



PATIENT

Abby Smolkin

SPECIES

Canine

BREED

Poodle Mix

SEX

Spayed Female

AGE

13 Years

WEIGHT

13.4 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Wixom Family Pet
Practice

INVOICE

14649

DATE

4/8/22

PRESENTING CLINICAL SIGNS

History: No clinical signs. Very mildly elevated BUN on pre op BW for dental. Presented for AUS prior to anesthesia.

Abnormal PE/Chem/CBC/UA Results: See attached BW.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is mildly distended with anechoic contents. Reevaluation of a fully distended bladder is recommended if there are lower urinary tract concerns. Apical urinary bladder wall is diffusely thick, measuring 0.36 cm. Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The left kidney is normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measured 3.71 cm.

The right kidney is normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. The right kidney measured 4.03 cm.

Adrenal Glands

Left adrenal gland is normal in size (0.47cm at cranial pole and 0.38 cm at caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.93 cm at cranial pole and 0.49 cm at caudal pole), shape and contour. Corticomedullary structure is unremarkable. 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). No focal nodules or masses are observed. Splenic vasculature appears normal.

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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.



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The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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.

Pancreas

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Pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no appreciable lymphadenopathy or free fluid in these images.

ULTRASONOGRAPHIC FINDINGS

AGE

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- Age-related kidney. This finding is expected/consistent with age-related mild degenerative disease and should be interpreted clinically in combination with laboratory changes.
- Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes. Reevaluation of a fully distended bladder is recommended if there are lower urinary tract concerns.
- Gallbladder debris. 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.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations for this patient include a urinalysis to check specific gravity +/- an SDMA for further evaluation of the kidneys. Although considered highly unlikely given the very mildly increased BUN, a discussion with the owners about whether or not there has been any evidence of melena in the stool is warranted. If the urine specific gravity is low or SDMA is high, recommendations include proceeding with management of kidney disease, as well as monitoring of urine for proteinuria and quantifying with a UPC, if present, and assessing blood pressure.

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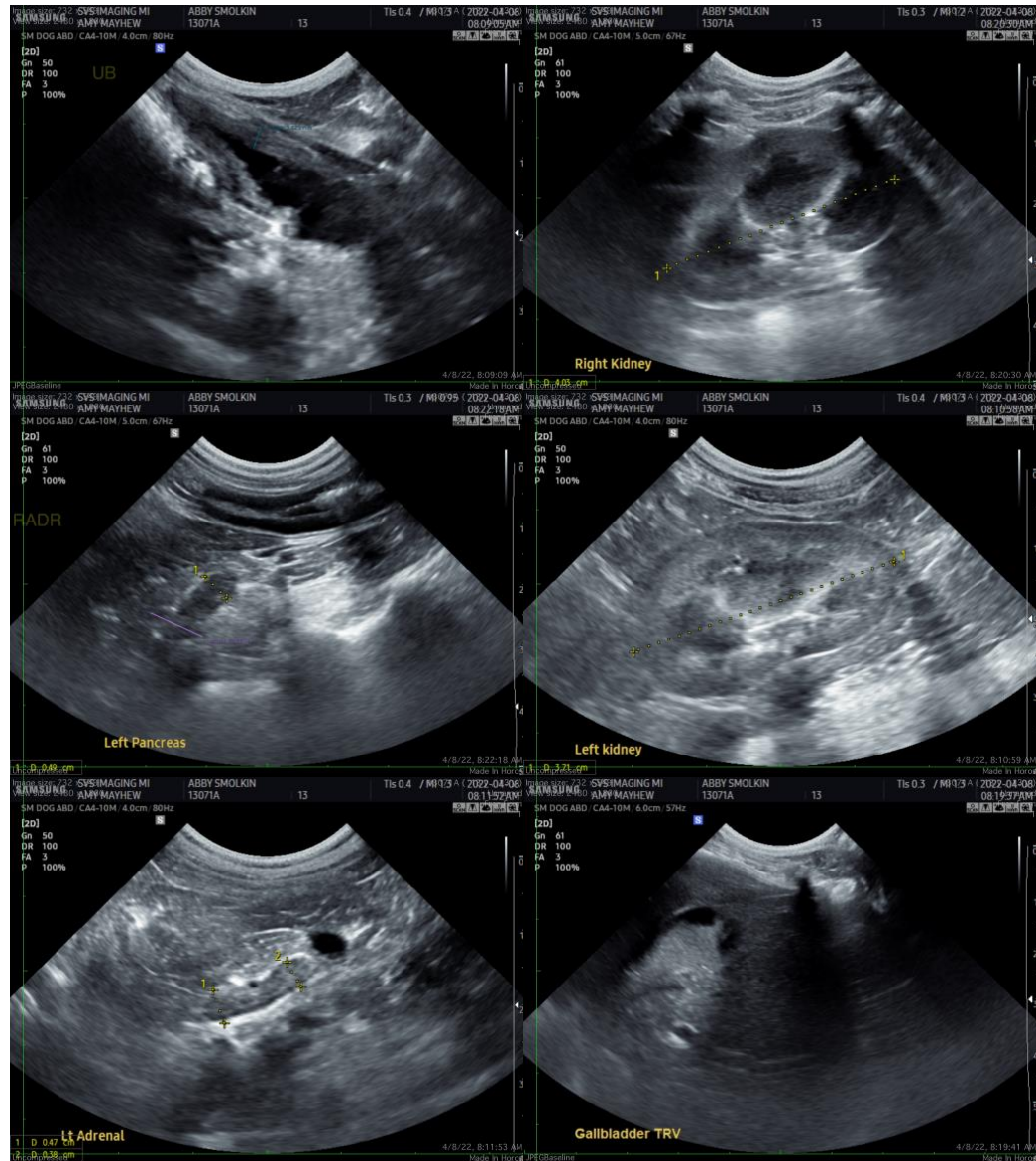
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

Beth.Johnson@SonoPath.com



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