



PATIENT

Niya Allen

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed female

AGE

16 years

WEIGHT

8.58 kgs

INTERPRETED BY

Remo Lobetti, BVSc,
MMedVet (Med),
PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Dr. McNeal

HOSPITAL NAME

Lone Mountain AH

REFERRING VET

Dr. McNeal

INVOICE

77989

DATE

5/26/26

PRESENTING CLINICAL SIGNS

History: Niya has a hx of IMTP, has been controlled without medication for the last 5-6 years, hx of chronic kidney dz stage 2, hx of obesity, and a hx of Grade 6/6 heart murmur. She was recently hospitalized earlier this month for aggressive diuresis due to kidney dz, but starting this Wednesday P began not eating, increased thirst and passing stool while asleep. P is on Maropitant, Entyce, Naraquin, Provable, Amoxicillin TID and Gabapentin and Trazodone as needed. Currently hospitalized on Pantoprazole and Cefazolin since yesterday.

Abnormal PE/Chem/CBC/UA Results: BUN: >140 Cre: 2.4 Phos: 10.9 ALk Phos: 969 ALT: 171 HCT: 28.5 HGB: 10 RBC: 4.71

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 4.4 cm, right measured 4.1 cm), with increased echogenic appearance, some loss of cortico-medullary differentiation, and normal pelvis, and capsule. No infarcts or renoliths evident. Mild, bilateral mineralization was evident in both kidneys. A few, small cortical cysts were evident in the left kidney.

Adrenal Glands

Both adrenal glands are plump in size, but maintained a normal shape, echogenic appearance, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.85 cm in width. The right adrenal gland measured 1.34 cm in length x 0.7 cm in width.

Spleen

The spleen was not fully visualized, but the visualized sections appear to be of normal size with a normal echogenic appearance, smooth homogenous parenchyma and regular curvilinear capsule. Incidental myelolipomas were evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident.

Liver

The liver was enlarged with rounded edges, diffuse increased echogenic and coarse appearance, normal portal markings, and regular curvilinear capsule. A few, parenchymal, hypoechogenic nodules measuring up to 2.0 cm in size. No masses evident. Normal appearance of the hepatic and portal vasculature.



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Gallbladder

The gallbladder is full containing a moderate amount of non-adhered, dependent, hyperechogenic sediment. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Normal appearance of the stomach, duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen.

Pancreas

The pancreas was not visualized.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Renal disease.
- Nodular hepatopathy.
- Gallbladder sediment.
- Mild, bilateral adrenomegaly.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The findings are similar to that of the previous ultrasound.

The appearance of the kidneys is consistent with chronic kidney disease. However, with a marked increase in the urea and creatinine, acute on chronic kidney disease would be an important differential diagnosis.

The most likely etiology for the nodular hepatopathy would be age related nodular hyperplasia, with chronic active hepatitis, granulomatous disease and infiltrative neoplasia a less likely differential diagnosis.

The gallbladder sediment can be considered an incidental finding.

Etiologies for the adrenomegaly would be age related reactive hyperplasia and disease stress with pituitary dependent Cushing's disease a less likely differential diagnosis.



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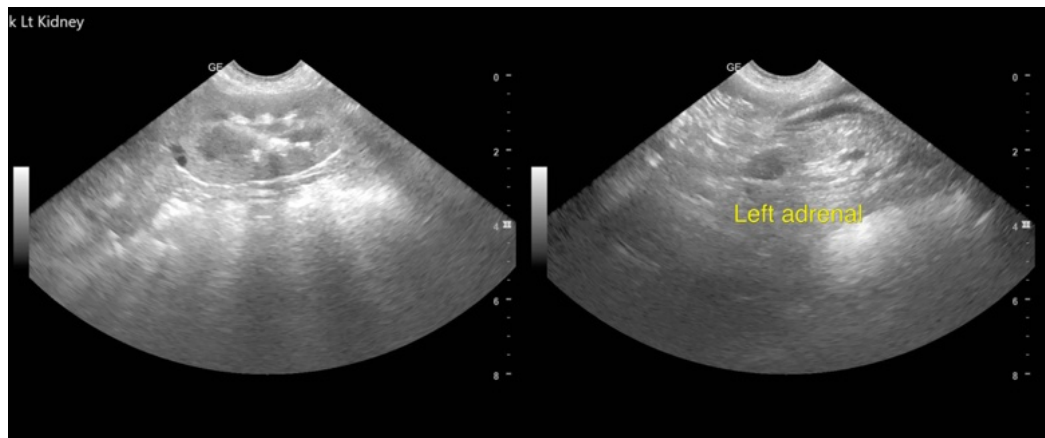
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Further assessment of the renal disease (if not already done) would be blood pressure, UPC, and urine cystatin B.

Further assessment of the nodular hepatopathy that could be considered would be FNA cytology. However, a tru cut or wedge biopsy may be required for a final etiological diagnosis.

Management of the renal disease would be feeding a renal diet, enteric phosphate binders, fluid therapy as needed and possibly an ace inhibitor or receptor blocker.





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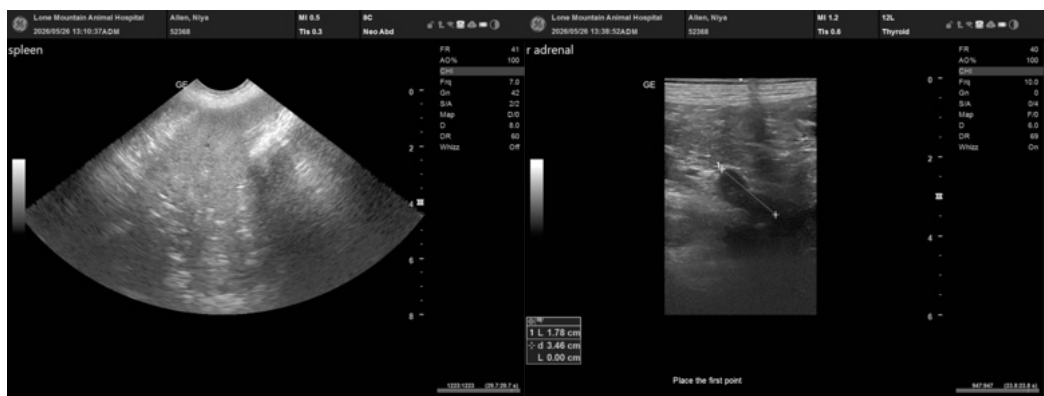
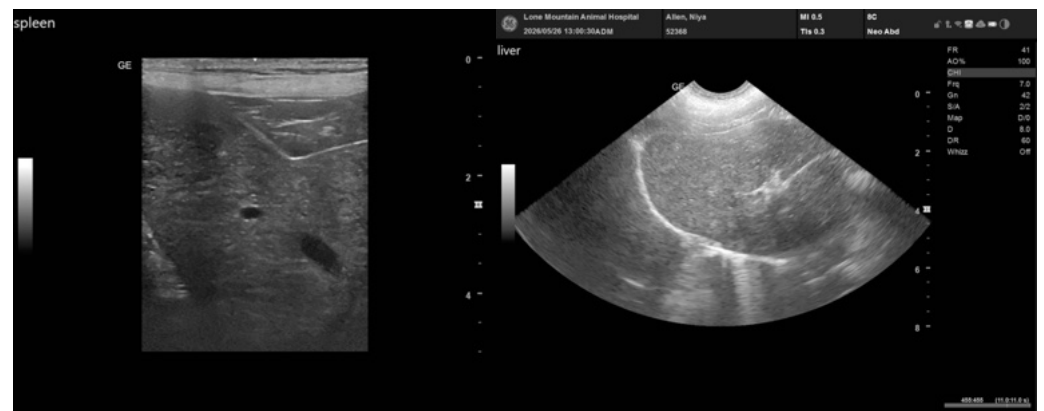
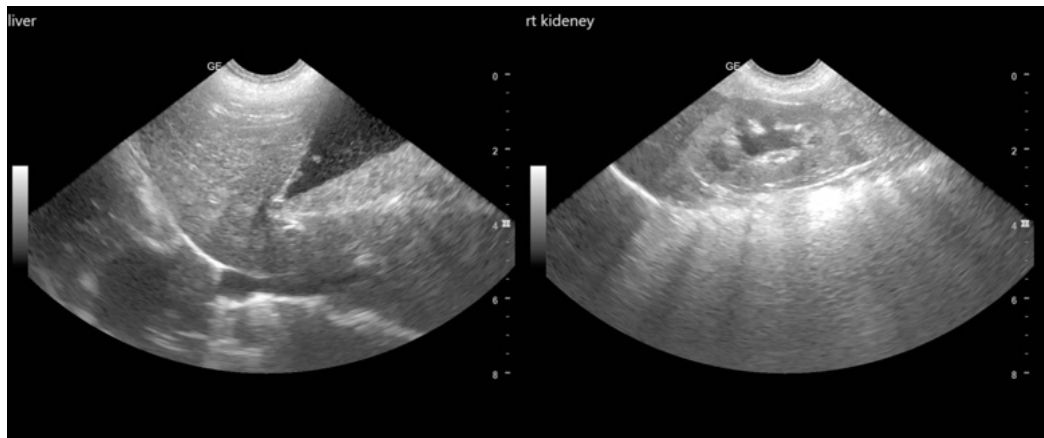
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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