



PATIENT

Phoebe Nameniuk

SPECIES

Canine

BREED

Shih Tzu/Maltese Mix

SEX

Spayed Female

AGE

13 Years

WEIGHT

16

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue Vet
Clinic

REFERRING VET

Dr. Jessie Evoniuk

INVOICE

16123

DATE

05/12/26

PRESENTING CLINICAL SIGNS

Long-standing HX of urolithiasis. Last year had full GI work-up for underlying factors. Last cystotomy 6/2024 (90% struvite/Ca phosph body; shell 90% ca oxalate dihydrate/10% ca oxalate monohydrated; Previous cystotomies. P/ refuses urinary diet and has failed maintenance attempts including UA/urine culture q3mo historically. Last check 9/2025 with concern of stones- O has held off on surgery due to few signs at home and age.

ALP: 169; BUN: 38; Calcium: 12.8; Glucose:117 Urine SpG 1.020, pH 7, prot 500, WBC >50, RBC >50. Epith >10, squamous cell cells 1-2/HPF, present rods, suspected cocci Previous TX AM panel, Protein C, urine cultures, previous Idexx Cystatin B elevation

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder revealed multiple calculi occupying majority to entirety of urinary bladder lumen with minimal anechoic urine present. Mildly thickened visible ventral urinary bladder wall with mildly asymmetrical luminal surface contour with ventral urinary bladder wall measuring 0.50 cm wall width. An example of calculus measured 1.0 cm in diameter. No obvious pathology area of the cystourethral junction. The urethra was normal in structure and tone to a depth of 3.0 cm.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient.

Nonobstructive medullary renoliths with no evidence of pyelectasia. The left kidney measured 4.5 cm in length. The right kidney measured 3.9 cm in length.

Adrenal Glands

The left adrenal gland was asymmetrically enlarged with subjective intact asymmetrical capsule contour and nonhomogenous focally mineralized caudal parenchyma. The left adrenal gland measured 2.2 cm x 1.65 cm width at the caudal pole.

A mildly expansive mildly hyperechoic nonmineralized nodule was present in the cranial right adrenal gland. The nodule did not exhibit signs of mineralization or vascular invasion. The nodule measured 1.66 cm x 1.1 cm in diameter. Overall mild asymmetrical right adrenomegaly measuring 0.62 cm width at the caudal pole.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Intermittent medial parenchyma to perihilar hyperechoic nodules were present with an example measuring 1.4 cm in diameter. 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 or neoplastic changes were not noted. The hyperechoic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver & Gallbladder



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The liver presented subjective mildly enlarged in size. Mild homogenous increased hepatic parenchyma echogenicity compared to the spleen. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. No mass or nodules were evident.

The gallbladder was non distended in size with variably hyperechoic nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

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 isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Multiple cystic calculi with cystitis bladder pattern.
- Chronic renal changes exhibiting nonobstructive renolithiasis.
- Asymmetrical left adrenomegaly with nonhomogenous focally mineralized parenchyma.
- Concurrent right adrenomegaly with nonmineralized nodule.
- Enlarged mildly hyperechoic liver.
- Nonorganized gallbladder debris (non-mucocele).
- Benign splenic nodules- probable myelolipomas.
- Mild pancreatic remodeling- suspect patient/age variant or benign remodeling, possible mild chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of significant hepatic disease or overt shunt as a contributing factor to the cystic calculi. Unilateral/bilateral adrenal hyperplasia, functional versus non-functional adenomatous change with potential unilateral/bilateral adrenal tumors given left adrenal mineralization and right adrenal nodule i.e. carcinoma or pheochromocytoma are possible.

Adrenal workup is indicated if clinical signs are consistent with Cushing's syndrome as well as serial monitoring of systemic BP for hypertension which may allude to pheochromocytoma is recommended. The overall liver is suggestive of benign criteria with hepatic neoplasia thought less likely. Serial sonographic monitoring of the adrenal glands for evidence of progression is indicated if advanced imaging such as CT evaluation is not possible.



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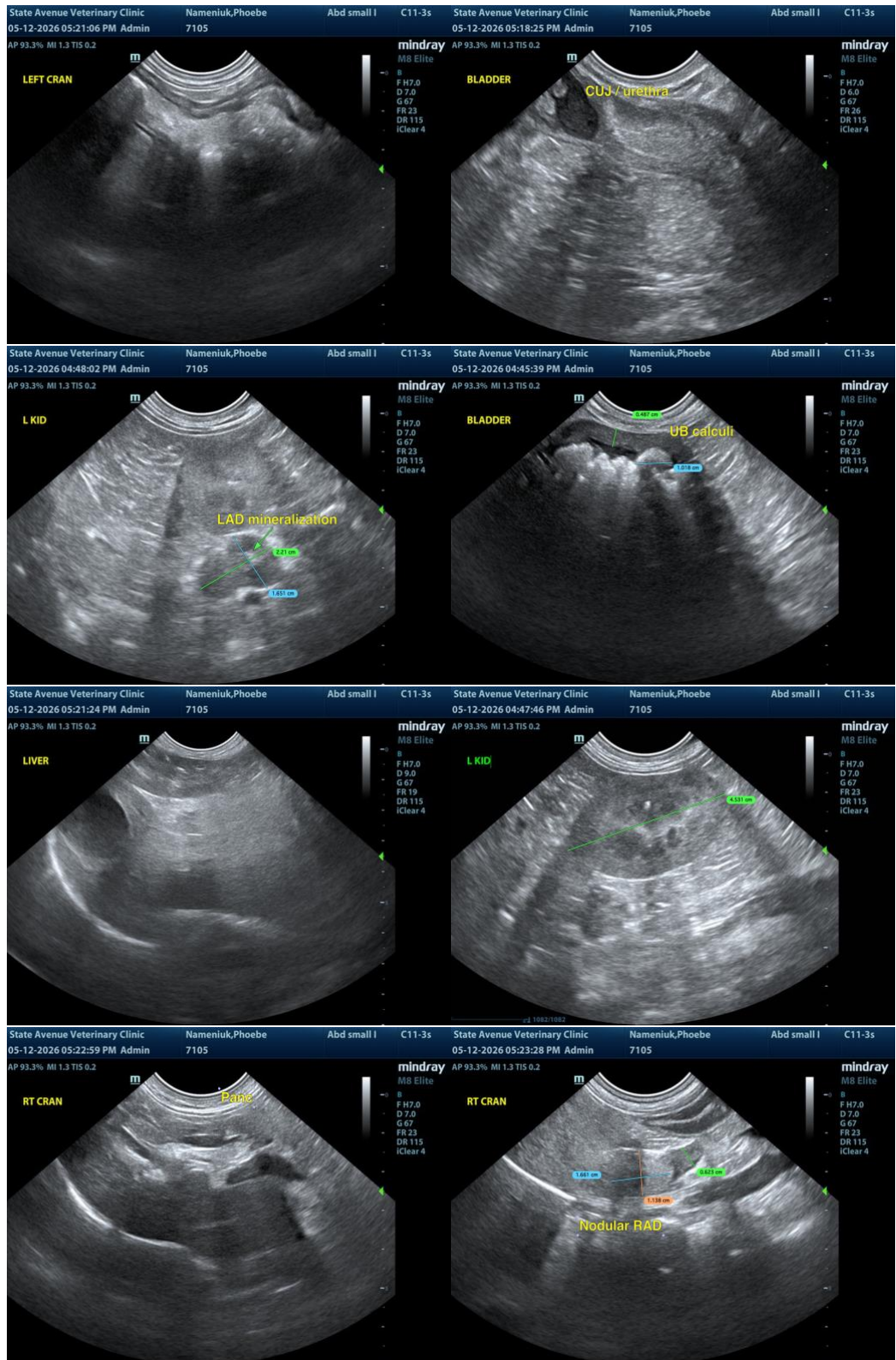
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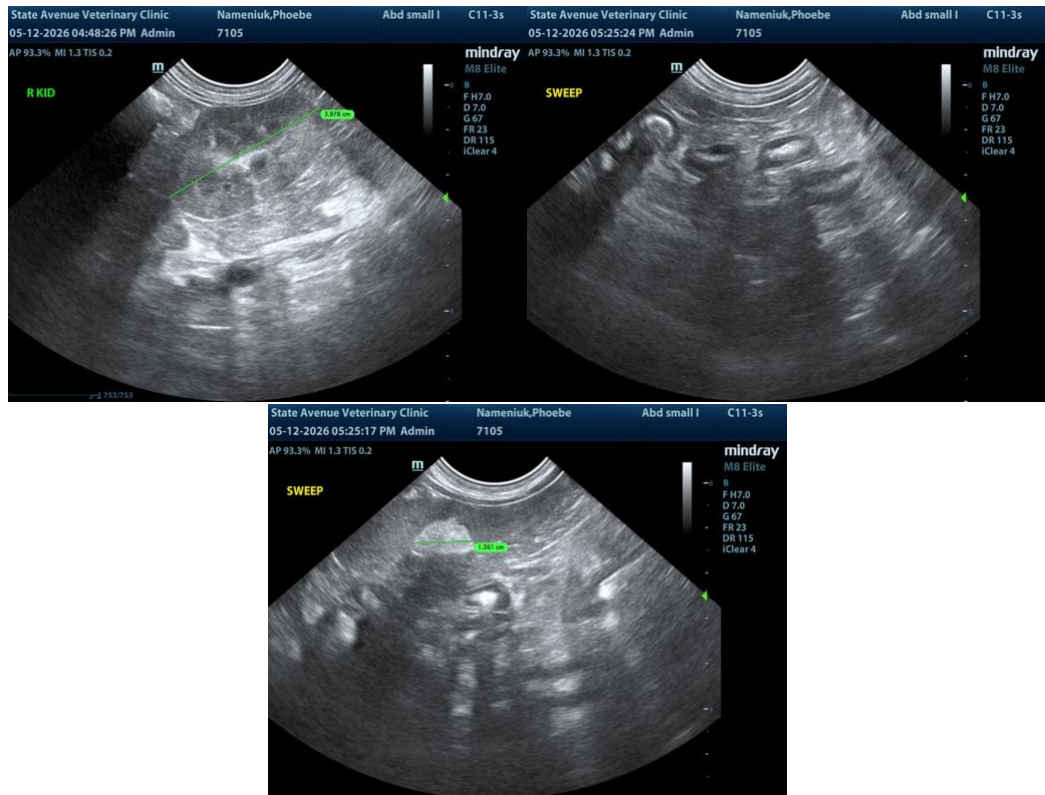
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com