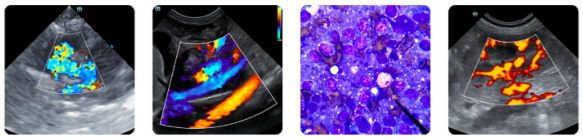


DATE

1/19/2026

PATIENT

Frazier Smoker

SPECIES

Canine

BREED

Boxer

SEX

MN

AGE

8 years old

WEIGHT

73 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Pleasantville Animal Hospital of Fallston

REFERRING VET

Dr. Gounaris

INVOICE

11156

PRESENTING CLINICAL SIGNS

Patient History: Presented 12/31/2025 for urinary accidents, drinking a lot of water, and frequently urinating large volumes. Urine is clear. Eating normally. No c/s/v/d. Normal energy level. No recent weight gain or excessive panting reported by owner. Owner reports a consistent urinary stream, large volumes at a time. Cardiac disease is managed by cardiologist. Patient has received annual lepto vaccines throughout his entire life. Unremarkable PE.

Current Medications: Sotalol 40 mg BID (03/2025), Mexiletine 150 mg capsules TID (began 09/2025)

Labwork Results: Labwork not attached, reported as: BW from 12/31/2025 visit - Hyperkalemia 6.6 - Mild hypernatremia 151 - Na/K 23 - CO2 31 (17-25) - Mild hemolysis. Resting Cortisol 1/3/2026 2.8 (1-4) Urinalysis/Sediment 12/31/2025 - 1+ protein - USG 1.016. USG 1/06/2026 after water deprivation overnight - 1.012

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture, and echogenicity for a neutered male.

The right kidney is normal is size (6.17 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (6.95 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.8 cm at cranial pole and 0.9 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.8 cm at cranial pole and 0.9 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- This is a largely unremarkable/normal structural abdomen without a definitive ultrasonographically visible intraabdominal explanation for patient's reported urinary signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Differentials for PU/PD are vast and include, but are not limited to:

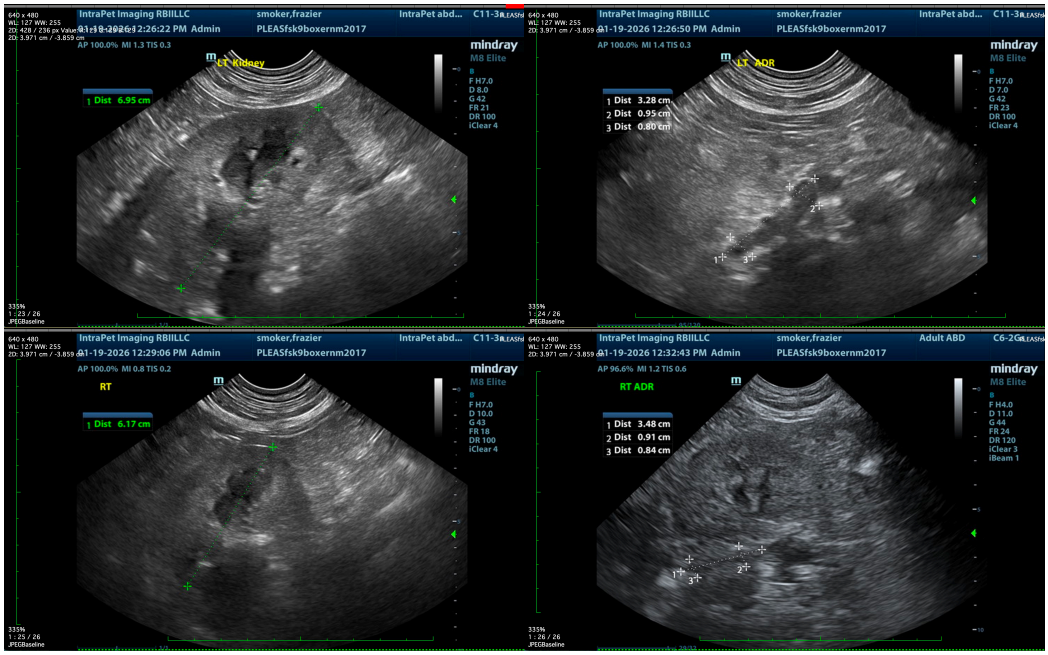
Primary polyuria caused by chronic kidney disease, pyelonephritis, liver disease, diabetes mellitus, hyperthyroidism, hypercalcemia, hyperadrenocorticism, hypoadrenocorticism, E.coli infections ie) pyometra

in females, polycythemia, central diabetes insipidus or primary nephrogenic diabetes insipidus. Primary polydipsia caused by psychogenic polydipsia, fever, pain, or central nervous system disease.

Most causes of PU/PD can be diagnosed with a comprehensive history and physical exam, a first AM urine specific gravity to see if urine concentration is possible (as most animals naturally consume less water overnight) followed by a comprehensive CBC, serum chemistry panel, electrolytes, and urinalysis.

If not, next step(s) may include a urine culture, low dose dexamethasone suppression test, T4, bile acids, Leptospirosis testing and/or an empirical course of antibiotics.

If a diagnosis is still not obtained, a more advanced work-up is indicated and consultation with an internist may be warranted.



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.

Beth Johnson, DVM, DACVIM
info@sonopath.com