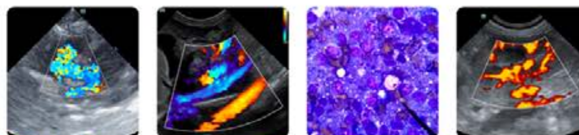


PATIENT
Molly Keenan

SPECIES
Canine

BREED
Mini Doodle

SEX
Spayed Female

AGE
6 Years

WEIGHT
21.18 lbs

INTERPRETED BY
Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY
Dr. Jones

HOSPITAL NAME
Northwind Animal Hospital

REFERRING VET
Dr. Jones

INVOICE
73857

DATE
3/20/26

PRESENTING CLINICAL SIGNS

Patient was seen on 14th for inappetence and increased urination. X-rays on 14th showed stomach distention but no mechanical obstruction. UA was performed and patient was then treated for UTI at urgent care on 3/15. P represented on 3/18 for repeat radiographs due to inappetence and lethargy

Abnormal PE/Chem/CBC/UA Results: UA: USG 1.050, pro 30, neg glu ,ket neg, cocci present on cytology, <1wbv/hpf, rbc 1/hpf -Amoxicillin/clav 125mg BID -Proviable probiotics

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. There is a 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: 4.68×2.11 cm, and the thickness of the cortex is 0.36 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color shows a normal vascular pattern.

The right kidney is normal in shape and size: 4.92×2.68 cm, and the thickness of the cortex is 0.36 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color shows a normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: the left adrenal gland measures 0.51 cm at the cranial pole and 0.71 cm at the caudal pole. A 5.18×5.46 mm hyperechoic, homogeneous nodule is identified (incidentaloma). The right adrenal gland measures 0.47 cm at the cranial pole and 0.45 cm at the caudal pole.

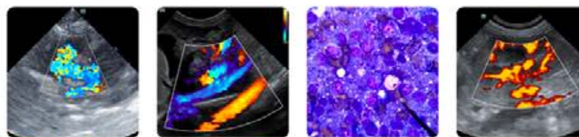
Spleen

Splenic thickness is 1.45 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture, with a small isolated myelolipoma at the level of the splenic hilus. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

Liver

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

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded, with mural thickness (2.07 mm) and preserved wall layering. The pylorus measures 5.69 mm, containing a small amount of fluid.

Duodenum: 2.66 mm. Jejunum: 2.07–2.43 mm, with normal wall layering. No signs of obstruction, ileus, or foreign material are identified. Colon: 0.53 cm, descending colon 1.23 cm, with normal layering, empty lumen, and mild gas content.

Pancreas

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

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Mild left adrenal enlargement (caudal pole 0.71 cm) with small hyperechoic nodule (5.18×5.46 mm).

SECONDARY FINDINGS

- Small splenic myelolipoma.

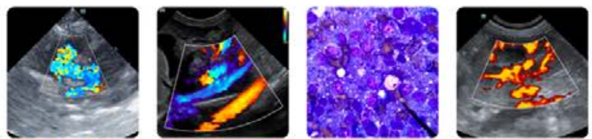
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastrointestinal tract is within normal limits in terms of wall thickness and layering. Reported values (stomach ~2.07 mm, duodenum 2.66 mm, jejunum up to 2.43 mm) fall within accepted canine reference ranges (generally <3–5 mm depending on segment and distension), and the preservation of layering argues strongly against infiltrative enteropathy or neoplasia. The pylorus, measuring 5.69 mm, is within normal limits, although the presence of a small amount of fluid and prior radiographic gastric distension suggests the possibility of transient or functional delayed gastric emptying rather than fixed obstruction. Importantly, no obstructive lesion is identified on ultrasound.

The urinary tract is unremarkable. The ultrasound findings do not provide support for an active urinary tract infection, which aligns with the weak inflammatory evidence on urinalysis.

The left adrenal gland shows mild enlargement at the caudal pole (0.71 cm), exceeding typical reference values for dogs (generally <0.6–0.7 cm depending on body size). The presence of a small, well-defined hyperechoic nodule (5.18×5.46 mm) is most consistent with an incidental adrenal lesion (cortical adenoma or nodular hyperplasia). In the absence of clinical signs suggestive of hyperadrenocorticism, this is likely incidental, although clinical correlation is recommended.

Overall, there is no ultrasonographic evidence of a primary structural abdominal disease explaining the clinical signs. The previous gastric distension observed radiographically, in combination with current normal ultrasound findings, supports a functional gastrointestinal disorder (delayed gastric emptying or transient ileus) rather than a fixed obstructive process.



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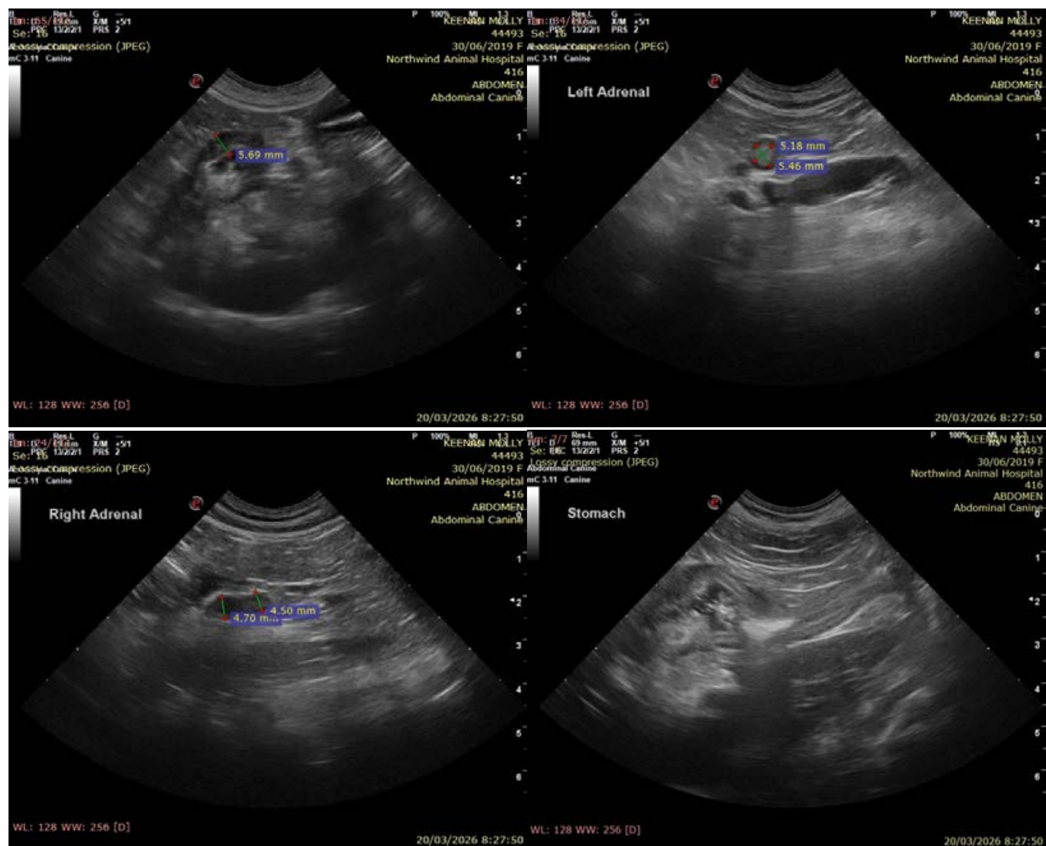
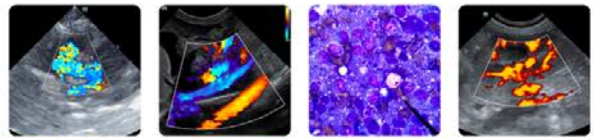
Recommendations

- Clinical monitoring of gastrointestinal signs, with consideration of prokinetic therapy if delayed gastric emptying is suspected.
- Consider pancreatic lipase testing if pancreatitis remains a differential.
- Re-evaluate the need for ongoing antibiotic therapy, as current findings do not strongly support active UTI.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status and ongoing response to treatment.





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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.

info@SonoPath.com