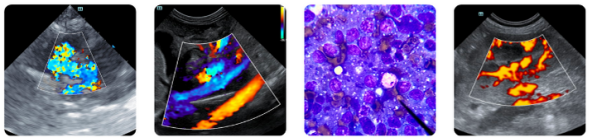


PATIENT

Ridley Potts

SPECIES

Canine

BREED

Lab Mix

SEX

FS

AGE

13.4 years

WEIGHT

72.7 lbs

INTERPRETED BY

Beth Johnson, DVM, DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Kristen Carpenter

INVOICE

11975

DATE

5/19/2026

PRESENTING CLINICAL SIGNS

Patient sedated with butorphanol. Hx of grade 1-2 L systolic murmur, first heard 12/2025 when patient was approx 3 months old and confirmed on subsequent exams. Patient is aclinical for any cardiac signs or exercise intolerance. Patient was neutered and did well with general anesthesia.

Chronic meds: Fluoxetine 20 mg PO SID, patient has been on heartworm prevention monthly.

Diet: Iams large breed puppy.

Abnormal PE/Chem/CBC/UA Results: 4/15/26 Full bloodwork: NSF 4dx neg x4 Fecal NOS - 5/19/26 Thoracic rads: Subjective cardiomegaly with slight reverse D sign, possible R sided cardiac enlargement. - 5/19/26 Blood Pressure 126, 123, 143 mm HG systolic.

***The hospital reached out and informed us that the provided history on the original report was for a different patient, and this is the accurate history.** *

Addendum:

Patient was sedated with butorphanol. Prev hx of encrusting cystitis in 2019 with complete resolution. Hx of L4-S3 myelopathy managed with one injection of Depo-Medrol via epidural. Hx of hepatopathy secondary to Carprofen in 9/2025 with sudden ALT increase - resolved with hepatoprotectants and discontinuing carprofen and ALT returned to normal range. Recent hx over the last several months of urinary accidents. Repeat UA and AFAST show no signs of cystitis. More recent history of reported PU/PD as well as now having urine leakage when resting/sleeping as well as awake/standing urinary accidents.

Diagnostics: 2/19/26: UA with reflex culture: cystatin B < 50, UA - USG 1.017, quiet sediment, Culture not indicated. 5/15/26 Full Bloodwork: Glucose 44 (low- suspect artifact), Creat 1.3, ALT 168 (H). UA USG 1.016, pH 5.5, quiet sediment. T4 2.2, 4dx chronically anaplasma+ and prev treated. 5/16/26: Spot check BG - 105 mg/dL. 5/19/26: Thoracic Rads: NSF, no evidence of metastatic disease.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

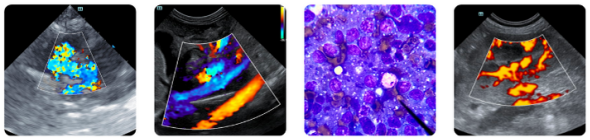
Urinary System

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 (6.05 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, or mineral observed. In some views there appears to be a very subtle indentation/misshaped area in the caudal pole of the right kidney that I believe is secondary to a small chronic infarct.

The left kidney is normal is size (5.64 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



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The right adrenal gland is normal in size (0.61 cm at cranial pole and 0.62 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.39 cm at cranial pole and 0.52 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.

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

- Other than a possible, subtle small infarct in the right kidney. This is a largely unremarkable/normal structural abdomen

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Further recommendations are further cardiac evaluation including an echocardiogram, if not already in place.

Further recommendations based on known history and abdominal study are not indicated at this time.

Unsure of patient's age. Submitted as 13.4 years old, but history states the patient was 3 months old in Dec 2025 and eats a large breed puppy diet. I believe the 13.4 years of age is wrong, but I do not believe it is relevant

Addendum:

New recommendations based on the newly provided patient history are:

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

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.

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

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.

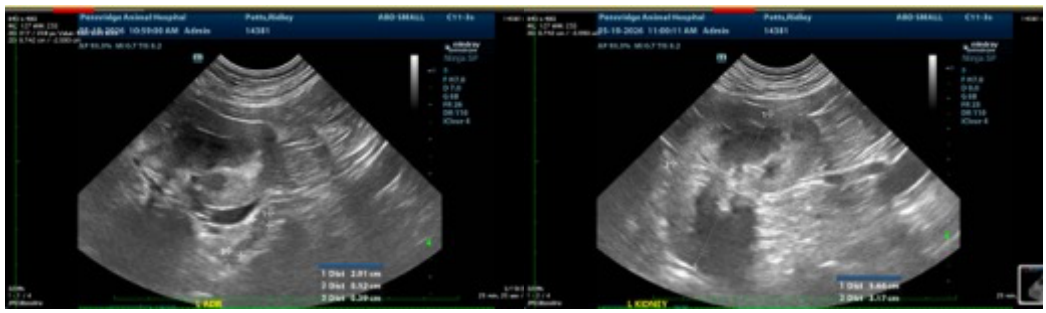
If not, next step(s) may include a urine culture, low dose dexamethasone suppression test, T4, bile acids, Leptospirosis testing and/or an empirical course of antibiotics.

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

Given the reported chronic infectious disease, the high/normal creatinine, history, etc., full consultation with a veterinary internist may be helpful.

For an additional charge an internal medicine consult can be utilized through Sonopath.com. You can select the internalmedicine drop down at http://spa.sonopath.com/.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services



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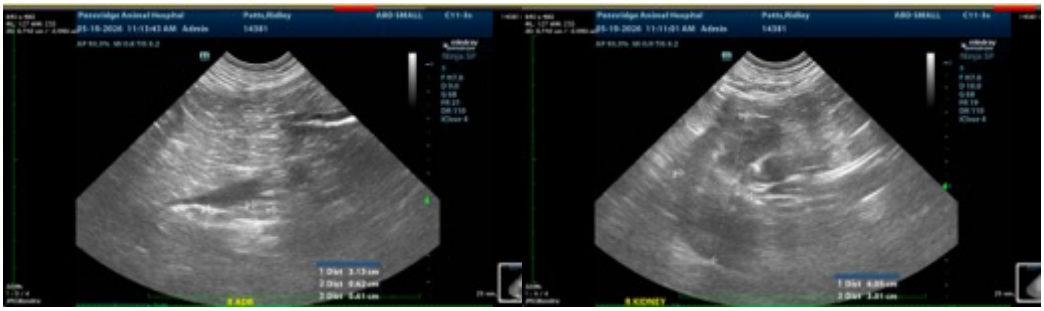

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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