephrosis – no overt left ureter obstruction
- Enlarged congested liver exhibiting discreet hypoechoic intraparenchymal nodules
- Nonorganized gallbladder debris (non mucocele)
- Suspect nonspecific gastroenteropathy – nonspecific or metabolic gastroenteritis secondary to renal disease, inflammatory bowel, or other with occult gastrointestinal neoplasia thought less likely
- Sonographically unremarkable area of pancreas

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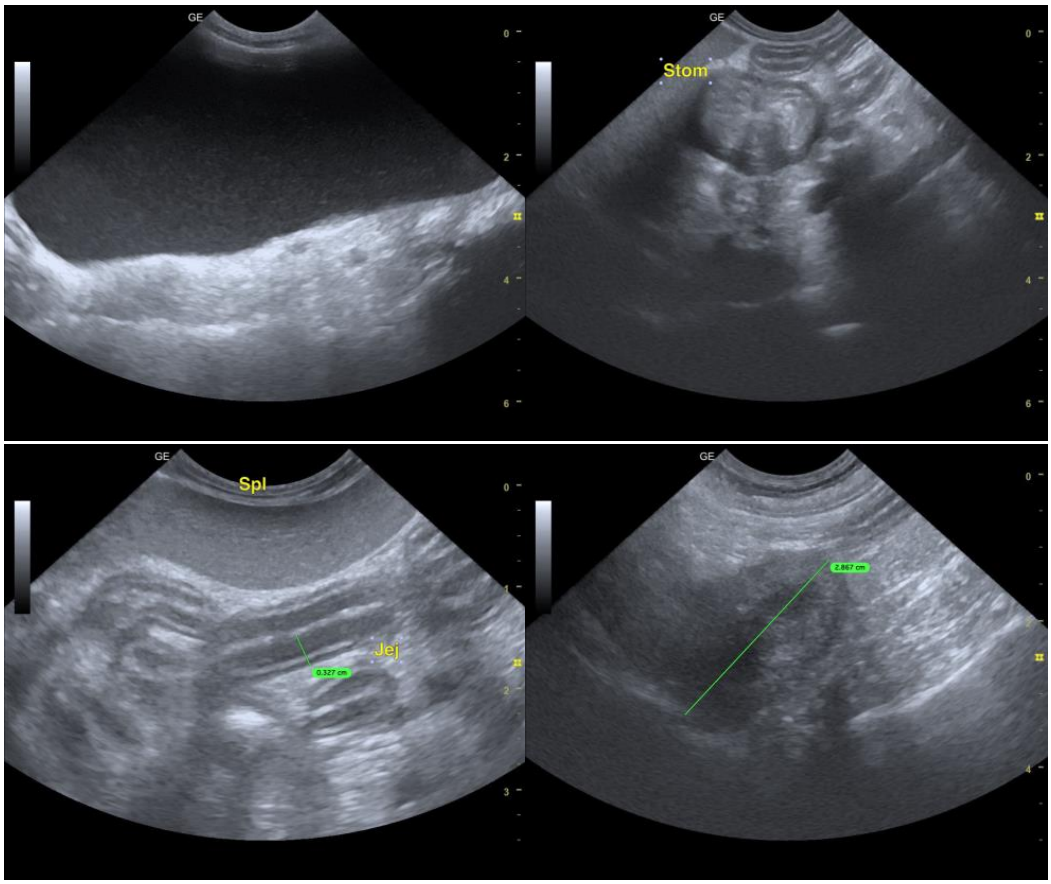
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Full urinary workup including urinalysis, C/S, and UPC level, if non-inflammatory proteinuria in conjunction with azotemia, is recommended. Mild to chronic pancreatitis may present as sonographically normal. A full GI panel to include PLI/TLI/Cobalamin/Folate may be considered. Thoracic radiographs are recommended if patient is non-sedated, given evidence of hepatic congestion. Vacuolar hepatopathy, discreet areas of hepatic hyperplasia, or hematopoiesis with potential for emerging hepatic neoplasia are possible.

Assuming normal clotting status and using a 25-gauge needle, screening hepatic FNA cytology could be considered for further assessment.



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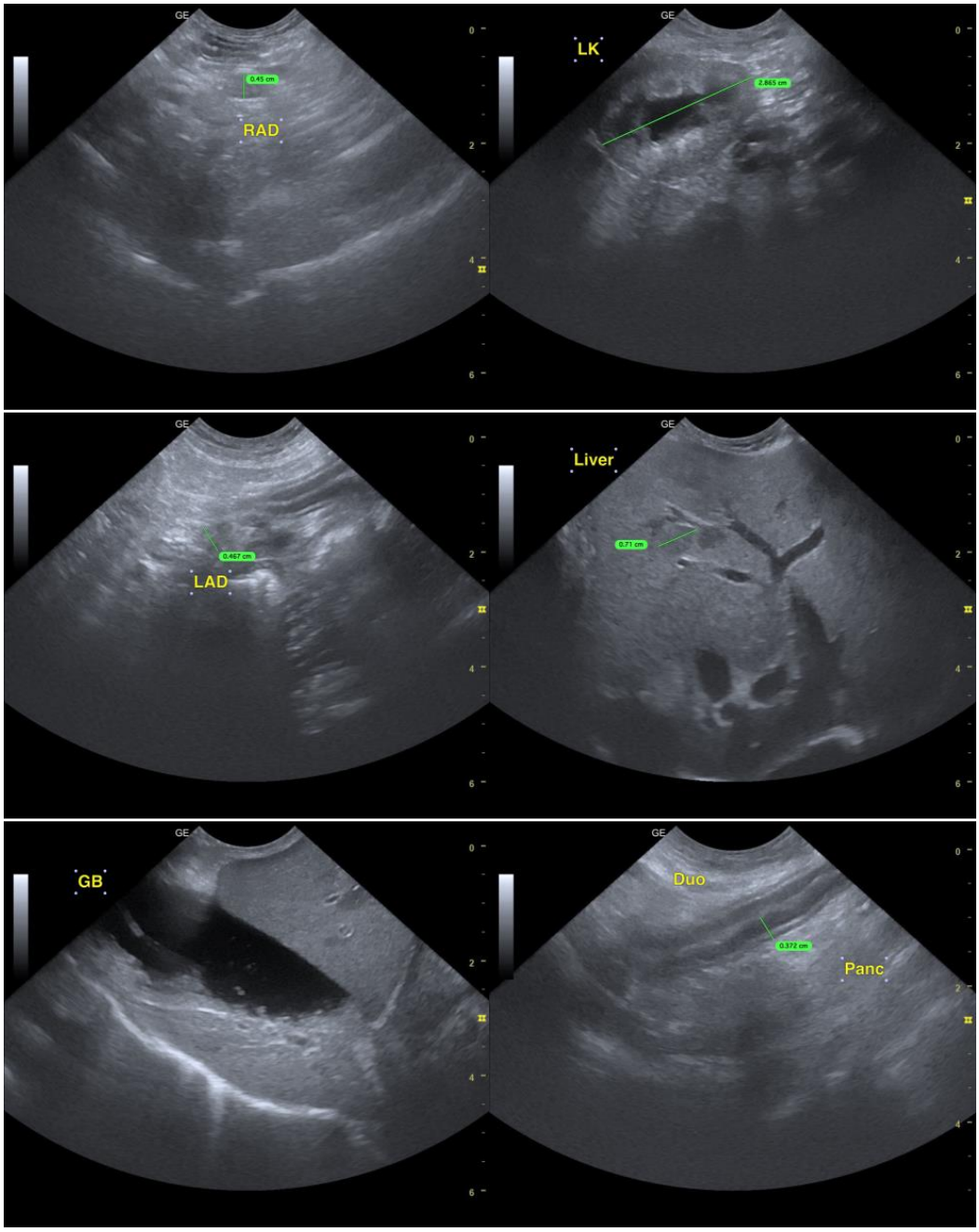

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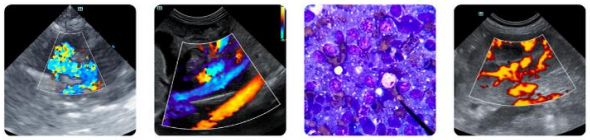

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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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)
info@sonopath.com