Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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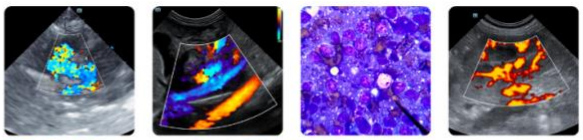

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Rufus Harris

SPECIES

Canine

BREED

Dachshund

SEX

Male Neutered

AGE

1/1/16

WEIGHT

22.70

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Waterway AH

REFERRING VET

Dr. Walker

INVOICE

23022

DATE

5-15-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Check teeth (mouth) - had a dental with extractions- periodically his mouth seems tender. esp. with hard treats. Concerned that he may have a UTI - for the last 7 days or so he has had frequent urination - with accidents in the house. Urine appears dark - but not bloody. When urine has been found in the house after drying it does appear dark. Urinalysis reveals a USG of 1.040. 2+proteinuria. No pyuria or hematuria. Struvite crystals present.
Current Medications: Rimadyl 25mg - 1 tab po every 12hrs, Filaquin

Radiographic Findings: 4 images dated 2/6/2026 are submitted for interpretation.
On the lateral views of the abdomen, the liver is normal size. A small amount of gas is noted within the stomach. The spleen is smooth. There is questionably a soft tissue bulge
associated with the tail of the spleen, or this could be overlying fluid-filled small intestine. The urinary bladder is mildly distended. No evidence of medial iliac lymphadenopathy is
detected radiographically. There is no evidence of a mineral calculus detected overlying the urinary bladder. Gas and fecal material are detected within the descending colon. No
definitive abnormalities are detected associated with the lumbar spine, sacrum, or include a coccygeal vertebra.

Note: On particularly the right lateral view, a round, faint mineral dense opacity is detected overlying the urinary bladder. Again, this may be secondary to ingesta within the small
intestine or could be within the urinary bladder proper.
On the ventral dorsal views of the abdomen, the head of the spleen is smooth. A small amount of gas is noted within the gastric lumen. Gas is noted within the cecum. The right
renal silhouette is normal size and smooth. The left renal silhouette cannot be adequately evaluated due to overlying gastrointestinal tract. Coxofemoral joint confirmation is
adequate. Gas and fecal material are detected within the descending colon.
Question bulge associated with the tail of the spleen–may be secondary to splenic folding or could be secondary to overlying fluid-filled small intestine.
Question a round, very faint mineral opacity overlying the urinary bladder–may be secondary to ingesta within the small intestine but could also be present within the urinary
bladder proper. It may be useful in this individual, to consider a focal abdominal ultrasound to further evaluate the urinary tract in this individual. Also consider peek at the tail of the spleen.
Consider a round of antibiotics for any evidence of cystitis. Consider a urine analysis.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 4.5-5.0 cm, are normal.

The prostate is normal in size (0.79 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.38 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal- to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.34 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal- to mild loss of

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corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.58 cm at cranial pole) (0.75 cm at caudal pole) with slightly irregular shape. A 0.72 x 0.54 cm hyperechoic nodule is observed at the caudal aspect. The remaining glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.42 cm at cranial pole) (0.3.9 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.25 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is distended. The wall is normal in thickness. A large amount of aggregated, echogenic- to mineralized, partially dependent sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. The wall of the descending colon is normal- to mildly-thickened (up to 0.34 cm) with a normal layering pattern. Granular-appearing fecal material is observed within the lumen. There is no obvious evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

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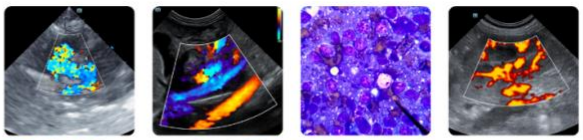

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gallbladder changes are suggestive of a developing mucocele.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely. However, correlation with the patient's liver values is recommended.

Secondary Findings

- Mild left adrenomegaly. The left adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.
- Mild bilateral nonspecific age-related renal changes
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The mild descending colonic wall thickening could be consistent with colitis or may be a normal variant for this patient. Emerging neoplasia is possible but considered less likely.

*An obvious cause for the patient's dysuria is not identified in this study. Considerations include occult urinary tract infection, distal urethral calculi, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A minimum database (including a CBC, chemistry panel, and T4) is recommended to assess overall metabolic function.
- A urine culture +/- UPC (if proteinuria persists in the absence of infection) should also be considered.
- Consider a lateral pelvic radiograph to assess for distal urethral stones (if not already performed).
- Depending on the results of the above diagnostics, further work-up may be indicated.
- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 4-6 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.

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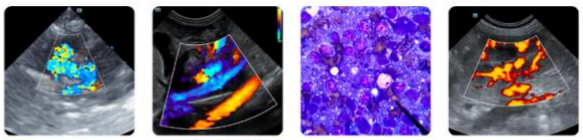

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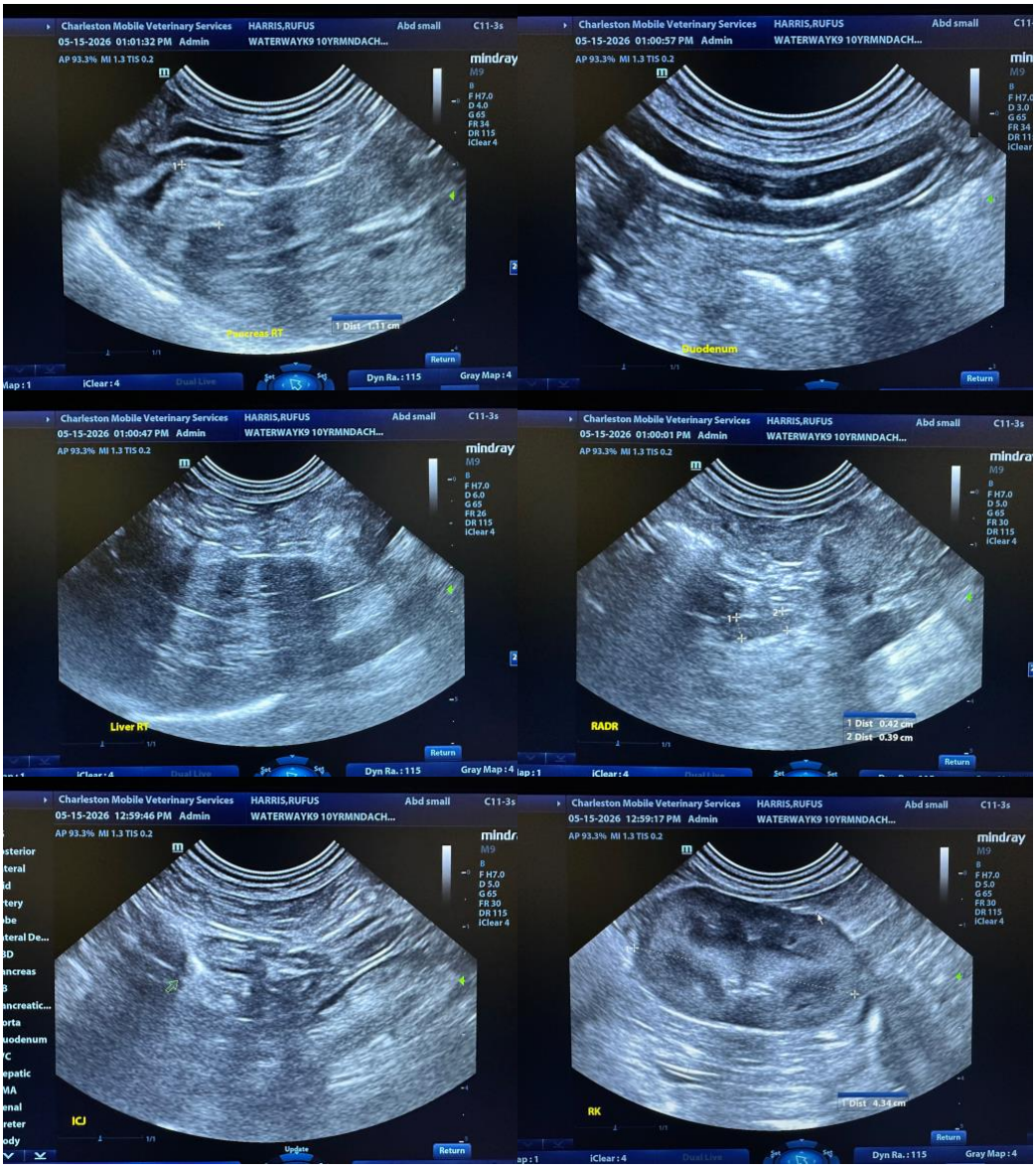

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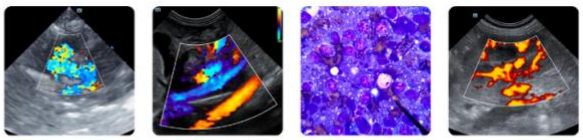

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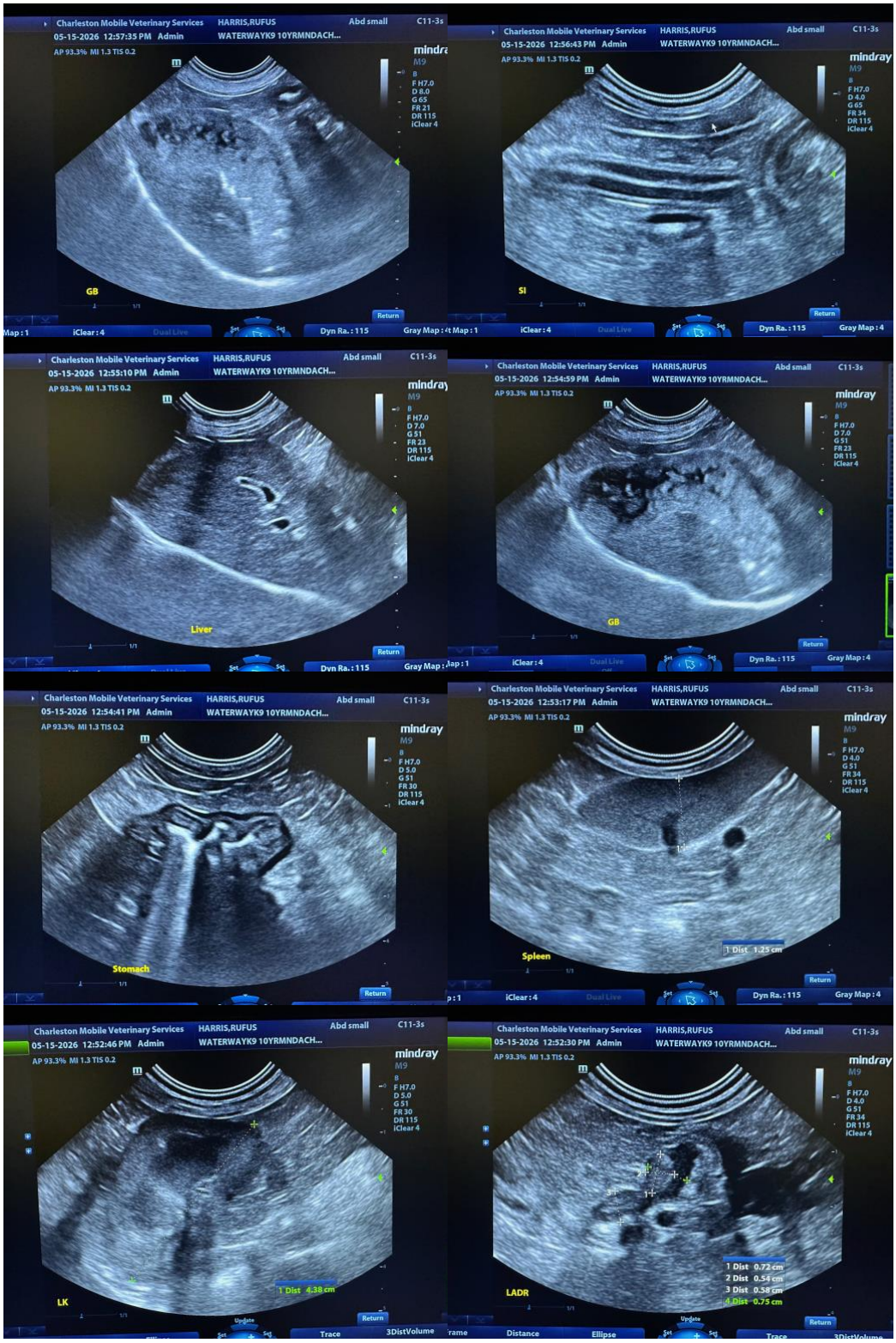

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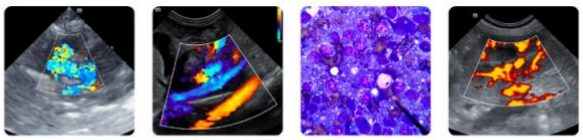

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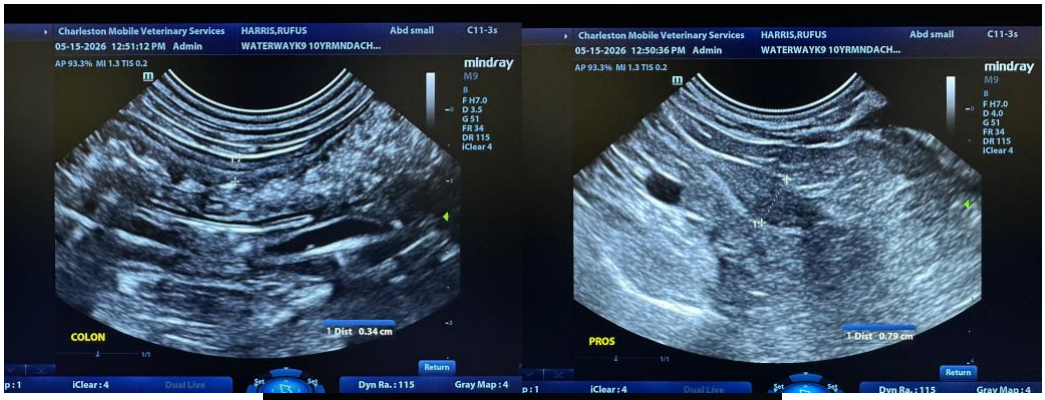

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com