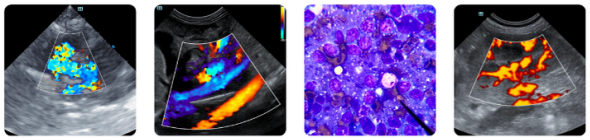


PATIENT

Dexter Apodaca

SPECIES

Canine

BREED

Terrier Mix

SEX

MN

AGE

15

WEIGHT

11.6 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Alexis Carvantes

HOSPITAL NAME

TLC Animal Hospital

REFERRING VET

Dr. Brenda Castorena

INVOICE

11951

DATE

5/13/2026

PRESENTING CLINICAL SIGNS

Patient is a 15-yr old, Male neutered, Terrier. Patient has been having urinary incontinence when sleeping and increased drinking. Bloodwork showed an azotemia. Started patient on Kidney diet and naraquin. Azotemia has improved significantly. Patient still having some urinary incontinence. Recommended full abdominal u/s. Goal: try to find a cause of urinary incontinence and to check kidneys

Abnormal PE/Chem/CBC/UA Results: PLT 601 (120-412) Previously increased CREA 1.1 (0.5-1.5) Was 1.6 in December and 2.2 in NOV 2025) Sodium 155 (142-152) USG 1.022 Otherwise U/A Unremarkable 4dx Negative x 4.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. The bladder neck, trigone region, and proximal urethra are unremarkable. The prostate is not visualized, consistent with prior neutering and/or marked prostatic atrophy. There are no urinary bladder calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.56×2.33 cm, and the thickness of the cortex is 0.41 cm in the sagittal plane. The cortex is isoechoic compared to the hepatic parenchyma. A 1.17×1.29 cm thin-walled anechoic cyst is present at the caudal pole. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size: 3.74×2.07 cm, and the thickness of the cortex is 0.50 cm in the sagittal plane. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates 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 0.54 cm at the cranial pole and 0.56 cm at the caudal pole. The right adrenal gland is not confidently visualized.

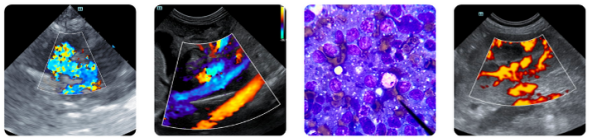
Spleen

Splenic thickness is 1.47 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. 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.

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



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Gastrointestinal Tract

The stomach is empty and folded, with preserved wall layering and normal mural thickness (2.32 mm).

The duodenum measures 1.82 mm and the jejunum measures 2.50 mm, both with preserved wall layering. No ultrasonographic evidence of focal gastrointestinal inflammation, mechanical ileus, or foreign material is identified.

Few formed feces are present within the descending colon.

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 iliac trifurcation is normal.

PRIMARY FINDINGS

- Left renal cortical/parapelvic cyst

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A solitary thin-walled left renal cyst is identified. This finding is most consistent with an incidental simple renal cyst and is unlikely to account for the patient's urinary incontinence. No ultrasonographic evidence of obstructive nephropathy, pyelonephritis, nephrolithiasis, hydronephrosis, or advanced chronic renal architectural change is identified.

The kidneys are otherwise ultrasonographically within normal limits, with preserved corticomedullary architecture and normal renal size. Given the previously documented azotemia and mildly decreased urine concentrating ability, early or mild chronic kidney disease remains possible despite the relatively unremarkable current renal ultrasonographic appearance, as functional renal disease may precede overt morphologic change.

No clear ultrasonographic cause for urinary incontinence is identified on the current study. The urinary bladder neck and proximal urethral region appear unremarkable, and there is no evidence of lower urinary tract inflammation, mass lesion, or urolithiasis. In an older neutered male dog, the clinical signs may reflect functional urinary incontinence and/or polyuria-associated leakage.

Recommendations

- Continued monitoring of renal values, SDMA (if available), urine specific gravity, blood pressure, and UPC ratio is recommended given the history of azotemia and persistent PU/PD.
- Urine culture may still be considered if clinical suspicion for occult urinary tract infection persists despite the relatively unremarkable urinalysis and ultrasonographic findings.
- If PU/PD remains clinically significant, endocrine testing (particularly screening for hyperadrenocorticism) may be considered based on overall clinical suspicion.
- If urinary incontinence persists or worsens, further evaluation for functional/neurogenic

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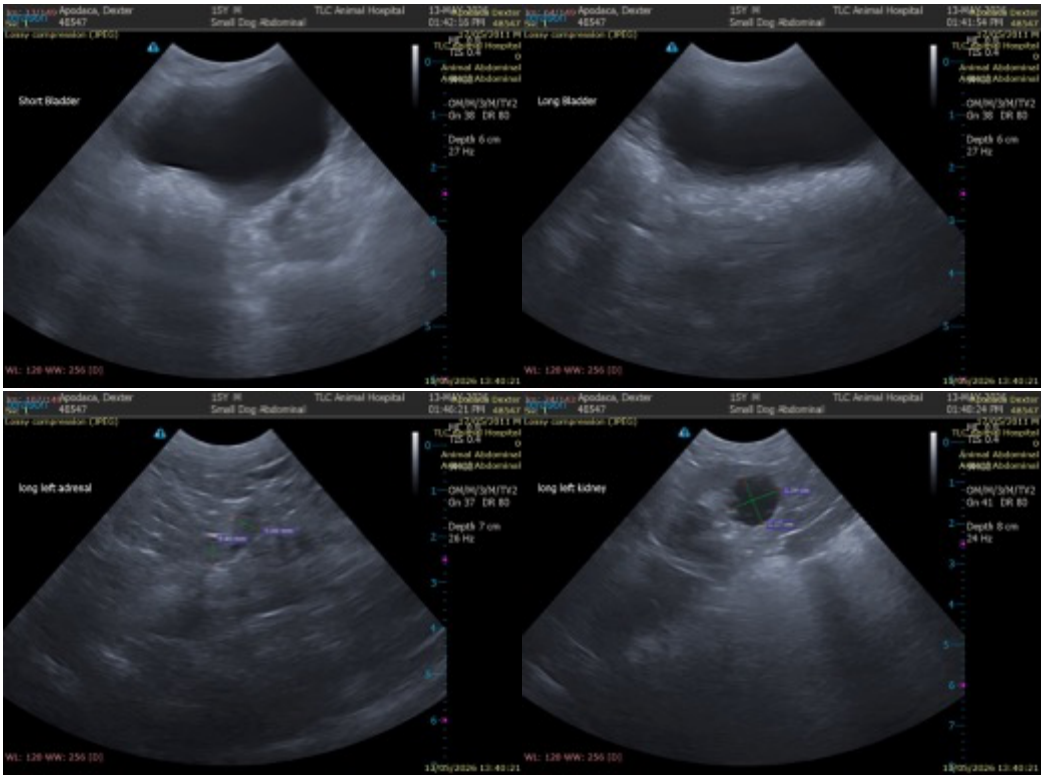
urinary incontinence may be appropriate, as no clear structural ultrasonographic cause is identified on the current study.

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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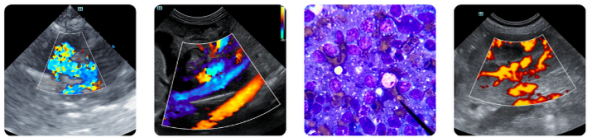

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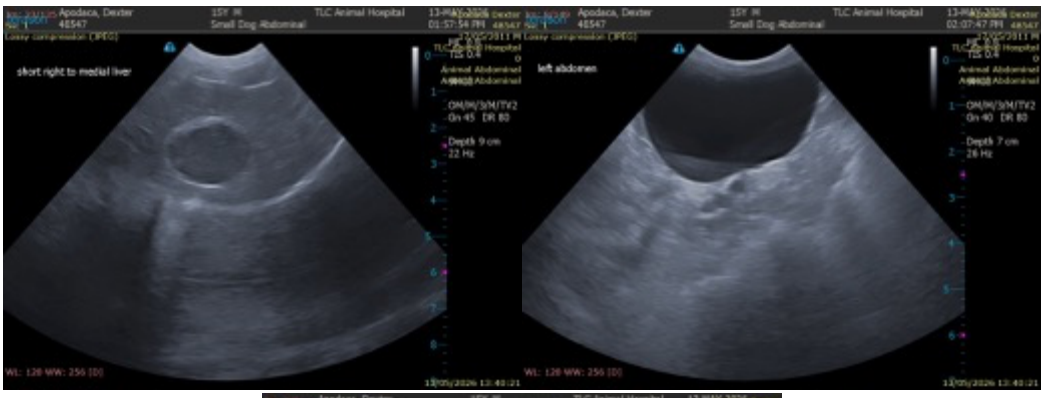

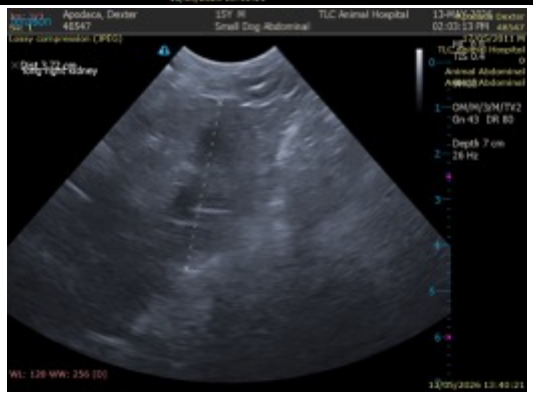

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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