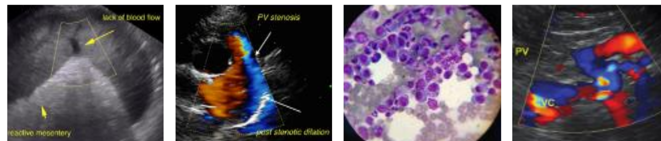
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Kiki Petrin

SPECIES

Canine

BREED

Boerboel

SEX

Intact Female

AGE

8 years

WEIGHT

55kg

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY

Lee Gregory DVM

HOSPITAL NAME

Casco Bay Veterinary Hospital

REFERRING VET

Lee Gregory DVM

INVOICE

10180

DATE

1/21/22

PRESENTING CLINICAL SIGNS

History: Establish care appt 1/20/21. Dx with mastitis, pseudocyesis, and azotemia 1/18/21 at ER. Bloodwork performed as pre-nsaid, azotemia was not an expected finding. Owners note that patient has always been PU/PD. No change in diet, no noted weight loss, appetite excellent, no vomiting. Not UTD on vaccine, Last heat cycle 2 months ago, no vaginal discharge noted since then. Hemorrhagic discharge noted from 2nd most-caudal mammary gland is what prompted visit to ER on Jan 18 Current meds: Clavamox 937.5mg BID, Gabapentin 400mg BID, 500ml LRS SC daily (started yesterday) SUBJECTIVE: BAR OBJECTIVE: EENT: mm pk, crt <2 H/L: NSR, HR 120, eupneic, PSS ABD: SNP PLN: WNL ASSESSMENT: Mastitis L 2nd to last Azotemia- r/o chronic RF, renal dysplasia, acute on chronic RF Anemia, mild, non-regenerative Pseudocyesis

Abnormal PE/Chem/CBC/UA Results: Bldwrk 1/18 (CBC/chem 17/lytes): HCT 33, Creat 8.7, BUN 129, Phos 9.7 M-S: decreased muscle mass over topline NEURO: mild generalized ataxia B PL UG: lactating x all mammary glands. Hemorrhagic discharge when mild expressed from 2nd to last left caudal mammary gland. No palpable mammary masses, gland is not warm, non-erythematous. No discharge from vulva Pending diagnostics: Lepto titers (on abic), C6 quant, UA with reflex UPC, (no culture- currently on amoxi/clav)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The wall is slightly thickened (up to 0.38 cm) with a subtly irregular mucosal surface in the region of the apex. No cystic calculi are observed. The region of the trigone, and the visible portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is small in size (7.12 cm in length); with. A relatively normal shape and smooth peripheral contours. The cortex is diffusely thickened and hyperechoic and there is moderate loss of corticomedullary distinction. A 0.91 cm nonobstructive nephrolith is visualized. Moderate pyelectasia is present (0.62 cm in the longitudinal plane). There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney presented normal size (7.43 cm in length); with a normal shape and smooth peripheral contour. The cortex is variably thickened and hyperechoic. There is moderate loss of corticomedullary distinction. At least 2 nonobstructive nephroliths are visualized, the largest measuring 0.76 cm in length. Moderate pyelectasia is present (1.11 cm in the longitudinal plane). A 0.90 cm cortical cyst is observed at the caudal pole. There is no evidence of hydroureter. Renal vasculature is normal.

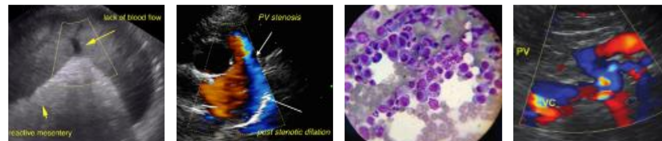
Adrenal Glands

One still image of the left adrenal gland is available for interpretation. The left adrenal gland is normal in size (0.67 cm at cranial pole) (0.58 cm at caudal pole; normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The caudal pole of the right adrenal gland is visualized and is normal in size (0.76 cm in width) with a normal shape, glandular echogenicity and detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (2.05 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.



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Liver

The liver is not visualized in its entirety. In the visualized portions, the peripheral margins are curvilinear. The parenchyma is of appropriate echogenicity and echotexture. No focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is distended with ingesta. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral non-specific chronic nephropathy with nonobstructive nephrolithiasis and pyelectasia.

Secondary Findings

- The mild urinary bladder wall thickening may be a normal variant for this patient and may represent mild cystitis. Correlation with clinical findings is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Baseline blood pressure measurement

- Three-view thoracic radiographs are recommended to assess cardiopulmonary status, particularly if fluid therapy is to be initiated.

- Supportive care, including IV fluid diuresis, broad-spectrum antibiotic therapy (while awaiting urine culture results), and symptomatic treatment as needed is recommended along with serial monitoring of the patient's renal values to assess for progression. Consider switching to a fluoroquinolone, which has better renal tissue penetration.

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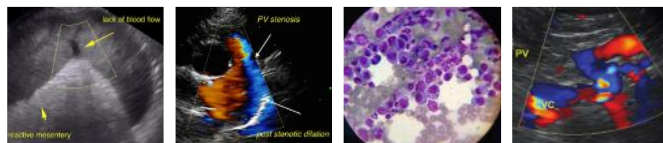

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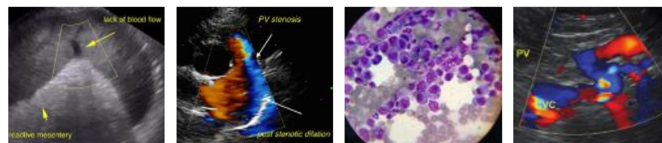

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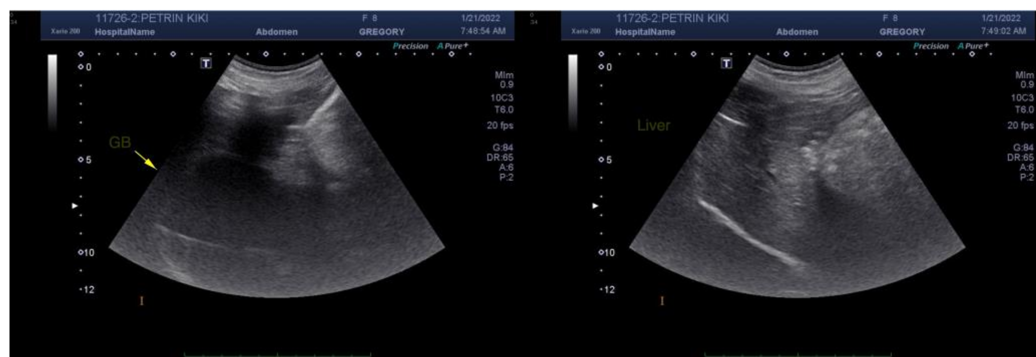

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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