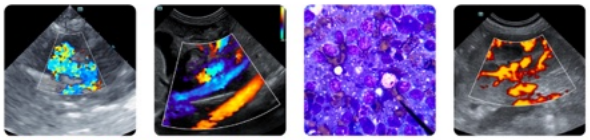


PATIENT

Arvee O'Keefe

SPECIES

Canine

BREED

Baegle

SEX

Spayed female

AGE

11 years

WEIGHT

33.5 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Jocelyn Smith, CVT

HOSPITAL NAME

Annville Cleona VA

REFERRING VET

Dr. Spingler

INVOICE

75048

DATE

4/30/26

PRESENTING CLINICAL SIGNS

History: Chronic allergy patient seen by a dermatologist recently with deep pyoderma that is improving. Has a history of MRSP, lip fold pyoderma, suspected food allergy, probable atopic dermatitis (with environmental allergies). Dermatologists recommended systemic work-up with abdominal ultrasound, chest x-rays, and full bloodwork to check for any other underlying issue.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is mildly thickened at the cranial pole, measuring 3.80 mm (normal canine bladder wall typically ≤2–3 mm when adequately distended). The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. There are no calculi and no evidence of focal inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 4.91×2.70 cm, with a cortical thickness of 0.52 cm in the sagittal plane. The cortex is isoechoic 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 demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 5.76×2.77 cm, with a cortical thickness of 0.46 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. A large renal cyst measuring 4.99×5.37 mm is present. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

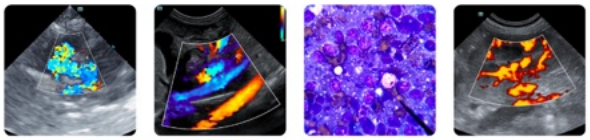
The left adrenal gland measures 0.53 cm in dorsoventral diameter (cranial and caudal poles), which is within normal limits for a dog of this size (typically <0.7 cm). The right adrenal gland is not visualized.

Spleen

Splenic thickness is 1.77 cm. The parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture. Multiple small hyperechoic nodules are present at the splenic hilum, measuring 5.64×6.56 mm and 6.19×8.13 mm, compatible with benign changes such as myelolipomas, fibrosis, or siderotic nodules (Bates bodies). The splenic capsule is smooth and regular.

Liver

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



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The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic with a very small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach contains ingesta, including several intraluminal structures, the largest measuring 2.50×1.37 cm, with a polygonal shape and soft tissue echotexture. These structures do not appear to arise from or attach to the gastric wall in the available images and are most consistent with ingested material. Correlation with dietary history is recommended. The gastric wall measures 3.79 mm with preserved layering. The pylorus measures 5.38 mm. Duodenum: 3.18 mm. Jejunum: 3.49–3.82 mm (mucosa 2.37 mm, submucosa 0.70 mm, muscularis propria 0.38 mm), with preserved wall layering. No evidence of mechanical ileus, obstructive foreign material, or focal inflammatory disease is identified. Colon: 1.24–1.45 mm, with formed feces in the descending segment.

Pancreas

The pancreas measures approximately 1.08 cm in thickness, which is within normal limits for dogs. The parenchyma is isoechoic relative to adjacent omental fat. There is no evidence of peripancreatic fat inflammation.

Free Abdomen

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

PRIMARY FINDINGS

- Mild focal thickening of the cranial urinary bladder wall (3.80 mm)
- Right renal cyst (4.99×5.37 mm)
- Small hyperechoic splenic nodules (likely benign)
- Intraluminal gastric content

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This is a largely unremarkable abdominal ultrasound with predominantly incidental findings, and no clear evidence of a systemic underlying condition contributing to the patient's chronic dermatologic disease.

The left adrenal gland is within normal size limits. The right adrenal gland was not visualized, which limits complete assessment. Therefore, while no abnormalities are identified in the left adrenal gland, hyperadrenocorticism cannot be excluded based on ultrasound alone.

The liver, spleen, pancreas, and gastrointestinal tract do not show abnormalities suggestive of clinically

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significant systemic disease. The small hyperechoic splenic nodules are most consistent with benign, age-related changes (myelolipomas or siderotic nodules) and are clinically insignificant.

The right renal cyst is very small and consistent with an incidental simple cyst, with no expected clinical relevance.

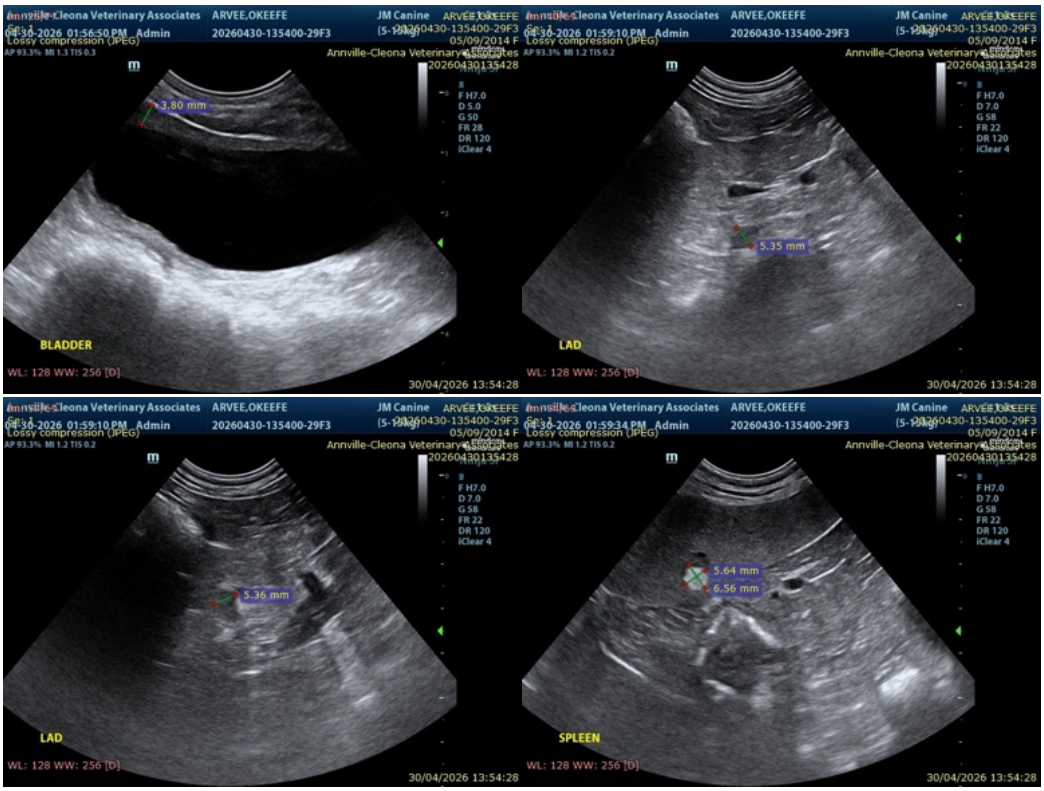
The mild focal thickening of the cranial urinary bladder wall (3.80 mm) is a subtle and nonspecific finding. Given the otherwise normal bladder appearance, this may represent mild focal inflammation, or variation in distension, and should be interpreted in conjunction with urinalysis and clinical signs.

The gastric intraluminal structures are most consistent with ingested material, as they do not appear attached to the wall and there are no secondary signs of obstruction or mass effect.

Recommendations

- Correlate the bladder wall finding with urinalysis, particularly if there are any lower urinary tract signs.
- If there is ongoing clinical suspicion of endocrine disease, functional testing (ACTH stimulation or LDDS) may be considered, as ultrasound alone cannot exclude hyperadrenocorticism.

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



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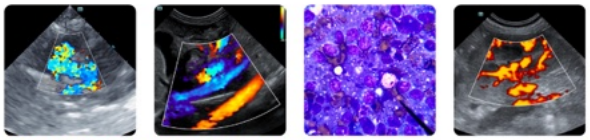

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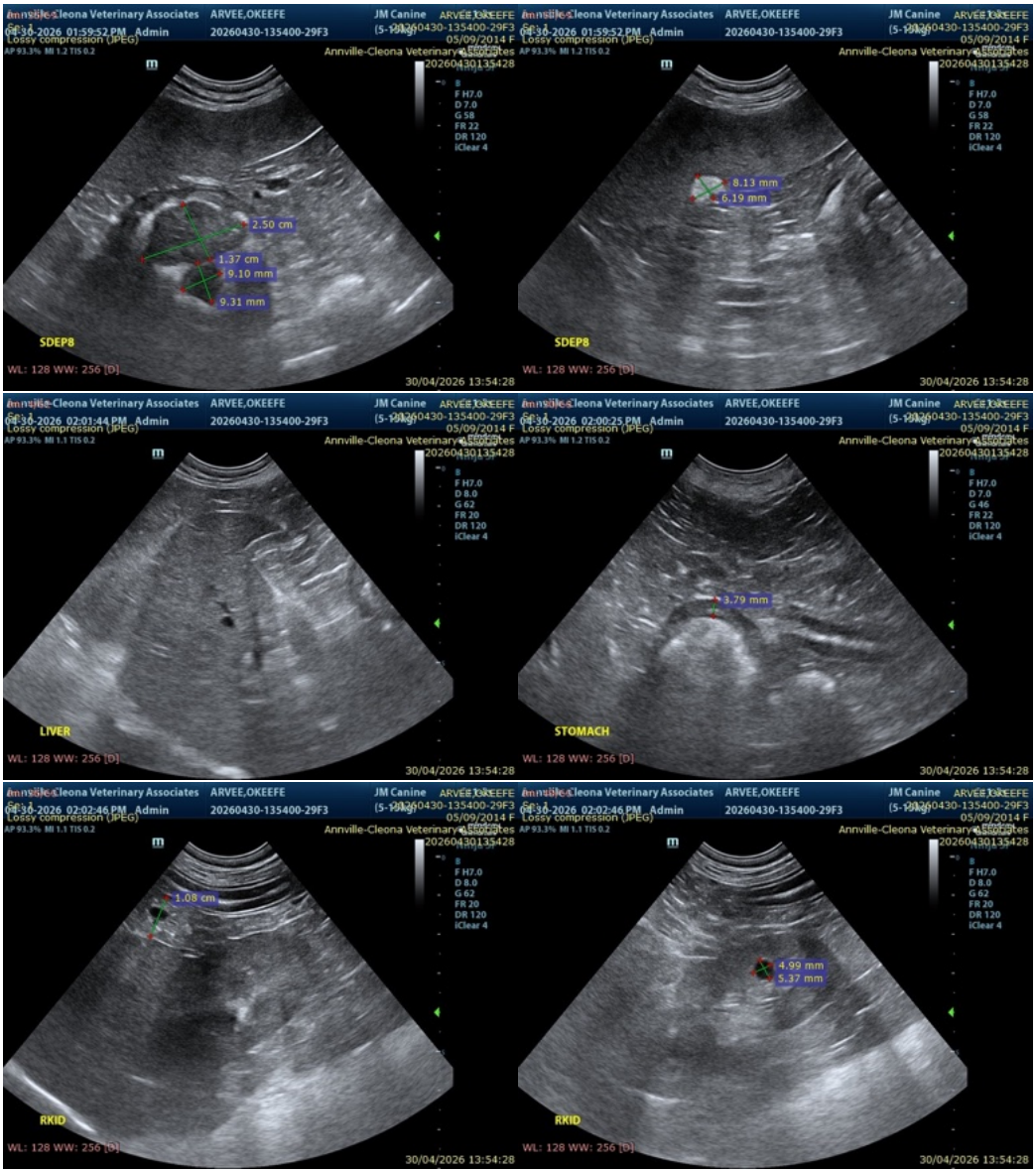

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com