



PATIENT

Daphne Baker

SPECIES

Canine

BREED

Corgi

SEX

Spayed Female

AGE

2 Years

WEIGHT

30 lbs

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons),
DACVECC

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

West Salem Animal
Clinic

REFERRING VET

Dr. Sirianni

INVOICE

75601

DATE

6/2/26

PRESENTING CLINICAL SIGNS

Scotting. Only urinating small amounts. Chronic UTIs. ABNORMAL Labwork Values: Urine Culture positive for bacteria. Current Medications: None

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was moderately distended with generally anechoic urine. There is some hyperechoic floating debris present. There is also a 1.3 cm gravity dependent accumulation of debris, which may represent a formed cystolith or may represent a conglomeration of debris/urinary bladder sand. The walls are of normal thickness with normal wall layering. There are no suspected mass or abnormal thickening visualized.

The kidneys have an irregular capsule and mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measures 4.44 cm. Right kidney measures 5.44 cm.

Adrenal Glands

The left adrenal gland is visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Left measures 2.07 cm in length x 0.44 cm at the caudal pole and 0.45 cm at the cranial pole.

The right adrenal gland is not distinctly visualized.

Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.



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Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

Free Abdomen

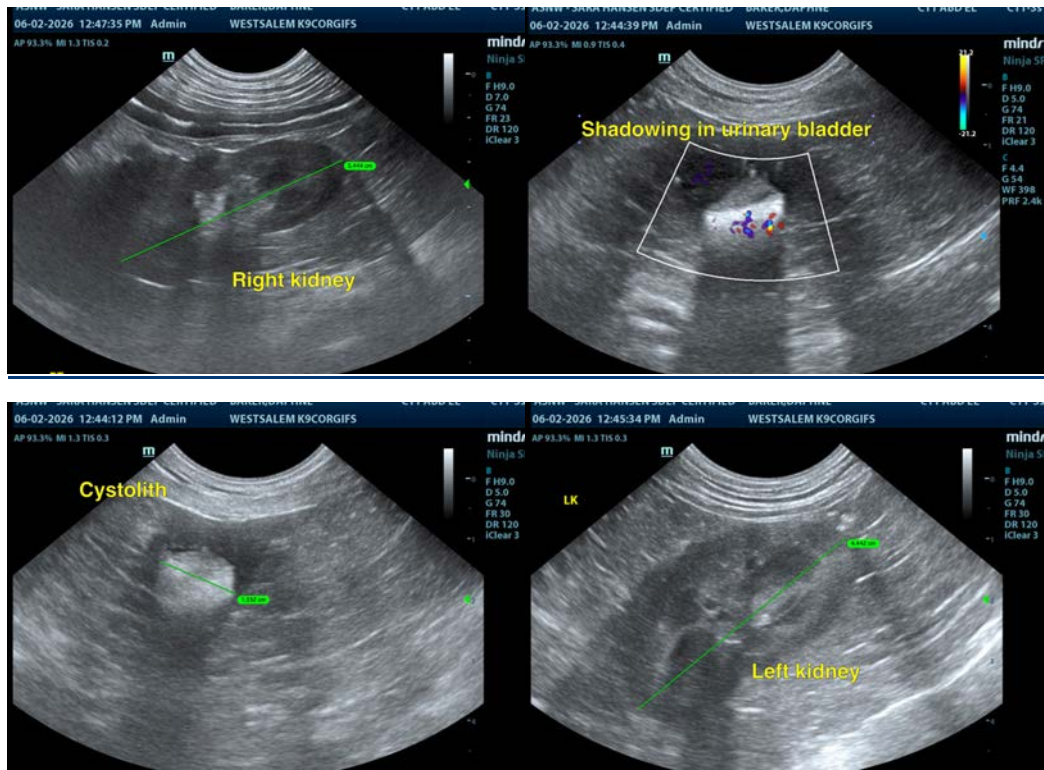
No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Shadowing urinary bladder debris – suspect accumulated bladder sand versus formed cystolith.
- Slightly irregular renal capsular margins with mild nephrocalcinosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The debris within the urinary bladder has a somewhat unusual appearance but is most consistent with an accumulation of amorphous urinary bladder/bladder sand. A true cystolith is possible, but this does not have the classic ultrasonographic appearance of a formed stone in most images. A dissolution diet and attempted control of urinary tract infection is recommended with recheck imaging to evaluate for resolution or progression of urinary bladder debris. Ultimately cystoscopy or cystotomy may be required.





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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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

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