



PATIENT

Taffy Drader

SPECIES

Canine

BREED

Maltese x

SEX

Spayed Female

AGE

9

WEIGHT

12.8 kg

INTERPRETED BY

Eric Lindquist, DMV,
DABVP (CFM), Cert.
IVUSS

IMAGING PERFORMED BY

Dr. Belan

HOSPITAL NAME

South West Veterinary
Hospital

REFERRING VET

Dr. Randhawa

INVOICE

72709

DATE

12/18/25

PRESENTING CLINICAL SIGNS

Previous report 1/21/2025. Inv 60256 Still having recurrent UTI s Since last scan has had a cystotomy as well as removal of a parathyroid adenoma (last March) at referral vet hospital Now is PU PD and polyphagic. Has put on weight and mildly distended cranial abdomen. Attending concerned about possible onset of Cushings

Abnormal PE/Chem/CBC/UA Results: Moderate elevation of ALP mild elevation lipase and normal cholesterol

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed a calculus measuring 0.43 cm and sand accumulation of 0.60 cm. Minor bladder wall thickening with mural remodeling. Bladder wall measured 0.32 cm. No evidence of masses. However, slight adhered debris or polyp noted on the ventral wall.

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 his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. Corticomedullary and pelvic calculi noted. The right kidney measured 5.5 cm. Left kidney measured 4.75 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. Right measured 0.65 cm at the cranial pole and 0.61 cm at the caudal pole. Left measured 0.54 cm at the caudal pole and 0.51 cm at the cranial pole.

Spleen

The **spleen** was folded upon itself caudally. It presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.



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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. Gastric wall thickness measured 0.40 cm.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxyphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

- Bladder calculus and sand, likely passing from the kidneys periodically.
- Age related abdominal changes otherwise.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Examination of the vaginal vault warranted for predisposing issues such as recessed vulva or urine pooling. Cystotomy, stone analysis and culture all indicated, and bladder wall biopsy and culture ideal. Dissolution protocol could be considered over a 6-8 week period yet may not be successful. Surgical approach may be the best option.

The following is to be utilized for UTI with chronic urinary tract changes found sonographically that may serve as nidus of infection and history of chronic or recurrent UTI is an issue.

I recommend Clavamox as a first level approach to chronic UTI at 12.5-25 mg/kg bid owing to optimal urinary concentrations. If bacterial resistance is an issue then **Enrofloxacin** (5-10 mg/kg SID PO) (In patients > 1 year of age) in late pm after urination to maximize urinary concentrations overnight. This assumes that culture supports this use. Repeat **culture** at 3-4 weeks and continue treatment at least 7-10 days post negative urinary sediment and negative culture. *Note: Negative culture does not necessarily mean lack of UTI.* Other favorite antibiotics for chronic UTI include third generation Cefa (Ceftiofur or similar s.i.d. injectable) or Clavamox. If suspicion of occult urinary incontinence is present, then **phenylpropanolamine (PPA)** (1-2 mg/kg BID) can be employed long term to enhance urethral tone.



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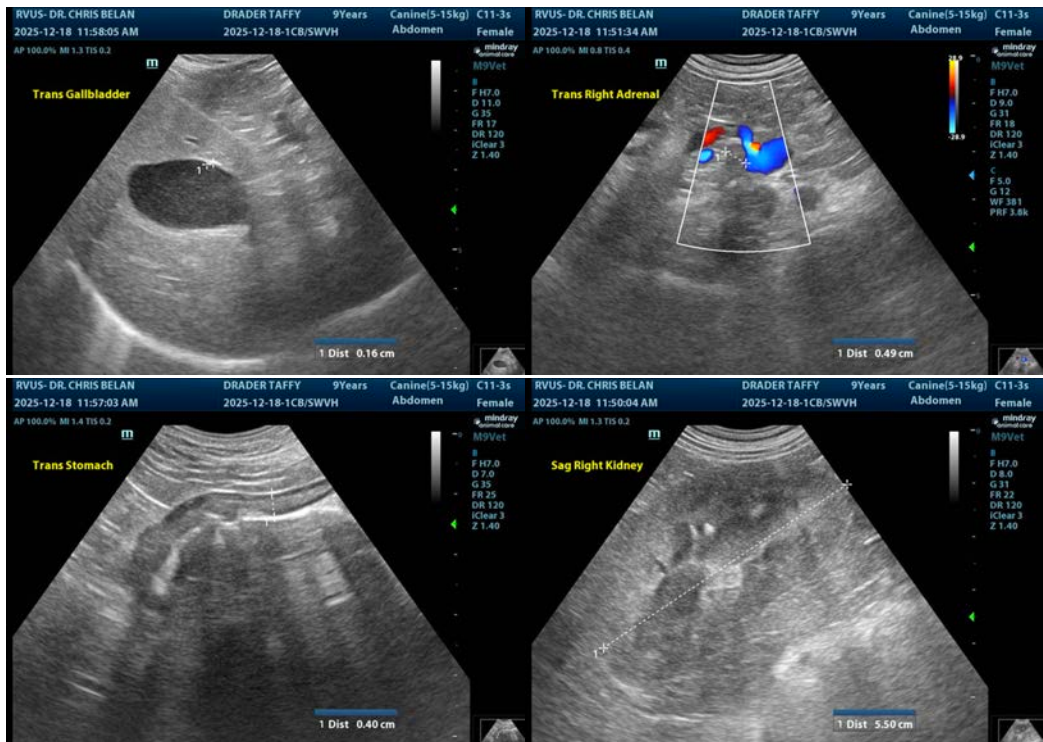
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UTI Types

Guidelines for management of UTIs. The Veterinary Journal 247 (2019) 8-25

- Sporadic Bacterial Cystitis** - simple, uncomplicated UTI, hematuria, pyuria, bacteria. Dogs and older cats primarily. Tx analgesic + Ab-clavamox or similar 3-5 days. No effect? Ensure no comorbidity or C/S result non compatible
- Recurrent Bacterial Cystitis** - 3+ episodes within 12 months. Look for underlying cause. Incontinence, recessed vulva/pyoderma, prostatitis, calculi, neoplasia, resistant bacteria. Analgesia, and culture and refine AB Tx up to 14 days. Culture 5-7 days after stopping Tx.
- Upper UTI** - Pyelonephritis, ascending or embolic. Comorbidity check for diabetes, cushings, lithiasis, prostatitis, neoplasia. Fever, Lethargy, PU/PD, painful kidney on clinical exam. Tx Fluoroquinolone (Marbo/enro not cipro) or Cefa (Naxcel injectable in larger dogs), C/S, tx up to 4-6 weeks (debate). Culture 1-2 weeks after stopping AB.
- Subclinical Bacteruria** - Commensalism, treatment debatable and variable depending on scan.
- EL recs** - scan, evaluate, Tx AB 5-7 days negative sediment + negative culture. Clavamox, Cefa, Quinolone





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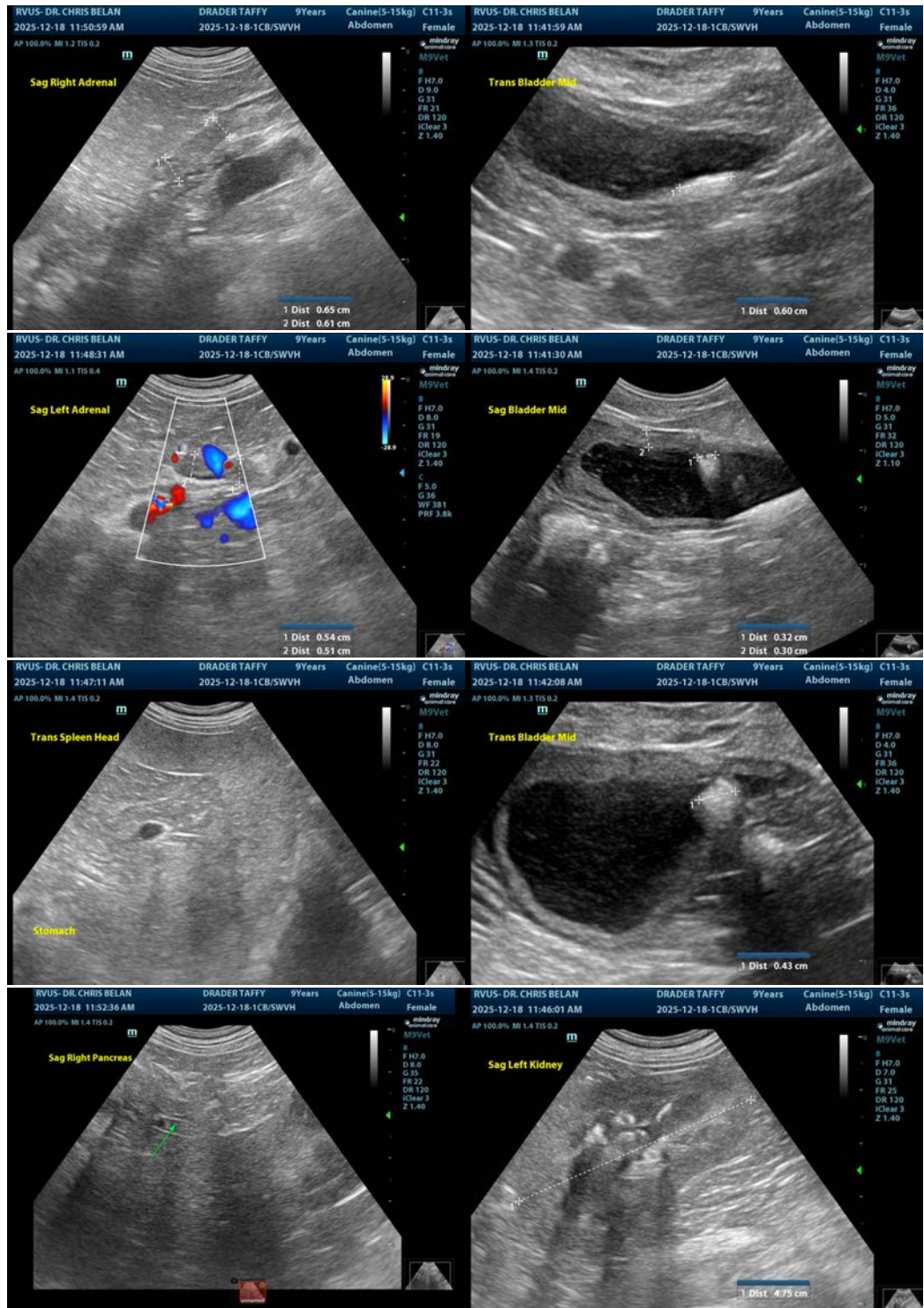
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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,
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