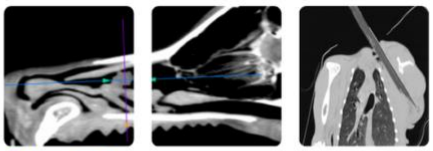


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Betsy Frieday

SPECIES

Canine

BREED

Schnoodle

SEX

Spayed Female

AGE

14 Years

WEIGHT

9 kg

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hamilton Region EC

REFERRING VET

Dr. Pask

INVOICE

35949

DATE

2/24/26

PRESENTING CLINICAL SIGNS

- Hematuria, dribbling urine, unable to urinate
- PE WNL, no obvious stones visible on radiographs
- Suspected IVDD on rads
- Buprenorphine
- Abnormal PE/Chem/CBC/UA Results: Potassium 3.4 ALP 270 Amylase 437

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

In the area of the urinary bladder is a perfectly round anechoic density with subtle echogenic lines running through it, down into the urethra, consistent in appearance with a possible foley catheter (there's no provided history, however, of patient having a catheter in place). Additionally, within the proximal to mid urethra is an approximately 0.64 cm x 0.91 cm in size, slightly mixed in appearance density, that may also be associated with the urinary catheter, if in place, although tissue pathology can't be ruled out. Very subjectively, the visible urethral wall appears mildly thick, echogenic and irregular, measuring 0.45 cm thick. Otherwise, the urinary bladder is unable to be assessed, including assessment of the urinary bladder wall due to lack of distention.

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.

Left kidney is normal in size (4.31 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 (4.32 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.

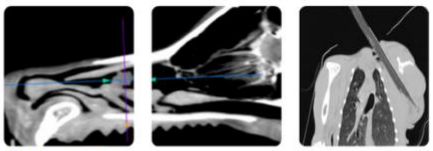
Adrenal Glands

Left adrenal gland is normal in size (0.58 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.1 cm at cranial pole and 0.43 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. 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.

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 a mild amount of anechoic free fluid present in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Suspect a foley catheter present within the urinary bladder, and a possible mildly thick urethra, but as described above, full assessment of the urinary bladder is unable to be provided due to the completely empty presentation.
- A mild amount of free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

Secondary Findings

- Hyperechoic splenic nodules- most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation,

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granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

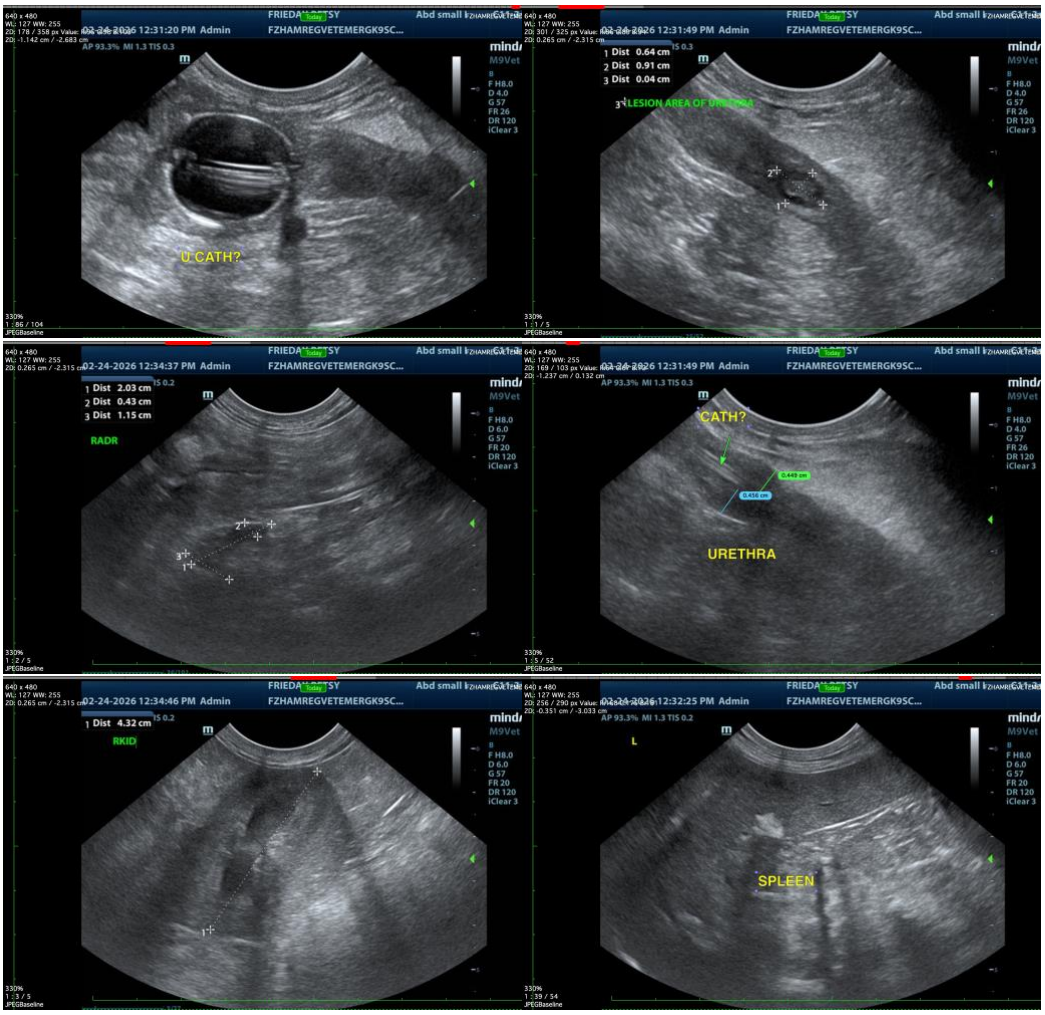
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis, and if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Additionally, submission of urine to look for BRAF gene mutation could be considered.

Pending results of above reassessment of a fully distended urinary bladder may be helpful in further identifying/ruling out wall pathology.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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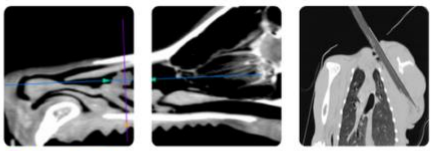

Teleradiology
Educational Teleconsultation Services™

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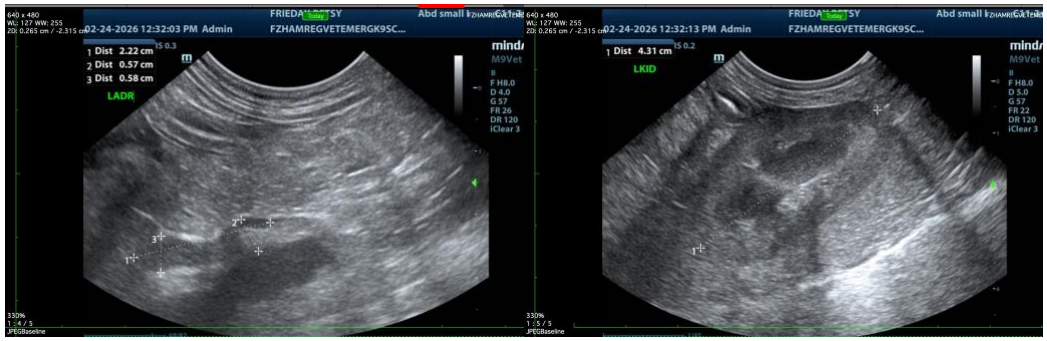

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@sonopath.com