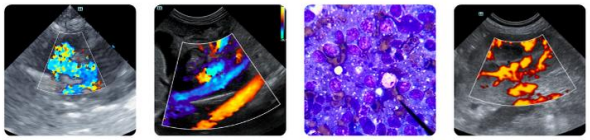

PATIENT

Emma Lavaglia

SPECIES

Canine

BREED

Mix

SEX

Female Spayed

AGE

14Y, 8M

WEIGHT

19.6

INTERPRETED BY

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

IMAGING PERFORMED BY

Christensen

HOSPITAL NAME

Tranquility Veterinary Clinic

REFERRING VET

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INVOICE

75082

DATE

5-20-26

PRESENTING CLINICAL SIGNS

Recheck abdominal ultrasound performed for Emma to investigate persistent and marked proteinuria. Owner reports current medications include telmisartan 10 mg PO q24h (1/2 of a 20 mg tablet), clopidogrel 18.75 mg PO q24h, Denamarin Advanced Chews for small dogs 0.5 tablet PO q24h, and ursodiol 100 mg PO q24h.
Abnormal PE/Chem/CBC/UA Results: Recent urine protein:creatinine ratios: 5.6 (05/13/26), 4.8 (04/28/26), 4.7 (05/15/25), 5.1 (04/29/25). Last labs (04/23/26): CBC normal except lymphopenia 0.972; chemistry showed SDMA 15, chloride 106, alkaline phosphatase 2,379, lipase 453; remainder within normal limits. Prior ultrasound 6 months ago showed hepatomegaly, immature gallbladder mucocele, bilateral renal cortical cysts with mineralized renal cysts, benign splenic nodules, and pancreatic remodeling.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal size and tone. Small sessile based potentially mineralized mid ventral wall mass lesions were present measuring 0.75 cm in diameter. Anechoic urine with mild nondependent particulate urine sediment and primarily dependent to possibly focally adhered lumen mineral was present. The ureteral papillae were normal. The ureters were not visible, which is normal. No evidence of inflammatory or neoplastic changes was noted.

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

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. Loss of corticomedullary distinction was also present. Medullary mineral to small renoliths were present. Minor pyelectasia and small cortical cysts were also present. The left kidney measured 4.8 cm in length. The right kidney measured 5.1 cm in length.

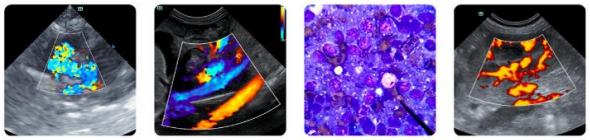
Adrenal Glands

The bilateral adrenal glands presented mildly enlarged in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.78 cm width in the caudal pole. The right adrenal gland measured 0.74 cm width in the caudal pole.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Intermittent, small, well-demarcated, hyperechoic nodules were present. An example of a splenic nodule measured 0.38 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 echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver/ Gallbladder



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The liver presented generalized hepatomegaly with symmetrical rounded contour and mild to variable nonhomogeneous hepatic parenchyma exhibiting discrete hyperechoic to nonhomogeneous nodules. A solitary caudal liver, mildly irregular, yet thinly walled, intraparenchymal cyst is present containing anechoic fluid measuring 1.4 cm in diameter. Normal hepatic vascular volume was present. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with normal wall. Echogenic, nonmineralized, non-dependent biliary sludge is present. The biliary sludge is congealed without organization. No signs of peripheral inflammation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty without evidence of retained ingesta, fluid, 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 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

- Static appearing hepatomegaly exhibiting nonhomogeneous discretely nodular parenchyma and static hepatic cysts.
- Static immature gallbladder mucocele.
- Subjectively static chronic renal changes exhibiting medullary mineral/small renoliths and cortical cysts.
- Static bilateral adrenomegaly.
- Static pancreatic remodeling.
- Static splenic nodules – consistent with myelolipomas.
- Ventral urinary bladder small sessile based mass lesion with urinary bladder sediment and dependent lumen/adhered mineral.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall similar sonographic findings compared to the previous study without evidence of overt or significant progressive pathology. Given marked proteinuria, chronic glomerular nephritis or other glomerulopathy with possible amyloidosis may be possible. Continued empirical therapy for protein-losing nephropathy with monitoring of urinalysis, UPC, and systemic blood pressure. Continued

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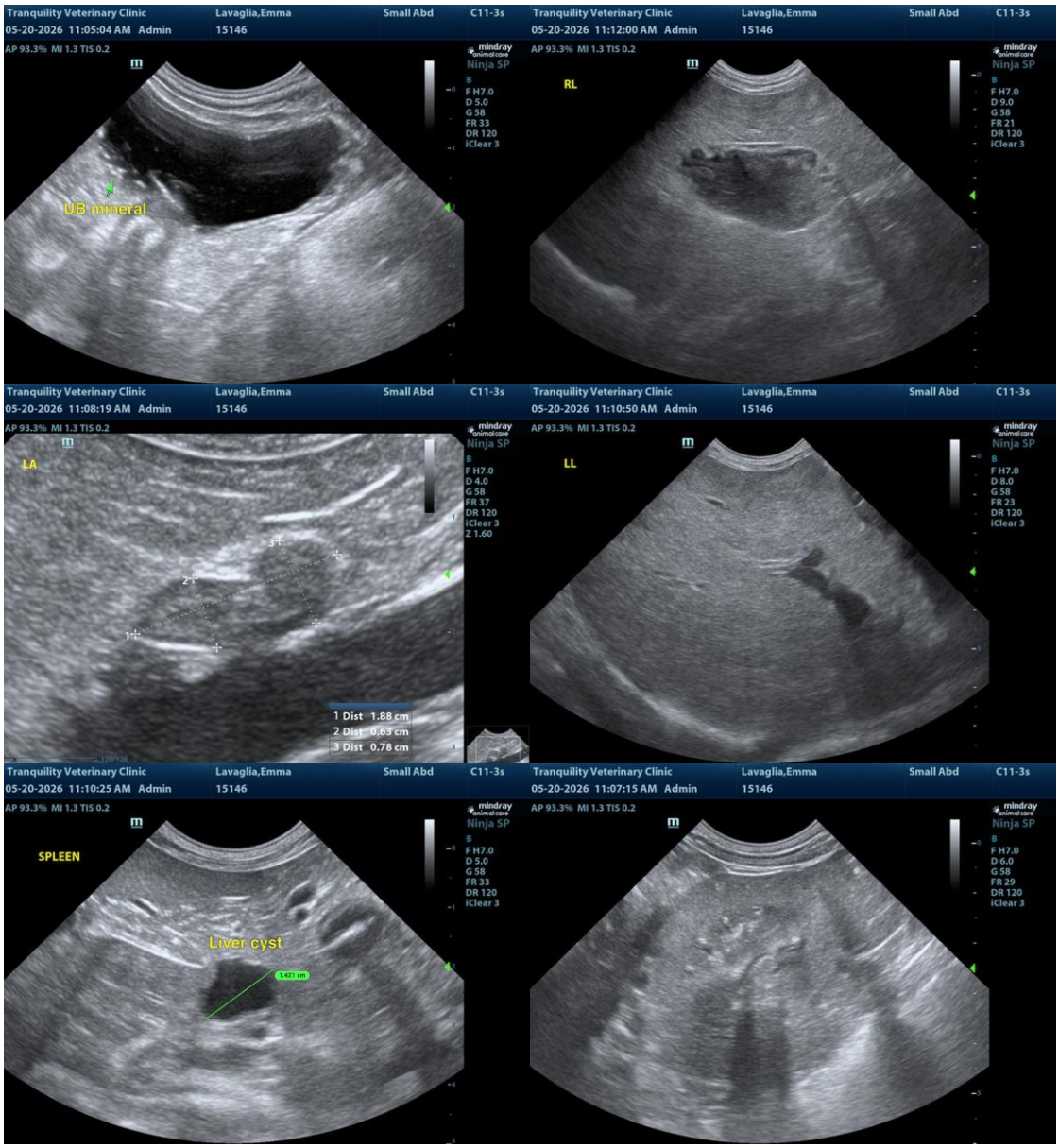
hepatosupportive medications indicated with sonographic reassessment of the kidneys and liver if progressive azotemia, proteinuria, or cholestasis.

Chronic pancreatitis may be suspected if concurrent gastrointestinal signs.

Adrenal workup warranted if clinical signs consistent with Cushing's syndrome.

Emerging ventral urinary bladder neoplastic mass i.e. transitional cell carcinoma is suspected with focal cystitis. Granuloma or atypical polyp thought less likely. Correlation with BRAF assay and urine C/S on sterile urine sample if inflammatory sediment on urinalysis is recommended.



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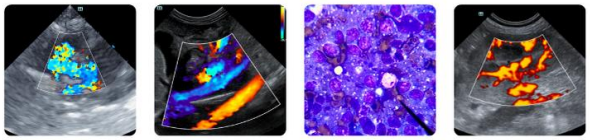

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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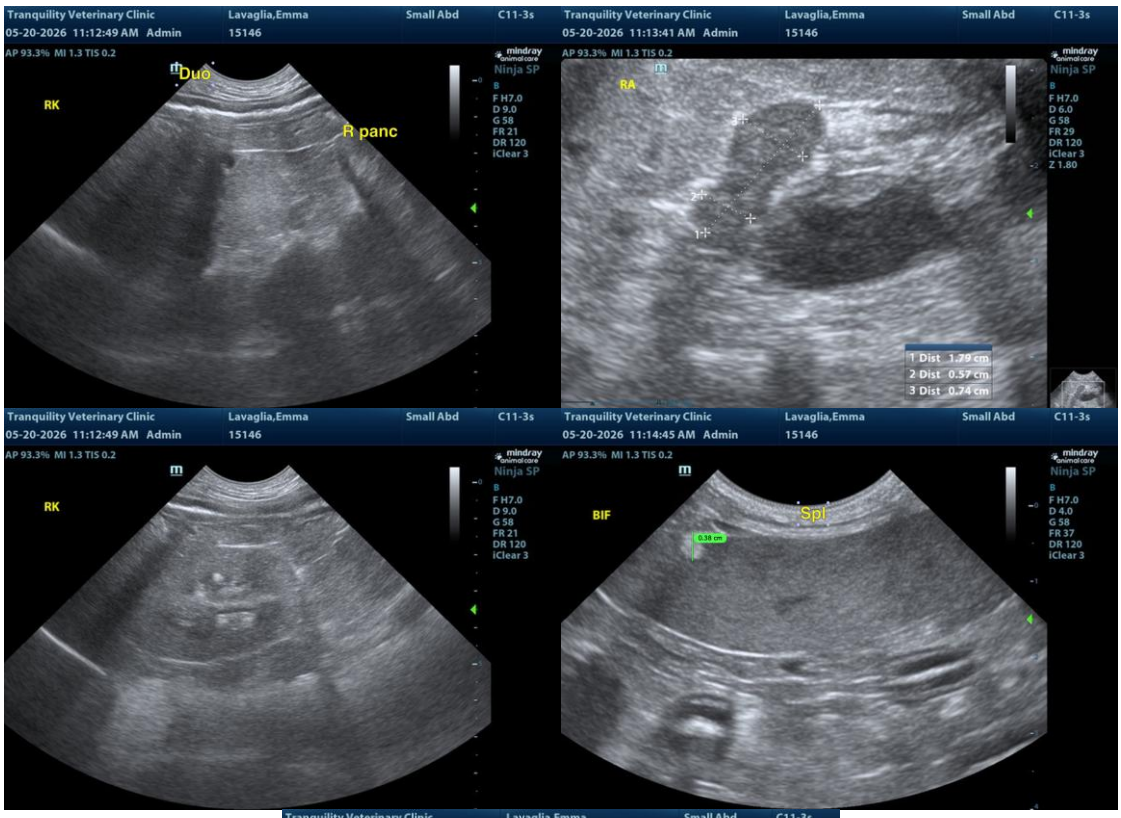

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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