



PATIENT

Akoah Capps

SPECIES

Canine

BREED

Mini Australian Shepherd

SEX

Spayed Female

AGE

13 Years

WEIGHT

14 pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Hadley Harris

HOSPITAL NAME

TotalBond Veterinary Hospital

REFERRING VET

Dr. Peter Rowan

INVOICE

14197

DATE

03/10/26

PRESENTING CLINICAL SIGNS

Urinary Incontinence: Persistent, refractory to Proin, with intermittent improvement noted previously after dietary adjustment. No consistent response to antimicrobial therapy; most recent urinalysis and urine cultures are negative for UTI. Acute Gastrointestinal Signs: Vomiting (onset 3 days prior to referral), persistent through boarding and at home; concurrent 1.5-day anorexia, which is atypical for the patient. Polyuria/Polydipsia: Noted by owner over the past month. Diet: No recent changes aside from possible yard ingestion while boarding. Medications: Previously on Proin ER (18mg PO q24h); recently discontinued due to lack of efficacy and possible GI side effects. DES (0.2 mg PO SID x 7 days, then q3d) recently prescribed, unsure if owner has started yet. Previous Medical Issues: History of calcium oxalate crystalluria; all recent urine cultures negative. Abd Rads (3-view, 03/05/2026): Mildly reduced hepatic volume. No convincing evidence of GI obstruction. Thin metallic foreign body noted in cranioventral abdomen, suspected incidental (not clearly within GI tract). Other: No clinical or imaging evidence of UTI, urolithiasis, or neoplasia. Differential Diagnoses Considered. Urethral sphincter mechanism incompetence. Chronic hepatopathy. Pancreatitis (mild lipase elevation). Gastroenteritis, partial GI obstruction, or IBD. Occult neoplasia (GI or urinary tract)

Abnormal PE/Chem/CBC/UA Results: CBC/Chem: Within normal limits Urinalyses (multiple): Specific gravity trend low-normal (most recent 1.018), isosthenuric/acidic, no proteinuria or bacteriuria, rare epithelial cells, no crystals on most recent analysis Mild, non-specific elevation in lipase

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.40×2 cm, and the thickness of the cortex is 0.33 cm in the sagittal plane.

The right kidney is normal in shape and size: 3.62×1.92 cm, and the thickness of the cortex is 0.33 cm in the sagittal plane.

Both kidneys: the cortex is slightly hyperechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler shows a normal vascular pattern.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: the left adrenal gland measures 0.37 cm at the cranial pole and 0.72 cm at the caudal pole. The right adrenal gland measures 0.47 cm at the cranial pole and 0.44 cm at the caudal pole.

Spleen

Splenic thickness is 0.89 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture with a 0.81×0.89 cm hypoechoic to anechoic lesion located at the distal portion of the dorsal extremity of the spleen. The splenic capsule is smooth and regular. Splenic vasculature appears normal.



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Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma appears uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is moderately distended. The wall is thin and the contents contain a large amount of biliary sludge. The sediment has a mottled echogenic appearance, consistent with heterogeneous sludge containing mixed hyperechoic areas and small anechoic foci (a "speckled" or "salt-and-pepper" appearance). No hyperechoic striations are observed. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal

The stomach is empty and folded, with gas content, mural thickness (1.53 mm), and preserved wall layering. The pylorus was not measured.

Duodenum: 3.85 mm.
Jejunum: 2.64–2.72 mm.
Ileum: 2.6 mm.

Normal wall layering is preserved. No signs of inflammation, ileus, or foreign material are identified.

Colon: 1–1.29 mm, with preserved layering and a largely empty lumen.

Pancreas

The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

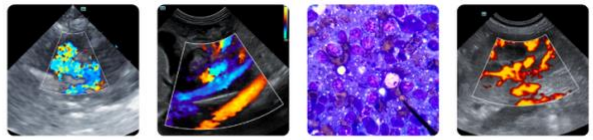
No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The lymph node at the iliac trifurcation appears normal.

PRIMARY FINDINGS

- Mild enlargement of the caudal pole at the left adrenal gland.
- Large amount of heterogeneous biliary sludge within the gallbladder.
- Mild bilateral renal cortical hyperechogenicity.
- Small hypoechoic to anechoic splenic lesion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gallbladder contains a moderate amount of heterogeneous biliary sludge occupying approximately half of the lumen, with a mottled appearance. This pattern is typically associated with chronic biliary stasis. In such cases, increased secretion of mucin by the gallbladder epithelium leads to the formation of a glycoprotein matrix that promotes aggregation of bile pigments, cholesterol crystals, and cellular debris, resulting in heterogeneous echogenic sediment. These changes are frequently encountered in older dogs and may occur secondary to endocrine disorders.



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Both kidneys are normal in size and architecture; however, the renal cortices appear mildly hyperechoic relative to the liver parenchyma. This finding is nonspecific but may be compatible with mild chronic renal parenchymal change, particularly in the context of the patient's low urine specific gravity (1.018) and reported polyuria/polydipsia. Despite this, corticomedullary definition and renal morphology remain preserved.

The left adrenal gland demonstrates mild enlargement of the caudal pole (0.72 cm). This asymmetry is nonspecific and may represent early adrenal hyperplasia. No nodules or masses are observed.

A small hypoechoic to anechoic splenic lesion is present at the distal portion of the dorsal extremity of the spleen. In an otherwise normal spleen, lesions of this appearance most commonly represent benign changes such as a small cyst, focal hematoma, or nodular hyperplasia, although definitive characterization is not possible based on ultrasound alone.

In particular, there is no ultrasonographic evidence of pancreatitis, gastrointestinal obstruction, or inflammatory intestinal disease that would clearly explain the patient's recent vomiting.

The urinary bladder appears normal, and no structural abnormalities are identified that would explain the patient's chronic urinary incontinence, which remains most compatible with urethral sphincter mechanism incompetence in this clinical context.

Recommendations

- Given the marked biliary sludge, periodic monitoring of the gallbladder and hepatobiliary parameters may be considered. Hepatobiliary support (ursodeoxycholic acid or hepatoprotective therapy) may be considered at the discretion of the attending clinician if clinically indicated.
- Because of the reported polyuria/polydipsia and borderline urine concentration, continued monitoring of renal parameters and urine specific gravity is advisable to evaluate for early renal dysfunction.
- If clinical suspicion for endocrine disease exists, endocrine screening for hyperadrenocorticism may be considered at the discretion of the attending clinician. Bilateral adrenal enlargement and ultrasonographic features of steroid hepatopathy are not identified on this examination.
- The splenic lesion is small and nonspecific; follow-up ultrasound monitoring may be considered to assess stability.



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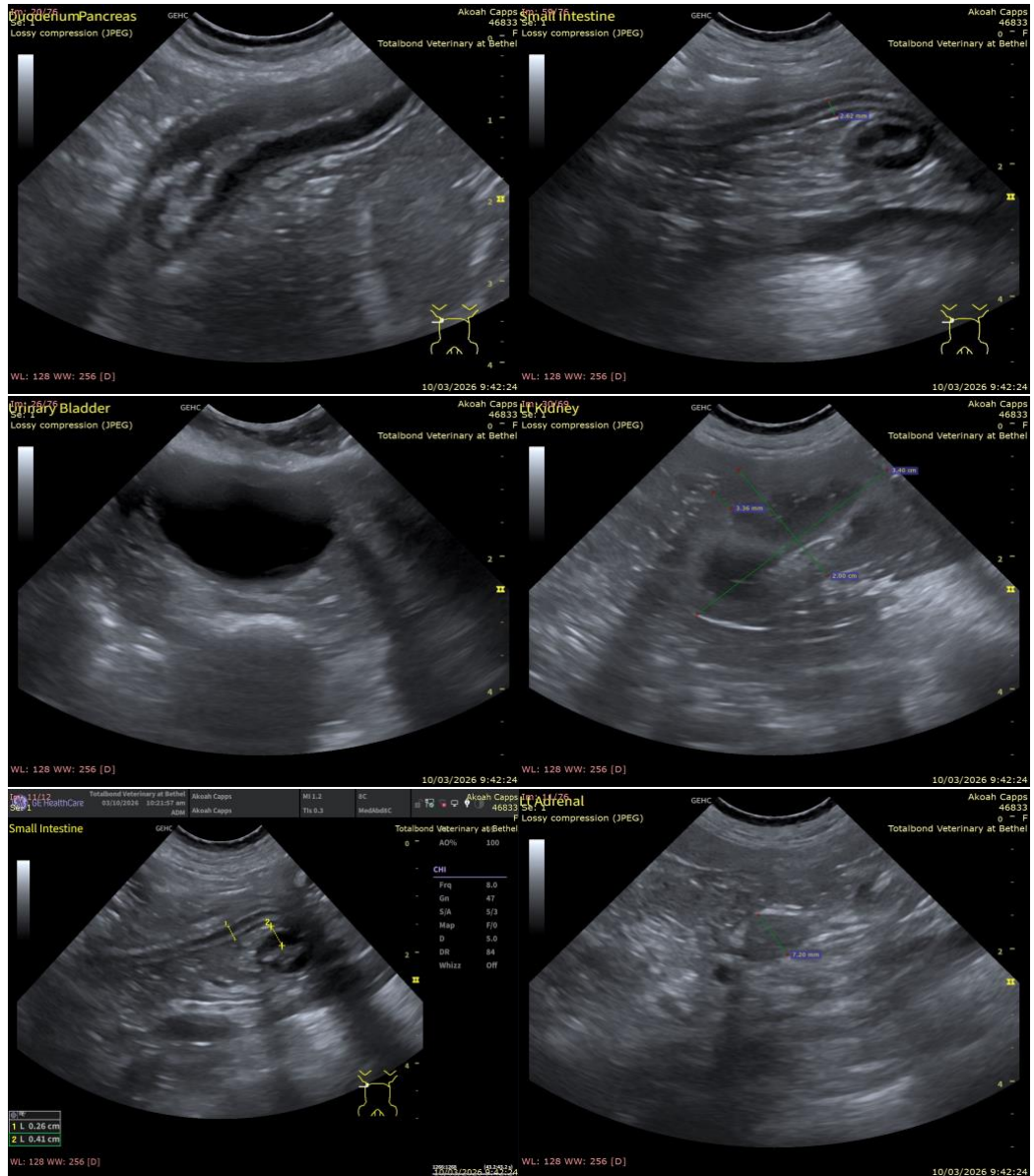
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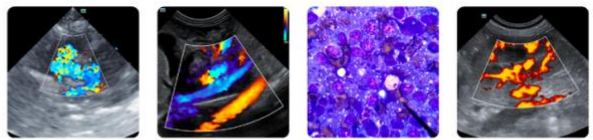
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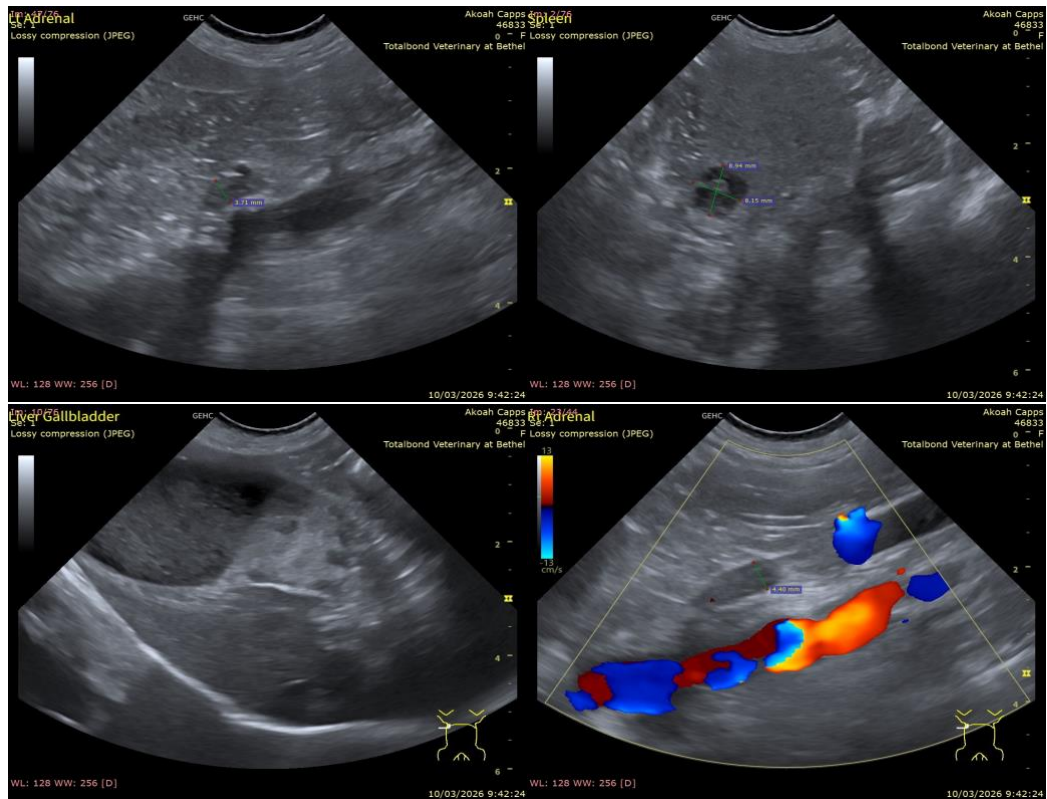
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

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