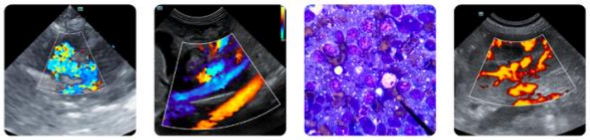


PATIENT

Rosalynn Geldard

SPECIES

Canine

BREED

Collie Mix

SEX

Spayed Female

AGE

7 Months

WEIGHT

28 pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small animal Internal Medicine)

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Veterinary Hospital

REFERRING VET

Dr. Lucas Budden

INVOICE

14255

DATE

03/11/26

PRESENTING CLINICAL SIGNS

- Clinical signs: PU/PD
- History: Patient presented on 2/5/2026 for goopy eye discharge from both eyes and a notable increase in thirst and urination. Patient had recently stayed at a kennel facility. Owner had noted she had drank 6 cups of water in the previous 24 hours. Her typical intake was closer to 4 cups. She was urinating in 1 long stream. She had 1 accident in the house after returning from an overnight stay in a kennel. Her appetite was slightly decreased after stay, but had returned to normal by presentation. Energy also normal. Rectal temperature was 104.8 °F. A urinalysis and culture was performed. NeoPolyDex was started for the eyes, Clavamox was prescribed (7 day course), and Rimadyl (7 day course) for the fever. Represented on 2/12/2026 and she seemed to have returned to normal but she was still having increased thirst and urination. Her rectal temperature at that time had been 103.1 °F. A CBC and chemistry was run along with a baseline cortisol. A first morning urine sample was also tested. Despite treatment patient's increased thirst and urination has persisted she is doing well otherwise at this time. On presentation today the rectal temperature was 103.1F rectal. She is up to date on lepto vaccine.
- Current medications: Neopolydex
- Acepromazine 12.5mg orally prior to visit to facilitate ultrasound

Physical exam: rectal temp 103.1F, well hydrated, peripheral LNs normal, slightly tense on abdominal palpation but nervous for exam, external genitalia appear normal Lab work: Lepto urine PCR pending 2/6/2026 urinalysis and culture USG 1.005 pH 7.5 Urine culture negative 2/13/26 first morning USG USG 1.019 2/13/2026 CBC/chemistry/baseline cortisol ALP high 152 Phosphorus high 6.5 White blood cell high 23.6 Neutrophils high 15,340 Lymphocytes high 5900 Monocytes high 1888 Cortisol low 1.1 ACTH stim test 2/21/2026 Pre sample 3.1 Post sample 13.3

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

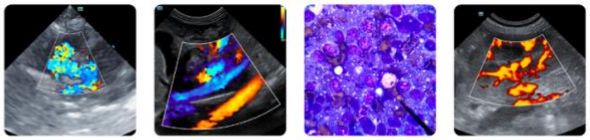
The urinary bladder is moderately distended with anechoic urine. The bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (5.33 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.36 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.32 cm at the cranial pole and 0.34 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.



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The right adrenal gland is normal in size measuring 0.27 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized. The spleen measured 1.52 cm.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed. The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains moderate fluid/ingesta. It measures at a normal thickness of 0.31 cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. 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. The duodenum measured as normal (0.53 cm in wall thickness) and the jejunum measured as normal (0.35 cm) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

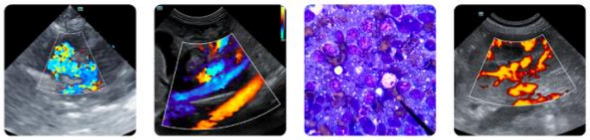
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. Occasional visible but not overtly enlarged mesenteric lymph nodes were present measuring 0.51 cm and 0.59 cm. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- No significant ultrasonographic lesions visualized.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious lesion responsible for the reported increase in thirst and urination was not visualized. Some issues such as early renal disease, Cushing's disease, behavioral, neurologic, dietary, electrolyte



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disturbances etc.. are not able to be diagnosed with ultrasound alone. These can be challenging cases. The top 10 differentials can be ruled in/out with routine bloodwork, urinalysis and culture, several more can be evaluated with a good history and imaging. Unfortunately, as you work your way down the list the differentials become harder to definitively diagnose. This is the differential list I start with.

Diabetes Mellitus

Chronic Renal Disease/Renal Failure (can present pre-azotemic, especially in dogs, but expect the BUN & creatinine not to be at the low end of the reference range)
Hypercalcemia

Urinary tract infection

Iatrogenic Disease due to medications (diuretics, phenobarbital, KBr; diets either high in salt [such as S/D] or very low in protein (such as U/D))

Hyperthyroidism
Hypokalemia

Liver Disease (hepatic encephalopathy may be a mixed primary PU and PD)
Pyelonephritis

Polycythemia

Renal Tubular Diseases (glycosuria or Fanconi & Fanconi-like syndromes or RTA)

Hyperadrenocorticism (may be a mixed primary PU and PD)
Hypoadrenocorticism (either Addison's or hypercortisolism)
Paraneoplastic Syndromes (particularly splenic hemangiosarcoma?)
Pericardial Effusion
Pyometra (including stump pyometra in spayed dogs)
Chronic Partial Urinary Obstruction or Post-Obstructive Diuresis
Pheochromocytoma
Psychogenic Polydipsia (as in a true behavior disorder with a compulsive element)
Primary Non-Medical Polydipsia (aka "I drink a lot because I like it or I engage in activities that promote it, but that doesn't mean I'm sick")
Primary Nephrogenic Diabetes Insipidus (Congenital Nephrogenic Diabetes Insipidus, other diseases that cause primary PU other than Congenital Diabetes Insipidus would be considered Acquired Nephrogenic Diabetes Insipidus)
cion
Atypical Cushing's and SARDS
Central Diabetes Insipidus

In such a young dog, I would first try and determine if the fever is real (consider the owner checking temperature at home at rest?). If the fever is real, then pursuing possible causes of a fever may be helpful. If not, you could consider pursuing issues that more commonly affect young dogs, such as a portosystemic shunt, psychogenic polydipsia, an ectopic ureter (seems less likely), etc.

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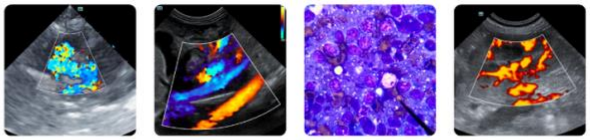

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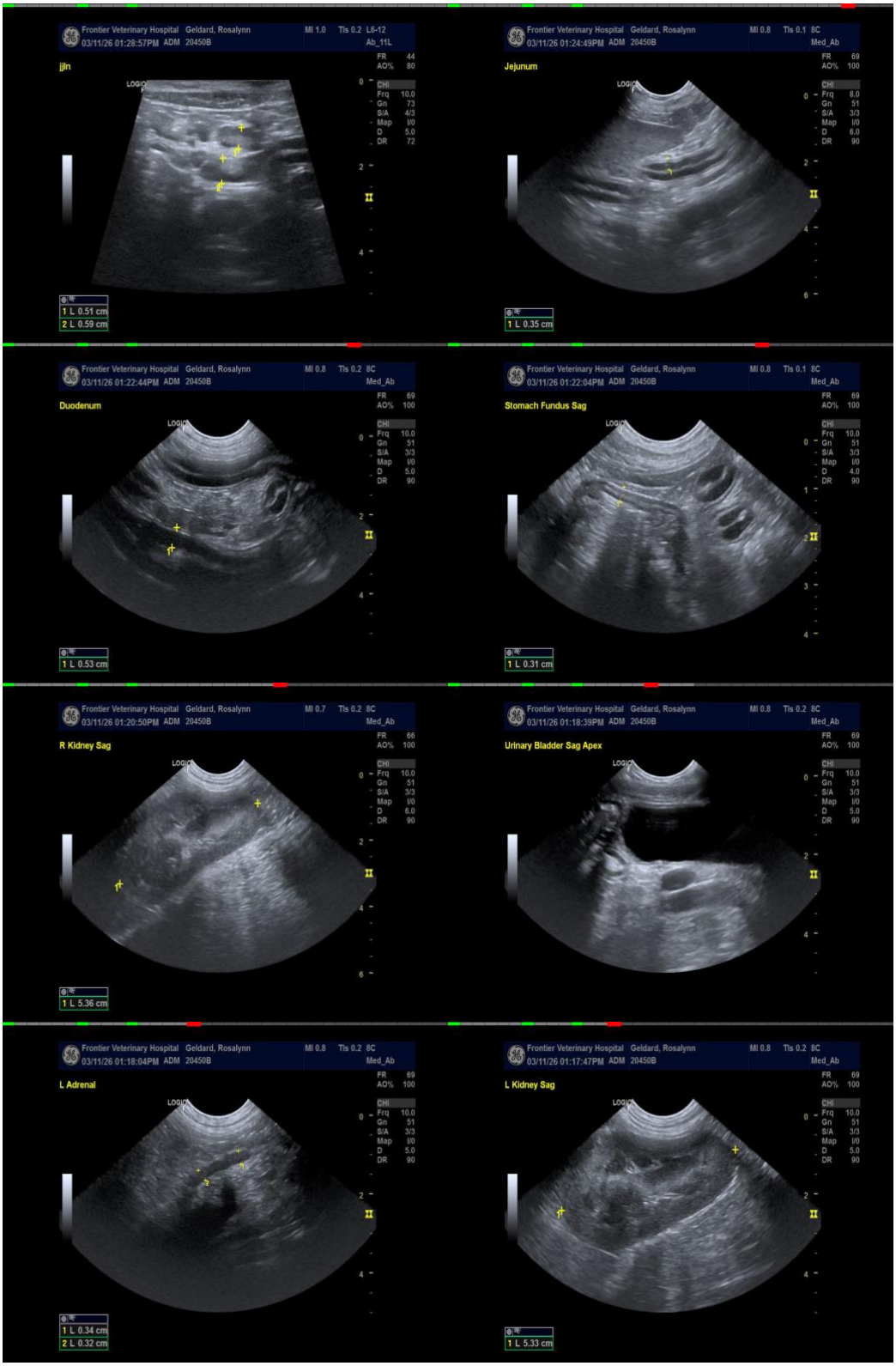

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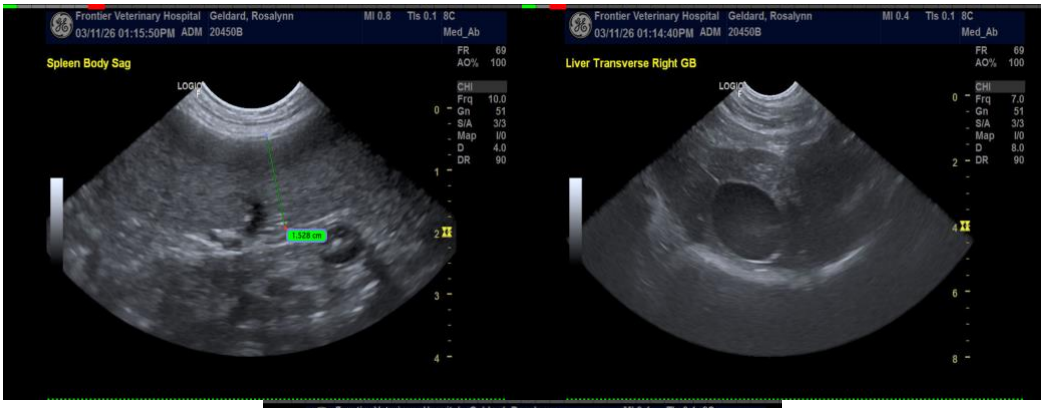

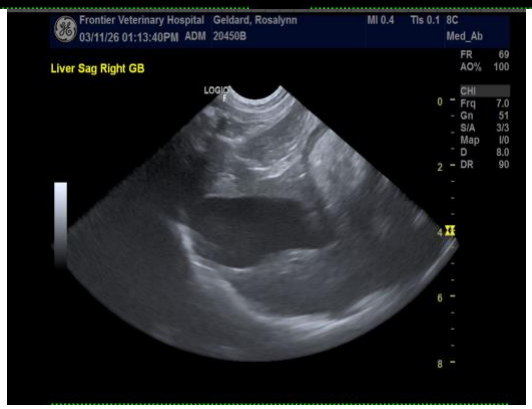

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com