



PATIENT

Niya Allen

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

16 Years

WEIGHT

9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dallas Reynolds LVT

HOSPITAL NAME

Lone Mountain Animal
Hospital

REFERRING VET

Dr. Emilie Dours

INVOICE

16033

DATE

05/09/26

PRESENTING CLINICAL SIGNS

Presented 5/8/26 for hematuria, dysuria, and polydipsia. Vomited once last Sunday. Currently on Denamarin, Probiotics, Cobalequin. IMTP 5 years ago. Hx of heart murmur. Hx of ALP elevations. Bloodwork done 5/8 showed kidney elevations which is new

Abnormal PE/Chem/CBC/UA Results: BUN - 68 Creatinine - 2 ALP - 643

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 thickness and 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. No evidence of inflammatory or neoplastic change were noted.

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 to moderate indistinct corticomedullary border demarcation expected for the age of the patient. Mild medullary mineral was visualized bilaterally with left kidney cortical cyst and mild right kidney pyelectasia. The left kidney measured 4.0 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

The bilateral adrenal glands were mildly enlarged in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.89 cm width in the caudal pole. The right adrenal gland measured 0.72 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. Solitary small noncapsule deforming caudal splenic hyperechoic nodule was present measuring 0.40 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 nodule tends to trend benign and is most consistent with benign hyperplasia or myelolipoma. Concurrent medial parenchyma to perihilar mildly expansive isoechoic nonhomogenous to focally hyperechoic splenic nodule was also present measuring 1.4 cm in diameter. Mild associated medial splenic capsule distortion.

Liver & Gallbladder

The liver revealed generalized hepatomegaly. The liver parenchyma was mild / moderate nonuniform and hypoechoic to the spleen with a mild / moderate coarse echotexture and with nonhomogenous remodeled to variably hyperechoic hepatic parenchyma exhibiting discrete nonhomogenous hypoechoic intraparenchymal nodules with an example measuring 2.0 cm in diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion.



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

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained variably echogenic, mild nonshadowing ingesta without signs of obstruction or foreign material.

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Chihuahua

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.

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

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The parenchyma of the pancreas base and right pancreatic limb was hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

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Free Abdomen

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No overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

- Enlarged nonhomogenous subtle nodular liver.
- Moderate nonorganized gallbladder debris- not consistent with mature mucocele.
- Chronic pancreatitis/fibrosis pattern.
- Mildly expansive nonhomogenous medial splenic nodule with concurrent probable benign caudal splenic myelolipoma.
- Chronic renal changes exhibiting cortical cysts, medullary mineral and mild right kidney pyelectasia.
- Bilateral mildly adrenomegaly.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinary workup including urinalysis, culture/sensitivity, and baseline UPC level, if non-inflammatory proteinuria, is recommended for further staging. Right kidney pyelectasia is suspected to be secondary to chronic renal changes or pelvic scarring with minor potential for chronic right kidney pyelonephritis. Chronic vacuolar/cholestatic or inflammatory hepatopathy with parenchymal remodeling, nodular hyperplasia, fibrosis, less likely hepatic neoplasia are all potentials.

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Adrenal workup is indicated if clinical signs are consistent with Cushing's syndrome. The mildly expansive splenic nodule may indicate hyperplasia, hematopoiesis, hematoma, infection/inflammation, or emerging tumor.

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Assuming normal clotting status and using 25-gauge needle, hepatic parenchyma and mildly expansive splenic nodule FNA cytology could be considered for further clarification. Sonographic monitoring,



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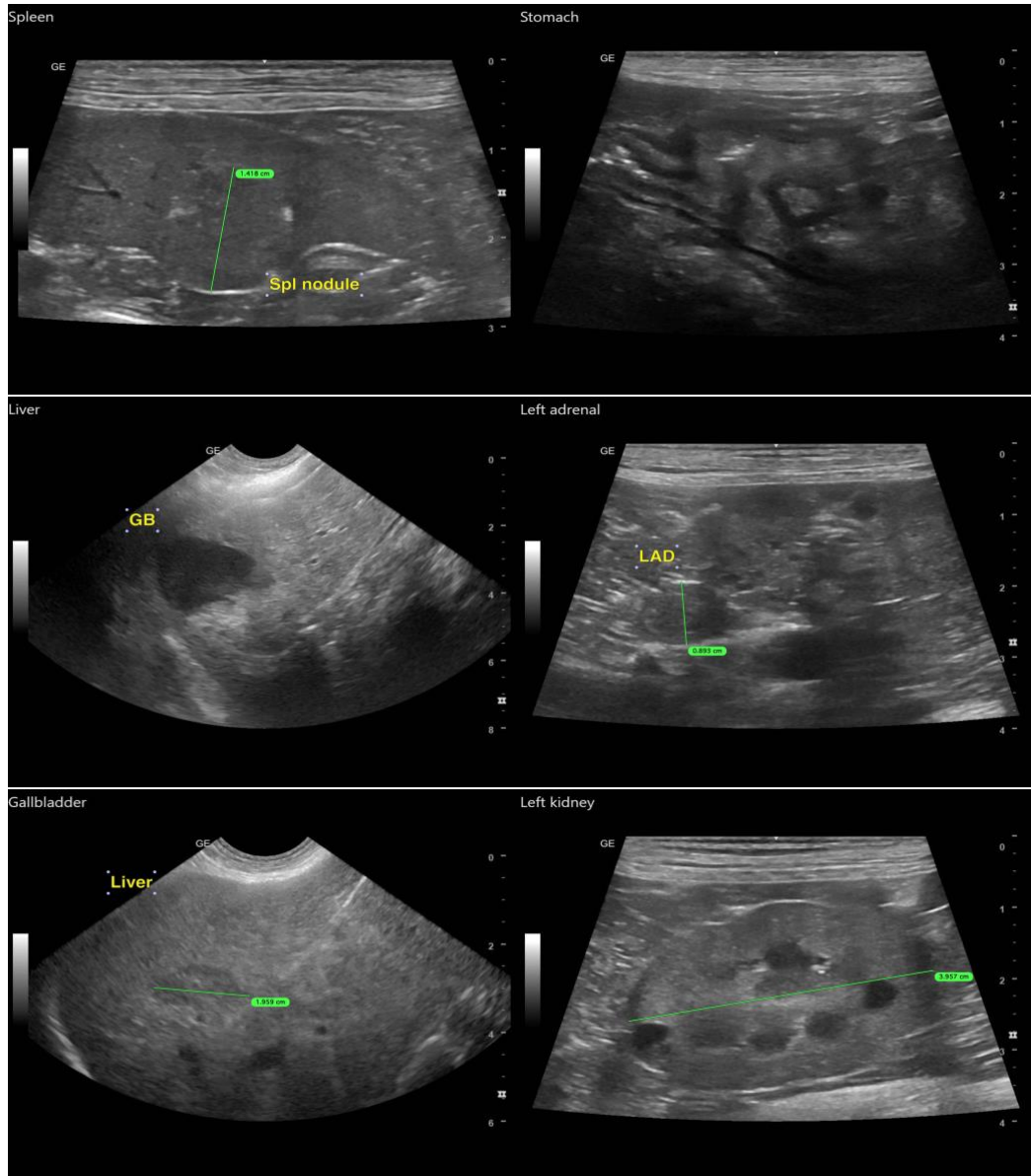
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specifically of the splenic nodule for evidence of progression with initial recheck in four weeks would be more conservative.





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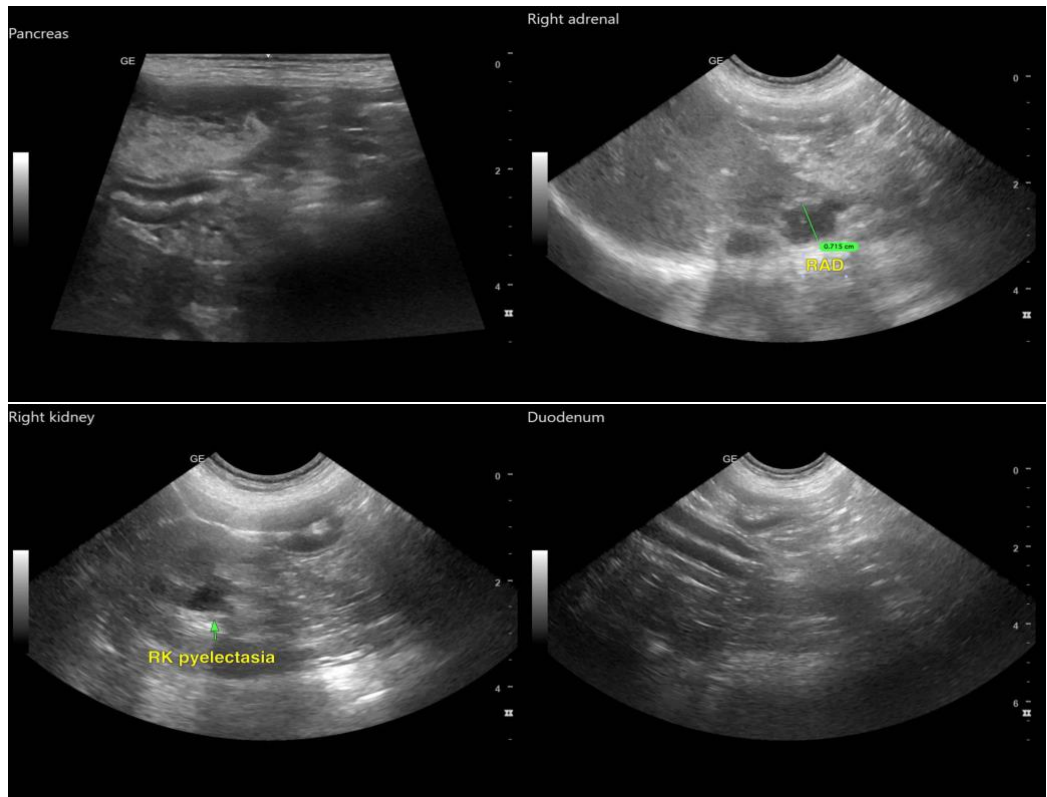
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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