



PATIENT

Jack Dedrick

SPECIES

Canine

BREED

American Bulldog x

SEX

Neutered Male

AGE

11.5 Years

WEIGHT

40.8 kg

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Queensway Veterinary
 Hospital

REFERRING VET

Dr. Addison

INVOICE

73523

DATE

3/10/26

PRESENTING CLINICAL SIGNS

Weight loss, PU/PD, panting more. Has been on Gabapentin.

Abnormal PE/Chem/CBC/UA Results: ALP 578(23-212U/L) ALT 257(10-125U/L) Na:K 27 K 5.5(3.5-5.8mmol/L) cortisol normal USG 1.007 4dx negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is subjectively mildly overdistended with anechoic contents. This finding should be interpreted in combination with when patient last urinated, any possible lower urinary tract signs, etc., as it is likely normal patient variant, given reported PU/PD. 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.

The area of the prostate is examined without evident prostatic pathology.

The right kidney is normal is size (6.77 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 (6.94 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 unable to be visualized in these images.

The left adrenal gland is normal in size (0.86 cm at cranial pole and 1.0 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.



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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.

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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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ULTRASONOGRAPHIC FINDINGS

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

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further investigation of patient's weight loss is largely dependent on appetite.

If not already evaluated, a thorough evaluation of daily caloric intake is recommended to assure an adequate daily caloric intake is occurring vs an inadvertent reduction in calories due to change in diet and/or feeding schedule, competitive eating environment, etc.

IMAGING PERFORMED BY

Crystal Hill

Especially in the face of normal or even increased daily caloric intake, if blood glucose has already been assessed and is normal, further evaluation of digestion and absorption should be considered, beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

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

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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.

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Primary polydipsia caused by psychogenic polydipsia, fever, pain, or central nervous system disease.

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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.



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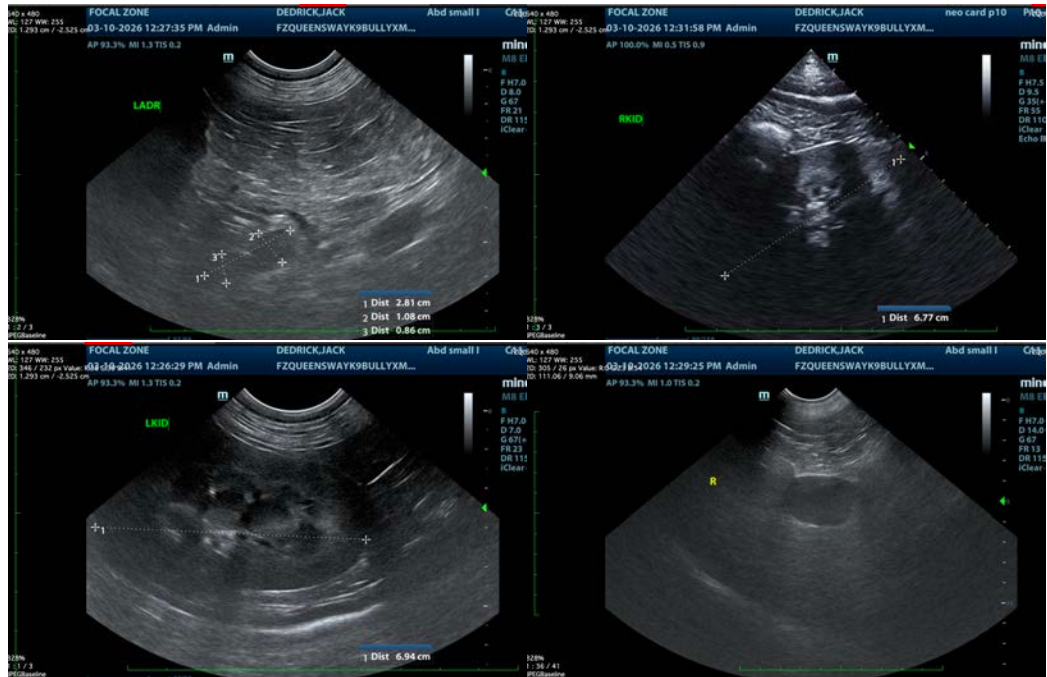
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If a diagnosis is still not obtained, a more advanced work-up is indicated and consultation with an internist may be warranted.

A sedated ultrasound may be helpful for deeper evaluation and visualization of the right adrenal gland.



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