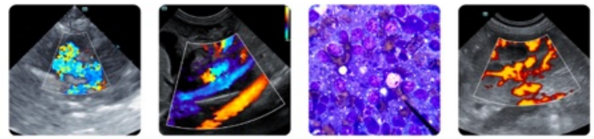


PATIENT
Luna Garten

SPECIES
Canine

BREED
Beagle Mix

SEX
Spayed female

AGE
11 years

WEIGHT
42.2 lbs

INTERPRETED BY
Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Dr. Brittany Gogliuizza

HOSPITAL NAME
Evendale Blue Ash Pet Hospital

REFERRING VET
Dr. Gogliuizza

INVOICE
70133

DATE
1/14/26

PRESENTING CLINICAL SIGNS

History: First complaint of urinary accidents polyphagia and panting Sept. 2025. She was diagnosed with UTI at that time. She responded well with Clavamox. Recheck showed resolution from UTI. Owner declined crushing's work up at that time. She represented 12/26/25 with similar symptoms and losing weight, Owners appreciated pot belly appearance. Diagnosed with another UTI. Treated with 10 days of Amoxi. Clav.. Recheck on 1/5/26 showed resolution of UTI. Symptoms persisted so performed a low dose dex. suppression test. Performed a UPC at that time as well. Current medication is T-Relief and Simparica Trio.
Abnormal PE/Chem/CBC/UA Results: Physical exam findings: Aging changes due to arthritis. dental disease, & cataracts. Progressive muscle atrophy, potbelly appearance, with cranial organomegaly. Diagnostics: 9/18/25: ALT 22, ALP 893, GGT 22, USG 1.024, 3+ protein and rods. 9/30/25: recheck UA, USG 1.028, protein 500 mg/DL, no bacteria. 12/26/25: UA- USG 1.004, Protein 30 Mg/DL, rods present. Urine culture was E.coli and susceptible to Amoxi. Tri. Clav. 1/5/26: UA- Specific Gravity 1.006, protein 100 mg/DL, no bacteria. 1/6/26: DLLST consistent with crushing's. UPC 9.2. Prescribed Telmisartan 20mg but not yet started. 1/14/26: BP average 155.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** presented apical dorsal wall thickening measuring up to 0.5 cm with suspended and partially dependent debris. The dependent debris continued into the cystourethral junction. Minor polypoid changes were noted in the cystourethral junction. The urethra was slightly thickened.

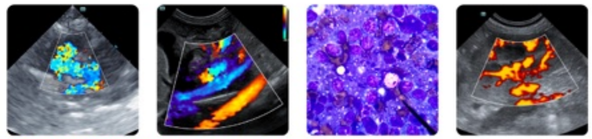
The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 6.35 cm. The right kidney measured 5.8 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 0.53 cm at the cranial pole and 0.53 cm at the caudal pole. The left adrenal gland measured 0.64 cm at the cranial pole and 0.52 cm at the caudal pole. Two sill images of the adrenal glands were submitted; however, these were not able to be repeated on video; therefore, not confirmed.

Spleen

The **spleen** revealed heterogenous parenchymal changes and a 2.5 x 1.7 cm mass with capsular expansion and disruption of architecture. This may not be neoplasia.



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Liver

The **liver** was uniformly swollen with minor. The liver presented coarse architecture with mildly increased portal markings and subtle, mixed echogenic changes. This is consistent with vacuolar hepatopathy and some level of remodeling and history of inflammatory component. There was no overt suspicion of neoplasia. Gallbladder presented multiple calculi with suspended and dependent debris. This is consistent with emerging mucocele.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

Apical dorsal bladder wall thickening with suspended and dependent debris. Likely chronic cystitis, yet underlying carcinoma is a potential.

Metabolic hepatopathy with remodeling. Differentials include metabolic hepatopathy with remodeling and gallbladder calculi and emerging mucocele.

Gallbladder calculi with suspended and dependent debris.

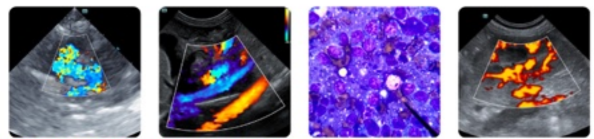
Age related renal changes.

Splenic mass. Differentials include infarct, splenitis, round cell neoplasia and emerging hemangiosarcoma less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Empirical treatment for UTI is indicated with Enrofloxacin or similar. I cannot rule out underlying carcinoma, yet this is not suspected. BRAF testing and free catch urine sample. Cytospin is indicated to assess for any abnormal transitional cells. Otherwise, cystocentesis, urine culture and sensitivity is indicated. Ursodiol therapy is recommended over a 6-8 week period.

FNA of the splenic mass and liver would be ideal in this patient. Eventual splenectomy, cholecystectomy and liver biopsy could be justified.



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Further imaging of the adrenal glands would be ideal to ensure adequate video capture of the adrenal glands as I cannot absolutely confirm that the measured images are that of the adrenal glands.

The prognosis is guarded depending upon FNA results of the spleen and liver.

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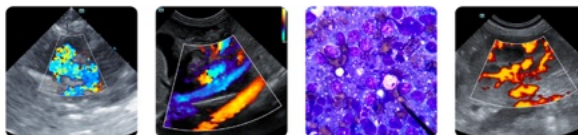

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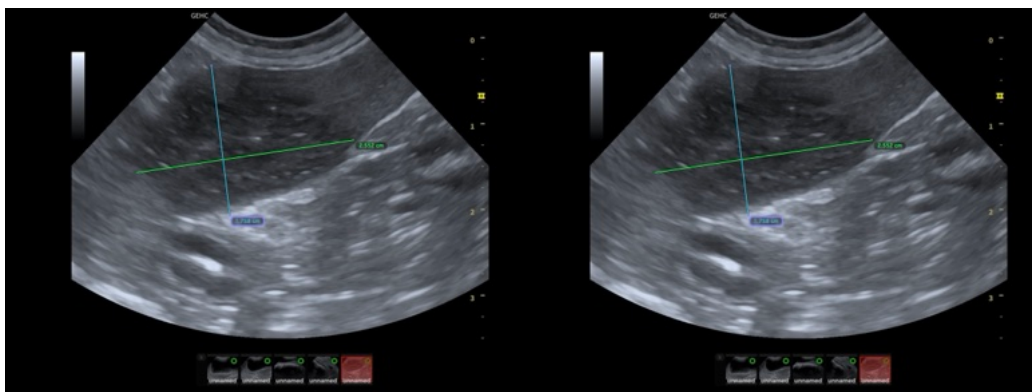

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com