



PATIENT

Teddy Briggs

SPECIES

Canine

BREED

Pomeranian

SEX

Neutered Male

AGE

3.5 Years

WEIGHT

2.7 kg

INTERPRETED BY

Tam Mengine DVM,
DABVP (Canine/Feline
Practice)

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey AEC

REFERRING VET

Dr. Cara Sinopoli

INVOICE

35574

DATE

11/22/25

PRESENTING CLINICAL SIGNS

History: Lyme + (we don't know chronic vs. acute) , azotemic Losing weight, hair loss, dry skin, V+/D+ Only eating with significant encouragement (steak or chicken, picking out of kibble) 2-3 days lethargy, yesterday not jumping on couch PE: dehydrated, pale pink mm, emaciated/muscle wasted, dry coat, still qar Problem list: lyme positive azotemia (improving since being hospitalized on fluids) hypoalbuminemia (stable since being admitted) mild thrombocytopenia anorexic/underweight.

Abnormal PE/Chem/CBC/UA Results: Diagnostics from RDVM 11/21/25: Chem: Albumin 2.0 L, BUN > 130 H, Creatinine 3.1 H, Phos > 16.1 H, Potassium 5.9 H, Globulin 4.9 H CBC: Hematocrit 33.6% L, Platelets 0K L (suspect error at rdvm) 4DX: Negative for Heartworm, Ehrlichia, Anaplasma, Positive for Lyme Cortisol: 3.42 (in house idexx slide) U/A: USG 1.1014, pH 6.5, UP 500, Blood/HGB 250; WBC 21/hpf, RBC 45/hpf, Sq Epith 3-5/hpf, Non-sq Epith 6-10/hpf, Non-hyaline casts suspect presence, unclassified crystals <1/hpf Lepto witness in house: Negative in house blood smear: platelet estimate 100,000.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 1.0 cm. There is a round structure within the bladder lumen, consistent with the balloon of a foley catheter.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). The left kidney is 4.4 cm in length. The right kidney is 5.0 cm in length.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland height is 5.0 mm at the cranial pole and 4.0 mm at the caudal pole. The right adrenal gland height is 6.0 mm at the cranial pole and 3.3 mm at the caudal pole.

Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. There is a cholelith present within the gallbladder lumen measuring 1.9 cm in diameter. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.



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Gastrointestinal

The stomach is empty. The gastric wall is subjectively normal in thickness, and exhibits appropriate wall layering, but cannot be accurately measured due to normal deviations of the rugal folds. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness, up to 1.0 mm, with intact wall layering. The ileocecal junction is not visualized.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

ULTRASONOGRAPHIC FINDINGS

- Large gallbladder cholelith, with normal gallbladder wall and no evidence of rupture.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There was no apparent cause for the patient's azotemia identified, and no simple explanation linking the patient's azotemia to the cholelith. While a toxic insult might result in acute renal failure without sonographic change to the kidneys, the patient's poor body condition suggests that a more chronic condition seems likely. If the urine specific gravity was obtained after fluid therapy had been initiated, then it is also possible that the azotemia is pre-renal. Although leptospirosis testing was negative, additional testing (either PCR or antibody titers) could be considered to completely investigate this possibility. Empiric treatment for Lyme would also be recommended, as the possibility of Lyme nephritis cannot be excluded. If the urine sediment clears, urine protein: creatinine ratio testing would be recommended to further investigate.

While cholelithiasis is often incidental in the dog, this patient's young age and the apparent pain with transducer pressure in the region of the cholelith suggest the possibility of underlying cholecystitis. Symptoms of cholecystitis in the dog can be subtle, and include weight loss, diarrhea and vomiting, which would correlate with this patient's clinical signs, though these same signs might also be expected with renal failure. Cholecentesis would be required to definitively determine whether there is bacteria cholecystitis present. If this is not performed, then empiric antibiotic treatment could be considered, particularly if cholestatic enzymes begin to increase or if the cranial abdominal pain is persistent.



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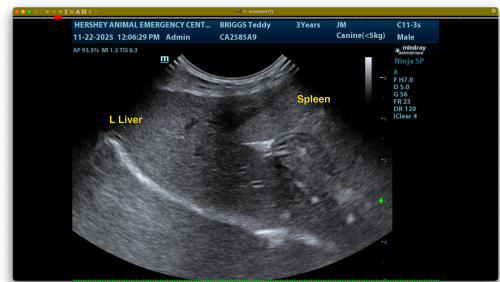
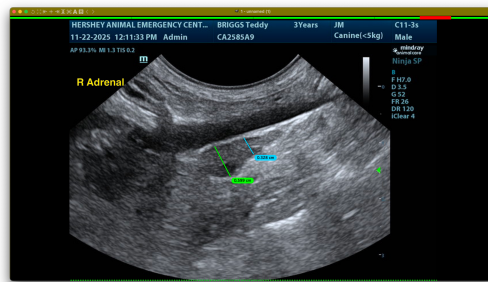
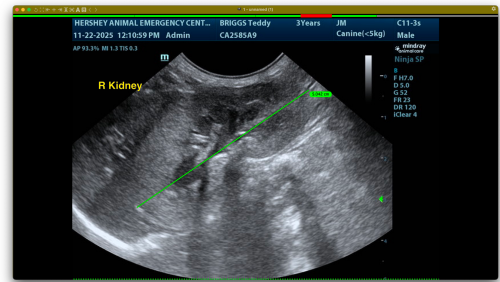
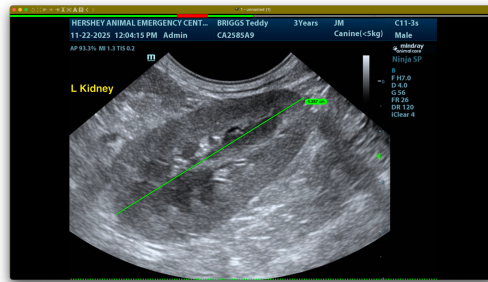
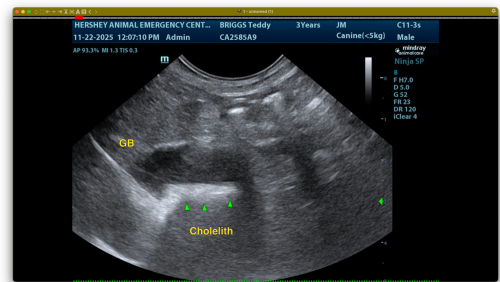
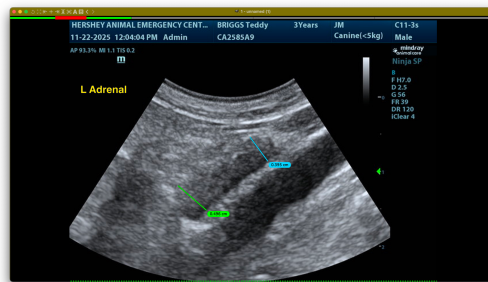
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice)

info@SonoPath.com