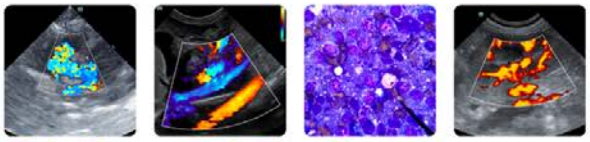


PATIENT

Boo SDRO

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

9 Years

WEIGHT

66.6 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jessica Bailes

HOSPITAL NAME

All Creatures Great & Small Corvallis

REFERRING VET

Dr. Brent Sadahiro

INVOICE

74364

DATE

4/9/26

PRESENTING CLINICAL SIGNS

Intake to rescue 1 month ago - no concerns @ intake. UTI dx @ initial UA; persistent despite amoxicillin BID x 7 days. Large amount heterogenous material noted dorsal bladder wall noted @ time of recheck urine collection 1 week ago. Not currently on abx

Abnormal PE/Chem/CBC/UA Results: Reactive for exam of rear end, otherwise NSF on PE

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with primarily anechoic contents as well as a very large amount of echogenic mineral/sand debris settled along the dependent wall. The apical urinary bladder wall is diffusely thick, measuring 0.80 cm thick, with an irregular, hyperechoic mucosa. No masses or definitive distinct cystoliths are observed. Thetrigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (6.92 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 mineral or infarcts observed.

The left kidney is normal is size (6.82 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 mineral or infarcts observed. Trace pyelectasia is present.

Adrenal Glands

Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.39 cm at the cranial pole and 0.57 cm at the caudal pole. Right measures 0.37 cm at the cranial pole and 0.45 cm at the caudal pole.

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.

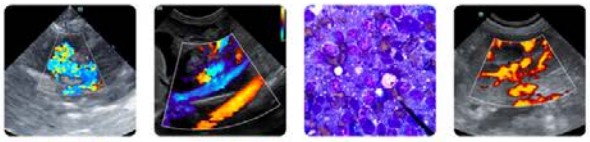
Liver

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. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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.

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

- Chronic cystitis changes with a large amount of mineral/sand debris.
- Trace bilateral pyelectasia.
- Flat adrenal glands – This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.
- Mild 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The adrenal gland changes are a subjective finding, but a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Recheck 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 ratio is recommended.

Additionally, a heavily sedated or anesthetized bladder flush/voiding urohydropropulsion could be considered, both as a therapeutic to remove as much of the sand debris as possible, as well as a diagnostic, to obtain the material for analysis, which may further help guide medical management.

In the meantime, longer-term treatment of the previously reported urinary tract infection may be necessary while monitoring the mineral debris for possible dissolution changes, etc.

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Regardless, after finishing antibiotics, a follow up culture a week to 10 days after antibiotics is recommended to ensure full clearance at that time.

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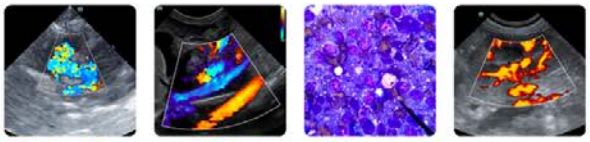

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Educational Teleconsultation Services™

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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