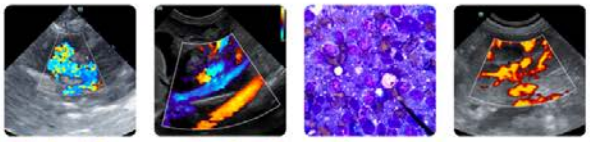


PATIENT

Pebbles Hunter

SPECIES

Canine

BREED

Mini Poodle

SEX

Female

AGE

5 Years

WEIGHT

12.2 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Meghan Myers, VMD

HOSPITAL NAME

Hershire Animal Hospital

REFERRING VET

Lindsay Bohling, DVM

INVOICE

75508

DATE

5/28/26

PRESENTING CLINICAL SIGNS

Patient has history of grade 6/6 heart murmur -- has ventricular septal defect left to right, subaortic stenosis, moderate aortic insufficiency, and asymmetrical enlargement of right aortic sinus of valsalva. Patient is on Vetmedin 1.25 mg - 1 tablet PO BID and Enalapril 2.5 mg SID. Patient was examined in April -was being treated from a different clinic for suspected UTI - placed on Clavamox. Patient has a firm mammary mass and significant dental disease. On radiographs- severe cardiomegaly, no radio-opaque urinary stones. After antibiotics finished- recheck urinalysis showed hematuria and bacteria-- placed on enrofloxacin and carprofen -- mild improvement per client -- but is still dark brown. Cultured urine- with no growth seen. Patient is intact.

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 (4.1 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. A subtle hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal is size (3.5 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. A subtle hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

The right adrenal gland is normal in size (1.1 cm at cranial pole and 0.54 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 cm at cranial pole and 0.33 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

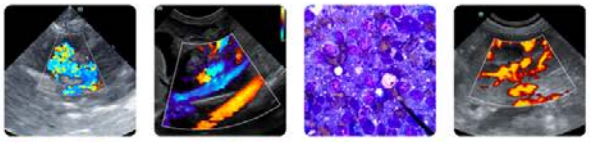
Spleen

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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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.

The uterine body is subjectively mildly thick-walled with no evident fluid distention noted in these images at this time.

Just cranial to the urinary bladder, near the left kidney, is an approximately 1.5 cm x 2.6 cm anechoic density of unknown etiology.

The ovaries are unable to be well visualized in these images.

ULTRASONOGRAPHIC FINDINGS

- 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.

- Mild subjective uterine wall thickness should be interpreted in combination with when patient's last heat cycle was, as it could represent cystic endometrial hyperplasia or other benign inflammatory endometritis. Infiltrative neoplasia is considered much less likely.

- The cystic structure in the left mid abdomen could be associated with the left ovary and represent an ovarian cyst, although other differentials including cysts of other origin, hematoma, etc. can't be ruled out.

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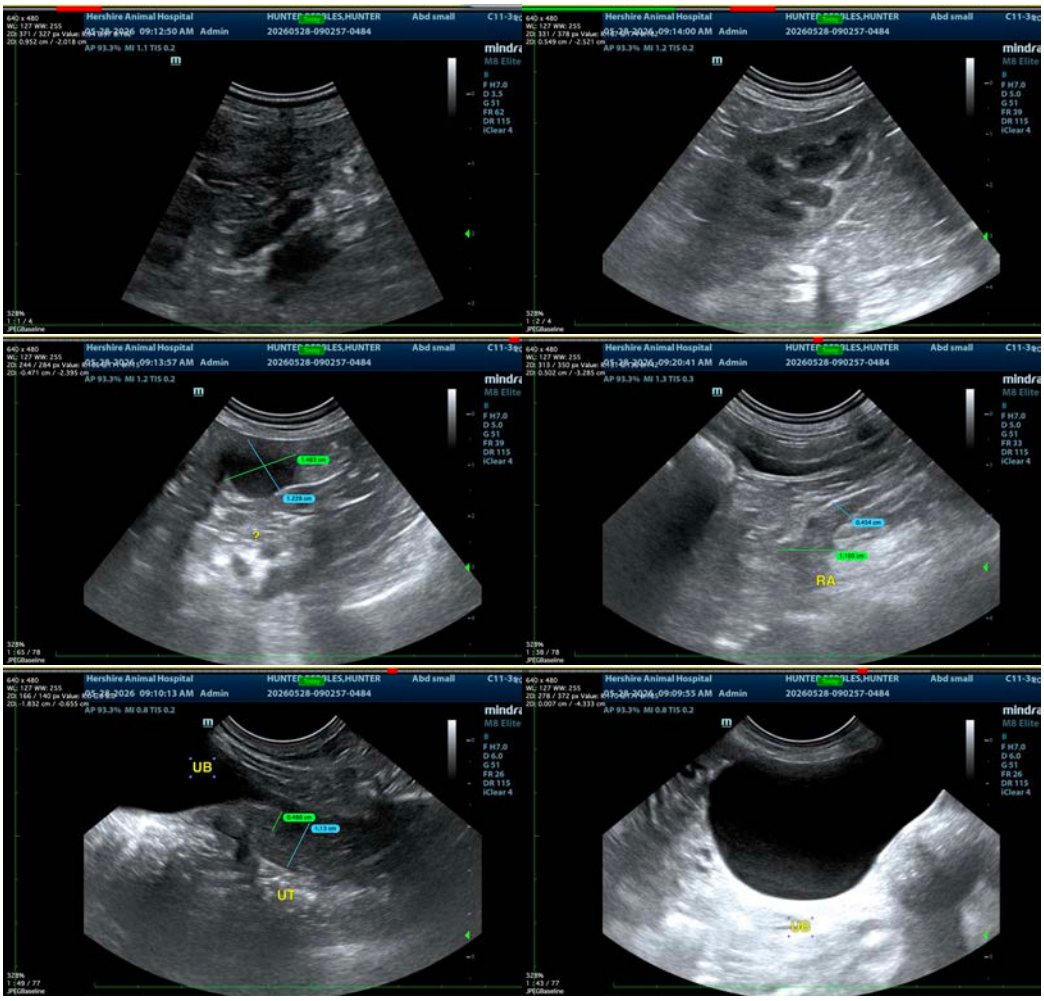
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations regarding patient's urinary signs are in part dependent on full urinalysis results as well as exact treatment course, duration, etc. If full treatment of a potentially complicated urinary tract infection based on culture and sensitivity results has been completed, it could be that some of the changes are reproductive tract in origin, although this differential should be suspected only if appropriate, and obviously not if urine sampling has been via cystocentesis. Ideally, given the suspect ovarian cyst and thick uterus, an ovariohysterectomy would be considered, but given patient's history, I suspect anesthetic risks may be hindering that approach. Full consultation with patient's cardiologist as well as a veterinary internist or even theriogenologist could be considered.



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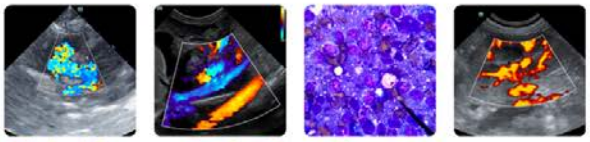

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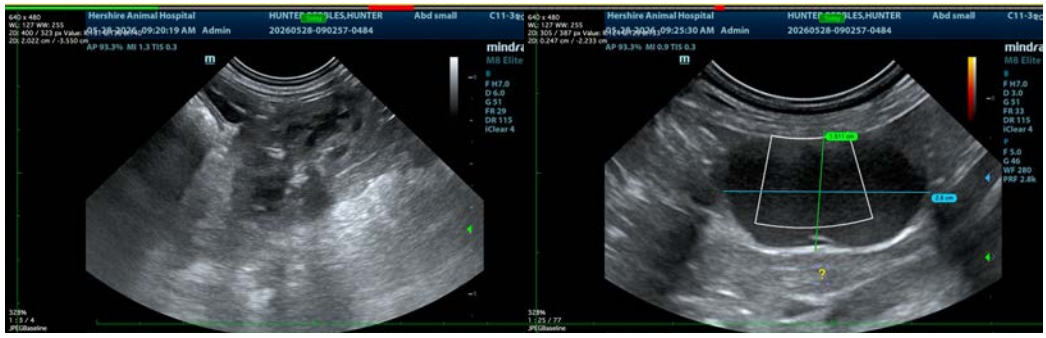

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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