



PATIENT

Teddy Pitkin

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Neutered Male

AGE

11 Years

WEIGHT

6.8 kg

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Dr. Alyssa Huntington

HOSPITAL NAME

Wilvet South

REFERRING VET

Dr. Alyssa Huntington

INVOICE

16423

DATE

06/06/26

PRESENTING CLINICAL SIGNS

P started to V+ early this morning O says it was very dark brown and mucousy. P is not able to walk much P will get excited to see O when getting home but he will just fall over. O says P is still acting like he can't see her. P got up in the bed and walked straight off of it like he didn't know where the edge was

Hydration: Slightly dehydrated Eyes: Abnormal: Cataracts OU, PLR reduced OD, absent OS; absent menace response, palpebral reflex intact OU Ears: Abnormal: Mild brown cerumen AU Nasal Cavity: Abnormal: Nasal depigmentation, dry mild hyperkeratosis NP Respiratory: Abnormal: Tachypnea, no abdominal effort noted Abdomen: Abnormal: nauseous on palpation of cranial abdomen (lip-licking, regurgitation) Integument: Abnormal: Greasy haircoat 5/18 BW: Chem 17: TP 8.4H, Globulins 4.6H, CBC: HCT 64.2 High Pancreatic Lipase: 138 Normal 6/6 BW: EPOC: Na+ 154 mmol/L (H) BUN 39 mg/dL (H) Glu 157 mg/dL (H) Hct 69 % (H)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder contains an ill-defined hyperechoic mass lesion in the bladder trigone with multifocal hyperechoic shadowing structures. The remainder of the bladder wall is normal. The trigone appears patent, and pelvic urethra appear patent. The bladder is otherwise normal in wall thickness and tone.

The kidneys are normal in size and structure. The cortices are hyperechoic with a loss of corticomedullary distinction. There are mild to moderate renal cortical cystic changes and mild dystrophic mineralization noted bilaterally. The left kidney measures 4.0 cm. The right kidney measures 3.5 cm.

Adrenal Glands

Both adrenal glands are not readily visualized.

Spleen

The spleen is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented. The spleen measures 1.2 cm at the hilus.

Liver

The liver is normal in size and contour with a diffusely mottled or heterogeneous parenchymal pattern. Vasculature is normal with no evidence of congestion. There is a moderate amount of suspended echogenic debris and dependent sediment within the gallbladder. The walls are appropriately thin. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

Gastrointestinal



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The stomach and intestines are free of stasis and peristaltic activity, with no significant dilation noted. There is normal wall thickness and acceptable curvilinear mural detail. The pyloric-duodenal junction and ileoceocolic junction are patent, and the colon contains normal shadowing feces. There is no evidence of shadowing obstructive material or overt infiltrative disease noted. No associated abnormal lymphatic activity is documented.

Pancreas

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

Free Abdomen

There is no significant lymphadenopathy or free fluid.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder lesion within the trigone may represent a trigonal mass effect. However, the hyperechoic shadowing foci may represent a urolithiasis with subsequent cystitis or inflammation within the region.
- There is increased renal cortical echogenicity and thickening with a mildly irregular capsular contour. Multifocal cystic cortical changes are noted. This is secondary cystic formation consistent with degenerative changes and remodeling. There is no evidence of abscessation or suspicion of neoplasia. Dystrophic mineralization was noted and is non-obstructive at this time, with no evidence of pyelectasis.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory, immune-mediated, metabolic, or endocrine disease. Infiltrative neoplasia or acute hepatitis cannot be ruled out.
- The gallbladder contains echogenic, suspended and dependent unorganized debris. This is not yet to the level of an organized mucocele, however early/developing mucocele cannot be ruled out. This dependent sediment is often an incidental finding or may be associated with concurrent endocrine disease such as hyperadrenocorticism or diabetes mellitus.
- The gastrointestinal tract appears normal, and there is no overt evidence for the acute gastrointestinal signs noted on this study.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection. Fine needle aspirates of the liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

A focal evaluation of the urinary bladder and trigonal region is recommended to better assess if this irregularity truly has the appearance of a mass lesion or there is the presence of mobile urolithiasis. If the lesion appears more solitary with no overt mobility, FNA of the lesion is recommended. Empiric therapy for acute gastroenteritis is recommended at this time. When gastrointestinal signs have resolved, consider the addition of ursodiol and Denamarin, given the gallbladder debris.



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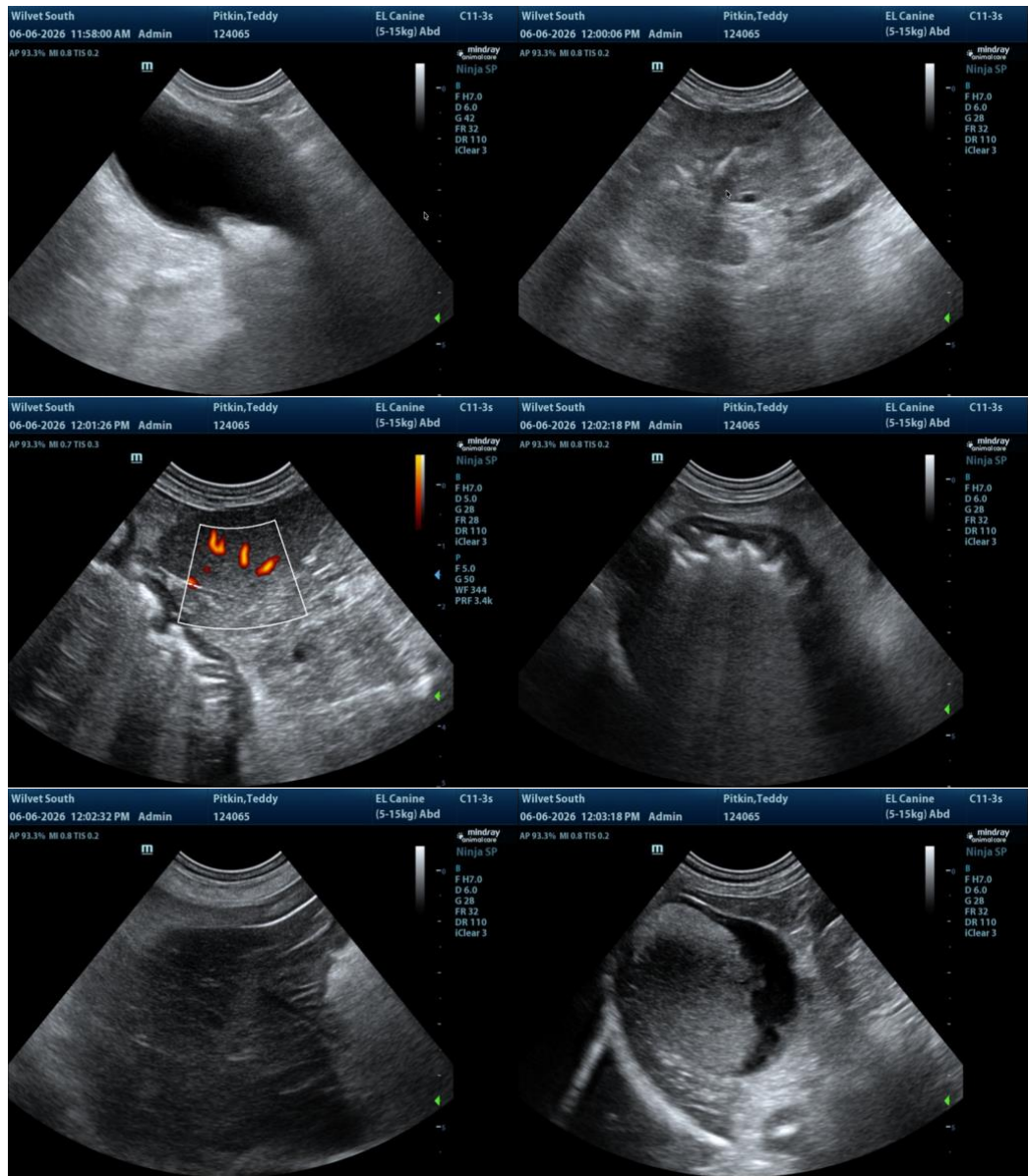
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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