

PATIENT

Ivy Berghausser

SPECIES

Canine

BREED

Schnauzer Mini

SEX

FS

AGE

6Y, 5M

WEIGHT

9.45kg

INTERPRETED BY

Beth Johnson, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Brian Barnes

HOSPITAL NAME

Westview Veterinary
Hospital

REFERRING VET

Dr. Brian Barnes

INVOICE

74565

DATE

4-13-26

PRESENTING CLINICAL SIGNS

Previous history of bladder stones , removed April 2023. Wre mostly Struvite , and Ammonia Acid Urate has been on urinary foods since. . Stoes reoccurring

Abnormal PE/Chem/CBC/UA Results: U/A: Free catch, dark yellow, sl cloudy, USG 1.024, pH 9, Leu neg, Pro 100, Glu/ Ket/ Bil Negative, UBG normal, Bld 250 . SEDI: WBC 4/HPF, RBC <50/HPF, Bac 0, Non-SEC 1-2/HPF, Cast 0, Crystals 0

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. At least three discrete shadowing cystoliths are noted within the empty urinary bladder, the largest of which measures approximately 1.1 cm in size. The smaller ones measure 0.3-0.4 cm in size. No visible masses are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

The right kidney is normal is size (4.69 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Trace pyelectasia and pinpoint nonobstructive mineral densities are noted.

The left kidney is normal is size (4.72 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Trace pyelectasia and pinpoint nonobstructive mineral densities are noted.

Adrenal Glands

The right adrenal gland is normal in size (0.32 cm at cranial pole and 0.37 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.31 cm at cranial pole and 0.42 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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. Some mineral/sand debris within the gallbladder is suspected. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.



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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.

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

- Multiple cystoliths.
- Trace bilateral pyelectasia with pinpoint nonobstructive nephroliths noted bilaterally.
- Moderate gallbladder debris – Some mineral/sand debris with no visible evidence of obstruction is suspected. Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's history of struvite and urate stones, ruling out a urinary tract infection is recommended via urine culture if not already evaluated.

Additionally, assessment of patient's liver function is recommended in the form of bile acids to begin with if patient's total bilirubin is not increased.

In the meantime, both of those historical stones are dissolvable so dissolution processes could be initiated or in case of an alternative non dissolvable stone, an anesthetized voiding urohydropropulsion/bladder flush could be considered to try to obtain at least one of the smaller stones for analysis.



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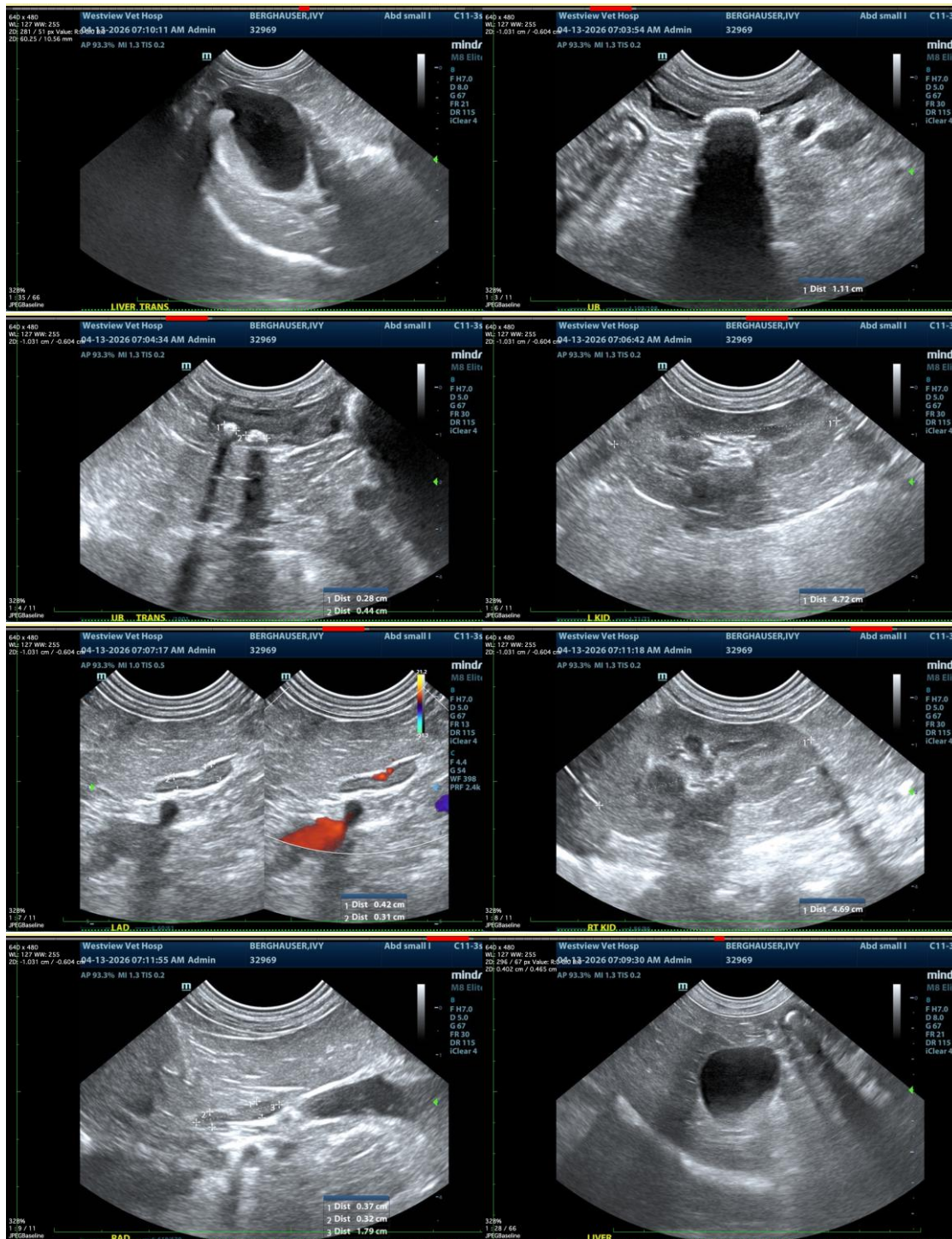
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com