

**PATIENT**

Ginger Bradshaw

**SPECIES**

Canine

**BREED**

Miniature Labradoodle

**SEX**

Spayed female

**AGE**

13 years

**WEIGHT**

26 Pounds

**INTERPRETED BY**

Lisa Carioto, DVM,  
DVSc, Diplomate  
ACVIM

**IMAGING PERFORMED BY**

Loetitia Saint-Jacques, RVT

**HOSPITAL NAME**

Dr. Barnes

**REFERRING VET**

Dr. Barnes

**INVOICE**

32149

**DATE**

8/4/22

**PRESENTING CLINICAL SIGNS**

History: Pet presented for abdominal ultrasound due to reoccurring UTI's. Pet presented for urinary issues. Pet is having accidents in the house. Hx of cystitis

Abnormal PE/Chem/CBC/UA Results: Culture Results: Status: FINAL Isolate 1: E. coli - 10,000 - 50,000 CFU per ml Isolate

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The **urinary bladder** is not fully distended, but its contents are anechoic. Wall thickness cannot be measured accurately as a result. The wall is moderately irregular, i.e., an underlying cystitis is suspected. There is no evidence of sediment, cystoliths, polyps or a mass within the lumen of the urinary bladder. No abnormalities are noted with the trigone or proximal urethra, however, the distal urethra is mildly thickened, however, there is no evidence of a mass. Filling of the urinary bladder is unremarkable.

**Kidneys**

The **left kidney** measures 5.40 cm. The capsule is smooth. The cortex is very mildly hyperechoic and a very mild loss of the normal definition of the cortico-medullary junction is present. Mineralizations and very small nephroliths of the diverticulae and pelvis are present, without evidence of pyelectasia. Blood flow is within normal limits. The surrounding mesentery is not hyperechoic.

The **right kidney** measures at least 5.08 cm. Findings are similar to the left kidney. In addition to the above, an anechoic structure is noted, which is consistent with a benign cyst.

**Aortic bifurcation/trifurcation** No abnormalities observed.

**Adrenal Glands**

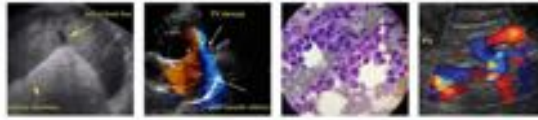
The **left adrenal gland** measures 0.60 cm at the cranial pole, 0.48 cm at the caudal pole. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

The **right adrenal gland** measures 0.65 cm at the cranial pole, 0.52 cm at the caudal pole. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

**Spleen**

The spleen is within normal limits in size, architecture, echotexture, and echogenicity. The capsule is smooth. Mild perivascular cuffing, consistent with myelolipomas is observed; these are not considered clinically significant. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

**Liver**



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There are no obvious signs of hepatomegaly and its borders are smooth and sharp. The liver's echotexture is homogeneous and it is within normal limits in echogenicity. Focal lesions are not observed and no abnormalities are observed with the hepatic vessels.

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The **gallbladder** (GB) is moderately to severely distended with a very large amount of inspissated and immobile echogenic material (sludge). A small amount of free floating and gravity-dependent sludge is also present. Some of the inspissated sludge is adhered to the intramural wall circumferentially. Furthermore, the sludge is of mixed echogenicities. The gallbladder (GB) wall is mildly thickened (1.5 mm) and very mildly hyperechoic.

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Sludge is present at the neck of the GB. There are no obvious signs of an obstruction. The cystic and common bile ducts cannot be followed due to the large amount of ingesta and gas in the stomach. The portions of the cystic and/or common bile ducts observed are not dilated or tortuous, i.e. there are no signs of an obstruction. The parenchyma surrounding the GB is not hyperechoic.

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**Gastrointestinal**

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A very large amount of ingesta is present within the lumen of the stomach despite having been fasted. The gastric wall is within normal limits in thickness and the wall layers are well defined.

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Duodenum: wall thickness is within normal limits and the definition of the wall layers is preserved. A large amount of gas is present within the lumen with a "to and fro" motion, i.e. decreased peristalsis is noted.

Jejunum: wall thickness is within normal limits and the definition of the wall layers is preserved. Ingesta is present within the lumen.

Ingesta and gas are present in the transverse colon.

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The colonic wall is not thickened and mural detail is considered normal. Gas and formed stools are present in the colon.

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**Pancreas**

No abnormalities are observed with the architecture, contours, echogenicity or echotexture of the pancreas. There is no evidence of hyperechogenicity of the surrounding mesentery, i.e., signs of active pancreatitis are not present.

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**Other**

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**Lymph nodes** No abnormalities are observed

**Abdominal effusion** is not visualized.

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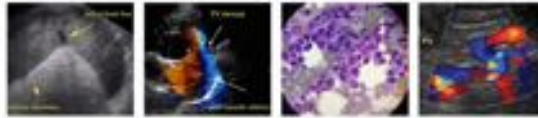
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**Heart**

A brief video clip of the heart was submitted. Pericardial and pleural effusion are not identified. Pulmonary edema is not noted. There is no evidence of a mass in any of the cardiac chambers, including

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the right auricle, however, a mass may be overlooked in the absence of pericardial effusion. No obvious abnormalities are noted with chamber size of contractility (measurements not performed).

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**ULTRASONOGRAPHIC FINDINGS**

- **Urinary bladder:** Chronic cystitis is suspected with possible urethritis. Granulomatous urethritis cannot be ruled out.

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- **Gastrointestinal (GI) tract:** A delay in gastric emptying is suspected as Ginger was fasted for the ultrasound. Obvious abnormalities are not visualized, however, subtle changes may be overlooked due to the presence of ingesta. A mild decrease in peristalsis is noted in the duodenum. The latter may be due to stress. There are no signs of an underlying chronic enteropathy, however, the absence of signs does not rule out the presence of disease.

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- **Gallbladder:** The appearance of Ginger's gall bladder is not consistent with a classical mucocoele, however, significant sludge is present. There are no signs of an obstruction or cholecystitis. A suppurative component cannot be ruled out.

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- **Kidneys:** Age-related changes are noted. Obvious signs of pyelonephritis are not observed, however, it cannot be excluded despite the absence of sonographic signs.

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- **Adrenal glands:** Bilateral adrenomegaly may be due to stress or chronic illness. Pituitary-dependent hyperadrenocorticism (HAC) is less likely based on the absence of clinical signs. Further testing is not suggested for the moment.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Treatment should be based on the antibiogram and clinical signs, i.e. 6-10 weeks of therapy may be necessary. A culture is recommended prior to discontinuation of antibiotics. A sonographic re-evaluation of the urinary bladder may also be considered prior to discontinuing the antibiotics.

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Sterile, digital vaginal exam, if not already performed

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Rectal exam to palpate the urethra

Ensure adequate water consumption, allow for frequent voiding, if once daily antibiotic being administered, give at night, etc.

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Basic hygiene should be pursued on a daily basis. Any fur in the surrounding area should also be trimmed to decrease risk of bacterial wicking.

+/- Analgesia, as needed (gabapentin)

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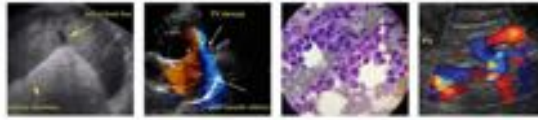
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Although controversial, an oral synbiotic, i.e., a product containing both pre and probiotics may help restore the vaginal and urinary microbiome.

Cystoscopy and biopsies are ideal if no response to antibiotics are observed.

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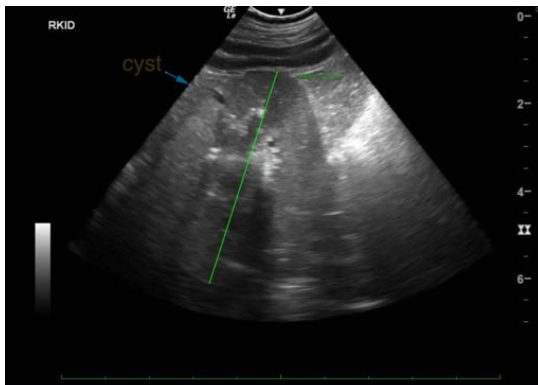
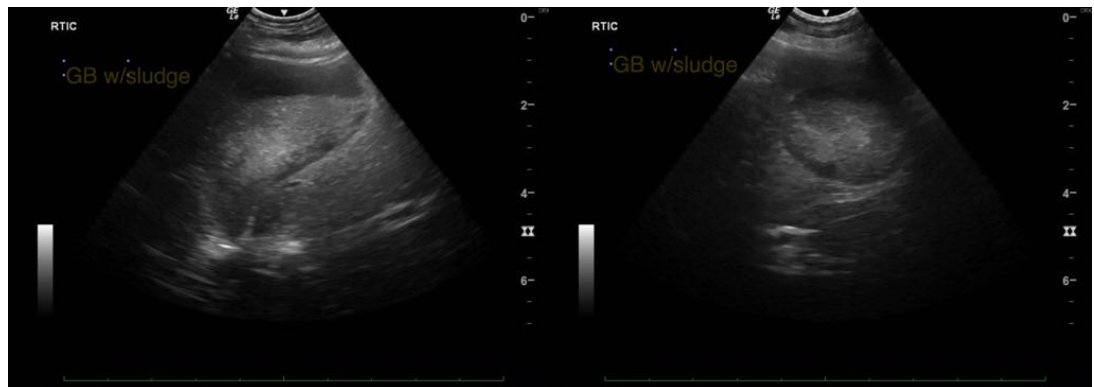
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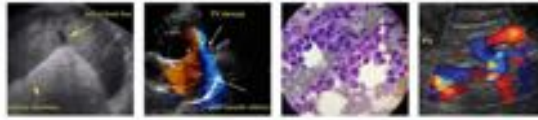
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ursodeoxycholic acid (Ursodiol): It should not be started concurrently with the other medications. Furthermore, it should be administered judiciously, at a very low dose, and slowly up-titrated to decrease the risk of GI side effects. For example, 3 mg/kg PO once a day for 5-7 days, then 5 mg/kg PO once a day for 5-7 days, then 7.5 mg/kg PO once a day for 5-7 days, then 10 mg/kg PO once a day for 5-7 days. She may not be able to tolerate the 15 mg/kg/day dose. The dose should be *divided* BID and given with a meal to decrease the risk of nausea, cramps, vomiting and diarrhea. There are potential risks of partial obstruction, which the clients should monitor for; another reason for very slow up-titration of the dose.





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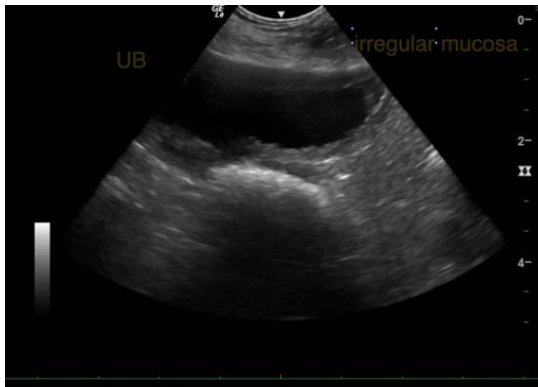
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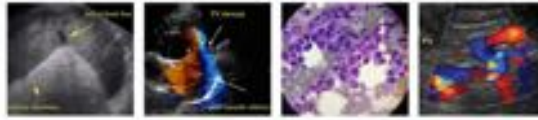
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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