

PATIENT

Paisley Park

SPECIES

Canine

BREED

Barbet

SEX

Spayed Female

AGE

10 Years

WEIGHT

23 kg

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Hartzel AH

REFERRING VET

Dr. Neill

INVOICE

35250

DATE

1/5/26

PRESENTING CLINICAL SIGNS

History: 11/13/2025 - Paisley presented to the Central Toronto Referral & Emergency Clinic for polyuria, blood seen in urine, and agitation - hematuria - pollakiuria - straining to urinate - agitation - mild pain on caudal abdominal palpation - mild erythema of the vulva Diagnosed with a UTI with crystalluria - discharged with Clavaseptin for 7 days and Gabapentin for 3-5 days. A recheck urinalysis was recommended 7-9 days after starting treatment. After follow up UA on 21/11/2025, an additional 7 days of Clavaseptin was dispensed. After Repeat UA on 12/20/2025, 14 days of Zeniquin was dispensed. Current Medications Zenrelia 8.5mg tablets, 2 tabs PO SID. Zeniquin 50mg tablets, 1.5 tabs PO SID.

Abnormal PE/Chem/CBC/UA Results: Free Catch UA on 11/13/2025: - pH of 9.0 - significant proteinuria (500 mg/dL) - hematuria (250 Ery/uL) - pyuria (500 Leu/uL) microscopic findings: - >50 WBC/hpf - >50 RBC/hpf - suspected cocci - struvite crystals 21-50/hpf Repeat Free Catch UA on 11/21/2025 pH: 7.0 - Sp. Grav: 1.035 - Protein: 30mg/dL - Hemoglobin: 10Ery/uL - Leukocyte Esterase: 25Leu/uL Microscopic Findings - WBCs 2/HPF - RBCs 3/HPF Repeat Free Catch UA on 11/29/2025 - pH 6.5 - Sp. Grav 1.041 - Trace Protein - Hemoglobin: 10Ery/uL - Leukocyte Esterase: 25Leu/uL Microscopic Findings: - WBCs < 1/HPF - RBCs 2/HPF Repeat Free Catch UA on 12/20/2025 - pH 7.0 - Sp. Grav 1.042 - Trace Protein - Leukocyte Esterase: 100Leu/uL Microscopic Findings: - WBCs 5/HPF - RBCs 4/HPF.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is not quite adequately or fully distended but contains primarily anechoic contents. No masses, inflammatory changes, echogenic sediment, or cystoliths are observed. The bladder wall is diffusely mildly thick, measuring 0.43 cm thick, with this thickness could be partially exacerbated by the underdistended state. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (5.9 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.

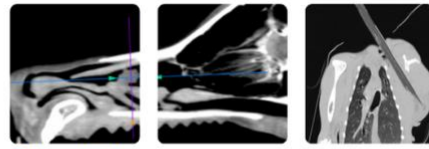
Right kidney is normal in size (6.52 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.57 cm at cranial pole and 0.51 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.3 cm at cranial pole and 0.4 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen



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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.

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Liver

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.

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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.

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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.

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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.

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

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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.

IMAGING PERFORMED BY

Kelly Reschny

Free Abdomen

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

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There is no apparent pathologic lymphadenopathy noted in these images.

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Dr. Neill

ULTRASONOGRAPHIC FINDINGS

- There is not a definitive ultrasonographically visible intraabdominal explanation for patient's reported urinary signs, which based on history, are most likely secondary to a urinary tract infection. Having said that, it's difficult to fully assess the urinary bladder wall for pathology without further distention.

INVOICE

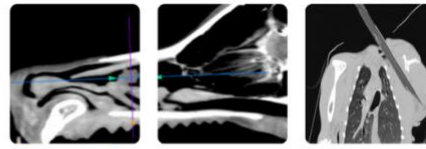
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further recommendations depend in part on patient's clinically and culture response to reported management of the suspected urinary tract infection. If clinical signs persist and/or infection hasn't full cleared or continues to return, next steps are, if possible, reassessment of a fully distended urinary



PATIENT bladder via ultrasound.

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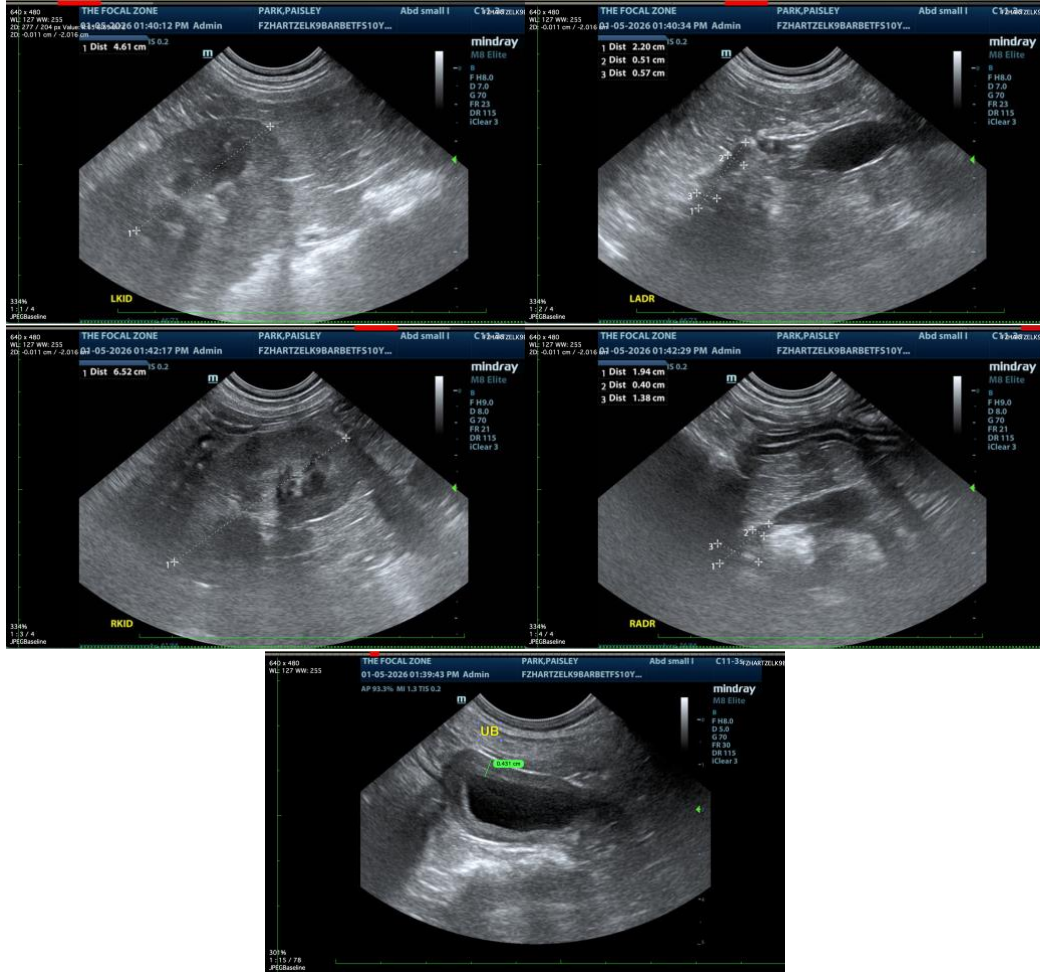
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

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