PATIENT

Dolly Smith

SPECIES

Canine

BREED

Mixed

SEX

FS

AGE

3 years

WEIGHT

10 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Pamela harrigan, RDCS

HOSPITAL NAME

Chase Veterinary Clinic

REFERRING VET

Dr. Hallie Lipinski

INVOICE

11831

DATE

4/29/2026

PRESENTING CLINICAL SIGNS

On-going urinary issues with stranguria and hematuria since January. discolored/bloody urine. No concerning findings on PE. Treated with amoxycillin with some resolution, not complete. Presented recently with similar signs. Treated with 10-day course of enrofloxacin 34 mg SID based on urine culture - no improvement of symptoms while on medications. Cysto done today - dark yellow/orange color. Chem: Cystatin B 112 (H), Glob 4.4 (H). UA: 2+ protein, 3+ blood, *3+ bilirubin*, occasional struvie and bilirubin crystals. Urine culture positinve for E.Coli <1000 CFU per ml.

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.

The right kidney is normal is size (4.53 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A very subtle hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (4.37 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A very subtle hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.36 cm at cranial pole and 0.33 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.35 cm at cranial pole and 0.37 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

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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted. 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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

- Very subtle bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The kidney changes described above are very subtle, but if a full general metabolic health screen, including CBC, Chem panel, and electrolytes has not been evaluated is recommended.

Otherwise, there's not a definitive ultrasonographically visible intraabdominal explanation for patient's reported ongoing urinary signs. Given the recent infection, continued medical management of the urinary tract infection based on culture and sensitivity results, is recommended, potentially treating the infection a little longer as a complicated infection, also to include a mid-treatment urine culture to assure no change in resistance pattern, secondary organisms, etc. as well as a final culture a week to 10 days after finishing antibiotics to assure that the infection has fully cleared to help better determine a persistent infection versus truly recurrent infections. If recurrent infections are present and underlying metabolic cause cannot be found, further evaluation of the urinary tract via advanced imaging such as cystoscopy could be considered.

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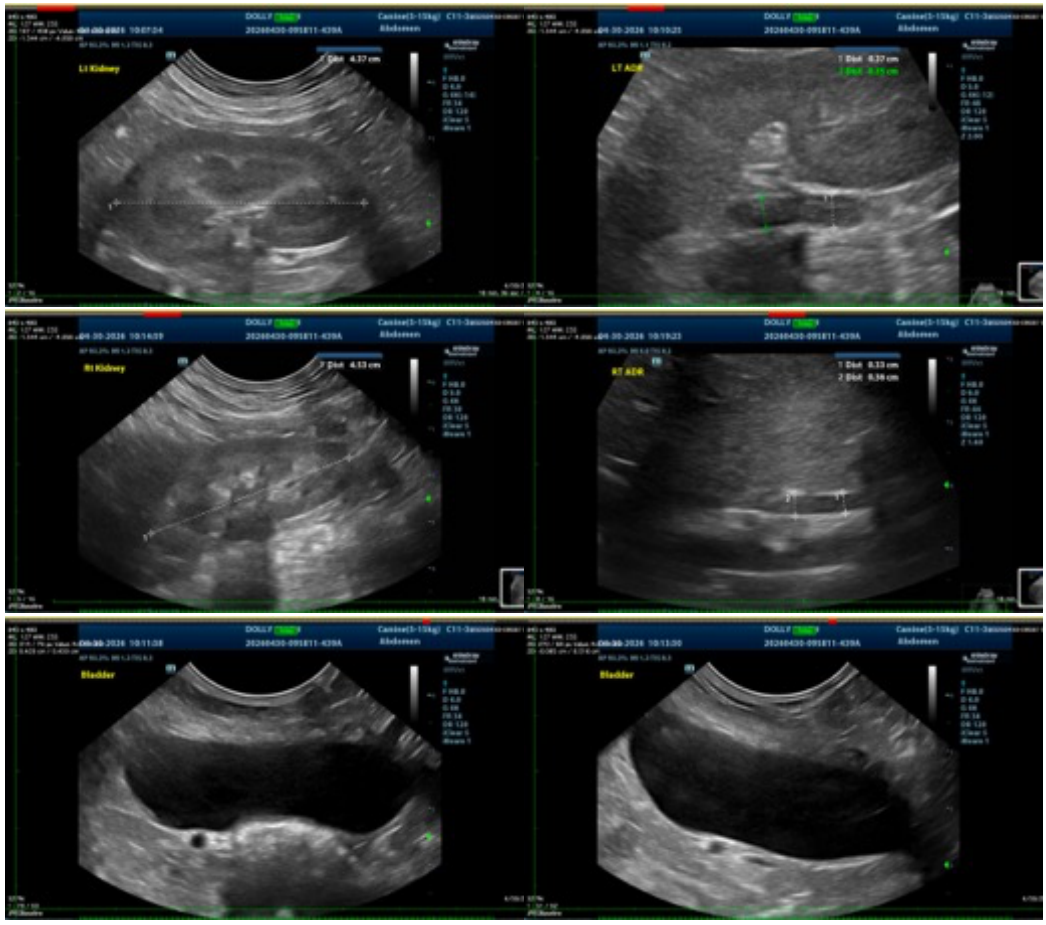

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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