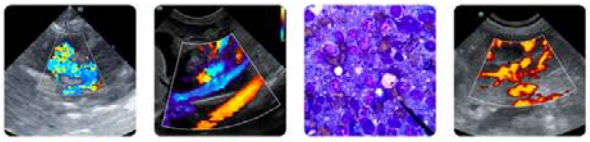


PATIENT

Melody Marie Vargas

SPECIES

Canine

BREED

Toy Poodle

SEX

Spayed Female

AGE

16 Years

WEIGHT

3.0 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Jose Garcia

INVOICE

75538

DATE

5/29/26

PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound due to stranguria and hematuria. Px originally visited rDVM due to elevated Creatinine levels observed on Senior Panel conducted at another clinic on Tuesday May 26th, a urinalysis via cystocentesis was also performed. Owner reports that Px has been stranguric, lethargic, and that only a few drops of blood are released when Px tries to urinate. Owner reports that before this issue Px has Hx of PU/PD. No inappetence, vomiting, or diarrhea reported.

Abnormal PE/Chem/CBC/UA Results: Bloodwork, radiographs, and urinalysis attached below for your reference.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The visualized areas of bladder wall appear of normal thickness with a smooth mucosal surface. In the trigone the ureteral papillae are visualized. The right appears slightly more prominent, but both are within normal limits. There is a small, hyperechoic dependent focus most consistent with hyperechoic debris or small stone/sandy mineralization measuring 0.10 cm. The urethra is difficult to visualize clearly, likely due to patient's small size and shadowing from the pelvic.

The left kidney has a normal shape and size (2.29 cm) with occasional shadowing non-obstructive mineralizations. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (2.27 cm) with occasional shadowing non-obstructive mineralizations. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

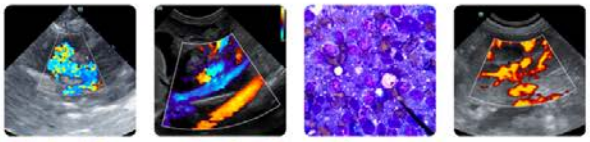
Adrenal Glands

The left adrenal gland is normal in size measuring 0.35 cm at the cranial pole and 0.35 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.

The right adrenal gland is normal in size measuring 0.31 cm at the cranial pole and 0.34 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 (0.70 cm), 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.



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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 significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.29 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. Duodenum wall measures 0.33 cm. Jejunum wall measures 0.30 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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 visible/mildly mottled. 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, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Small, hyperechoic foci/mineralization visualized in the dependent portion of the urinary bladder – Findings are most consistent with hyperechoic debris or small sandy mineralization. This should be small enough to pass.
- Age related changes and non-obstructive mineralizations visualized associated with both kidneys.
- Large gallbladder debris – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.

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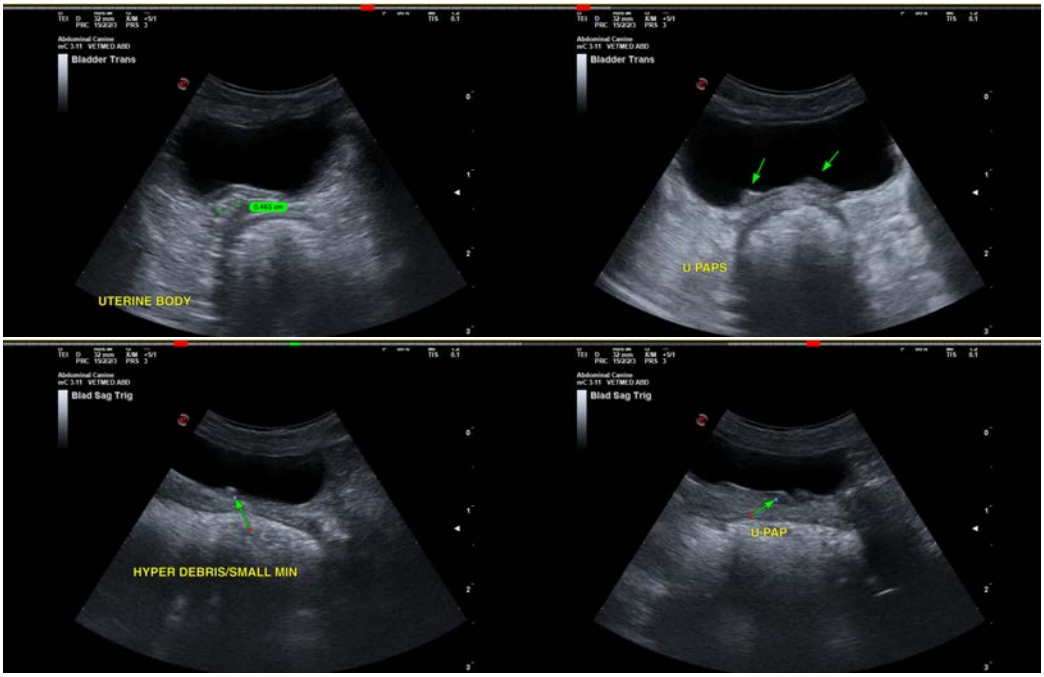
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder appears relatively normal. The ureteral papillae are slightly prominent but likely within normal limits. At this time, recommend continued monitoring, looking for progressive enlargement. The urethra is difficult to visualize in this very small dog. An intraluminal stone, mass effect, etc. cannot be ruled out. Recommend a digital rectal exam to palpate for any evidence of urethral thickening and to evaluate for any vaginal abnormalities. If this area cannot be visualized with more significant sedation, etc., you could consider a contrast study, cystoscopy, etc. A urine culture should be performed. Additionally, there are small shadowing stones visualized in both kidneys. Small passing ureteral stones could occur. None were observed, but with the patient's small size this could be difficult to visualize. If this is a concern, a contrast study (contrast CT scan or excretory urogram) could be considered to further evaluate.

There is a large amount of debris visualized in the gallbladder with no evidence of wall thickening. Recommend chronic Ursodiol therapy and close continued monitoring of the gallbladder.

Consider further evaluation for the hypoalbuminemia reported, including a urine protein to creatinine ratio +/- a liver function test, looking for protein loss from the kidneys or lack of production from the liver. If this is excluded, then there is the possibility of GI protein loss that may require further evaluation.



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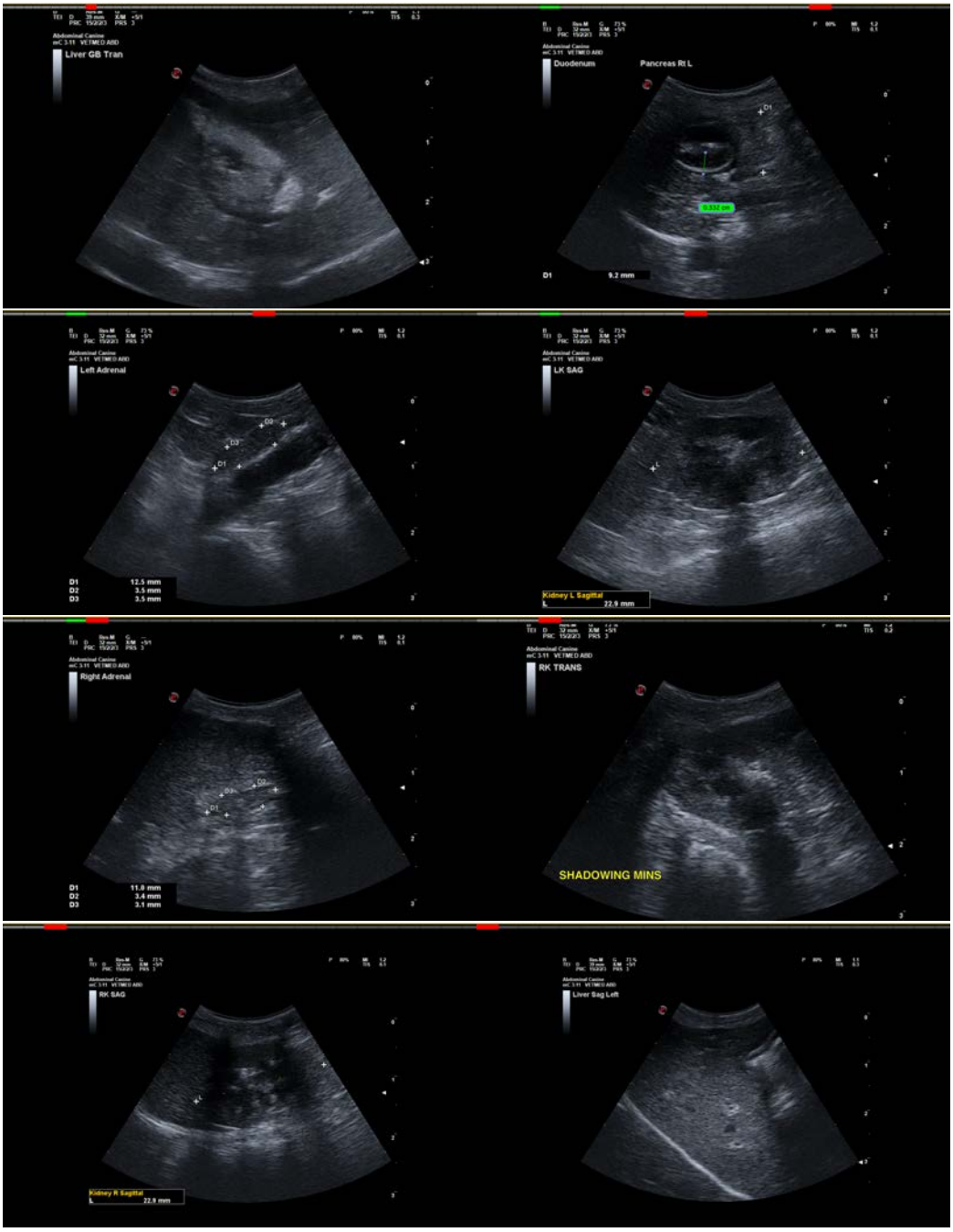

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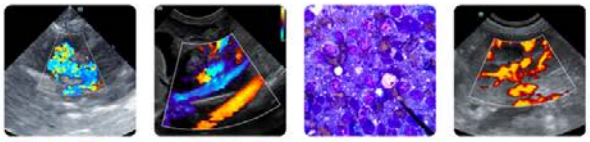

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Educational Teleconsultation Services™

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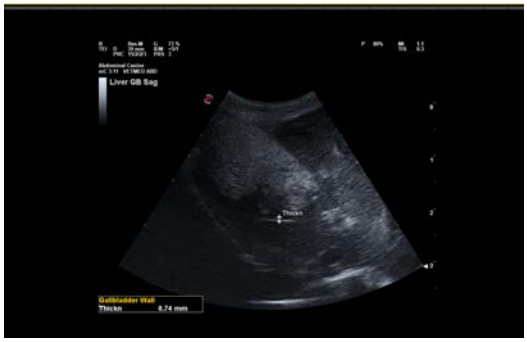

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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