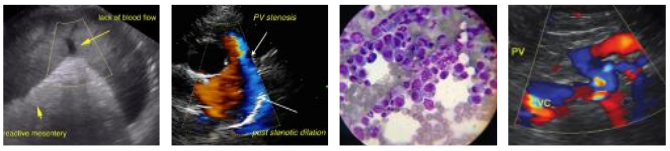
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Calvino Knotts

SPECIES

Canine

BREED

Boxer Mix

SEX

Neutered Male

AGE

9 year 11 mo

WEIGHT

37.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Green

HOSPITAL NAME

Healing Spirit Animal Wellness

REFERRING VET

Sarah Green

INVOICE

10266

DATE

2/3/22

PRESENTING CLINICAL SIGNS

History: Presented 3 days ago due to progressive hyporexia, lethargy and weight loss with recent onset vomiting. Outpatient hospitalization with IVF has reduced Cr from 13 mg/dL to 9.1.

Abnormal PE/Chem/CBC/UA Results: BP=203/85 mmHg CHEM: glucose=129 (60-110) mg/dL, BUN>180 (7-25) mg/dL, Cr=9.1 (0.3-1.4) mg/dL, albumin=2.3 (2.5-4.4) g/dL, P=17.1 (2.9-6.6) mg/dL, Na=164 (138-160) mmol/L, Cl=121 Í(95-119) mmol/L PCV=34 % UA: usg=1.021, UP:C ≥ 2.0, quiet sediment, culture pending Lepto, Lyme both negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small amount of aggregated echogenic suspended debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.03 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (5.46 cm in length) with a normal shape and smooth peripheral contours. The cortex is hyperechoic and moderately thickened with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney presented normal size (7.02 cm in length); with a normal shape smooth peripheral contours. The cortex is hyperechoic and moderately thickened with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.70 cm at cranial pole) (0.79 cm at caudal pole) (2.44 cm in length); 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 right adrenal gland is mildly enlarged (1.15 cm at cranial pole) (0.90 cm at caudal pole) (2.96 cm in length); 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.

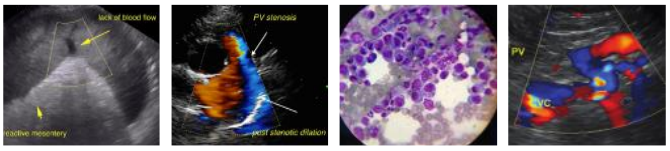
Spleen

(No images provided.)

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of



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mostly gravity dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is mildly fluid distended and hypomotile. The gastric wall is diffusely thickened and irregular (up to 1.00 cm), with questionable retention of the normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

Pancreas

The right limb is prominent to enlarged with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not dilated. The mesentery effacing the serosal surface is hyperechoic.

Free Abdomen

The mesentery in the cranial abdomen is hyperechoic. Trace free fluid is observed. A few mesenteric lymph nodes are visible, the largest measuring 0.83 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

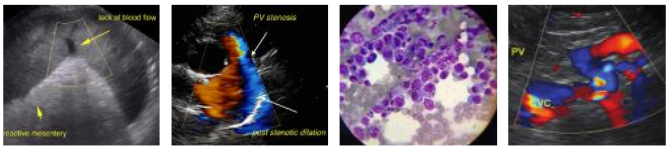
- Bilateral chronic nephropathy. Based on the clinical history, a protein-losing nephropathy is suspected. Most cases are idiopathic. However, protein-losing nephropathies can sometimes be secondary to infectious or neoplastic causes.
- The diffuse gastric wall thickening is most consistent with an inflammatory process (i.e, gastritis). However, emerging neoplasia (i.e, lymphoma), cannot be completely excluded.
- The pancreatic changes are consistent with acute, mild to moderate pancreatitis.
- The cranial abdominal peritonitis is likely secondary to pancreatic and gastric pathology.

Secondary Findings

- Mild bilateral adrenomegaly

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider the following treatments for PLN:
    1. Angiotensin II receptor blocker (e.g., telmisartan)
    2. Antithrombotic (e.g., clopidogrel at 2.5 mg/kg PO q 24 hours)
    3. Omega-3 fatty acids (65 mg/kg of DHA and EPA combined daily)
    4. Prescription renal diet
    5. Baseline blood pressure measurement with serial monitoring thereafter



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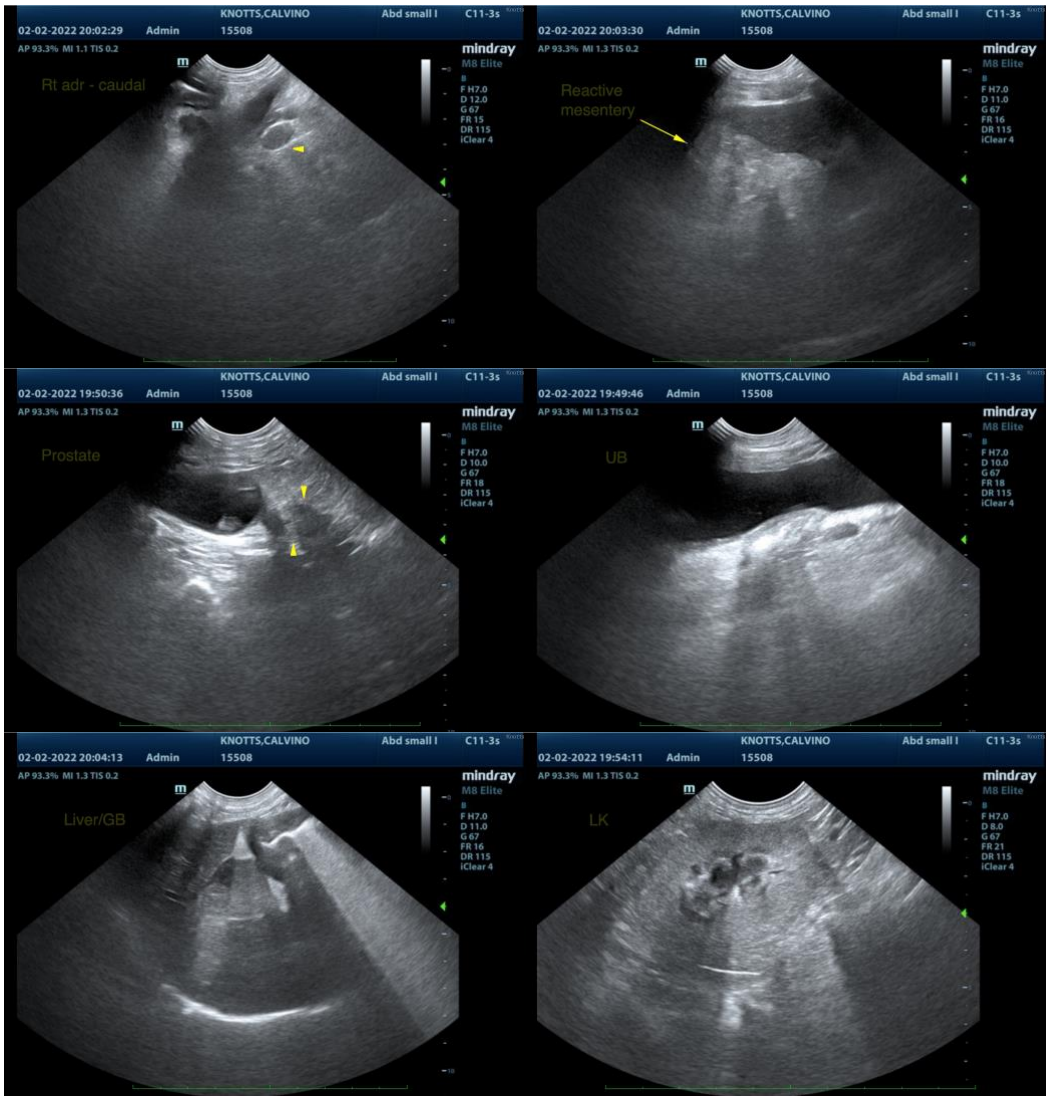
6. Routine monitoring of UPC and bloodwork (CBC, chemistry panel) to assess for progressive disease

- Supportive care for acute pancreatitis and uremic gastritis is recommended. A fine-needle aspirate of the gastric wall can be considered to rule out infiltrative neoplasia.
- Three-view thoracic radiographs are recommended to assess for occult disease in the chest.



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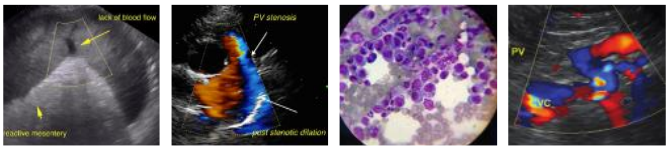

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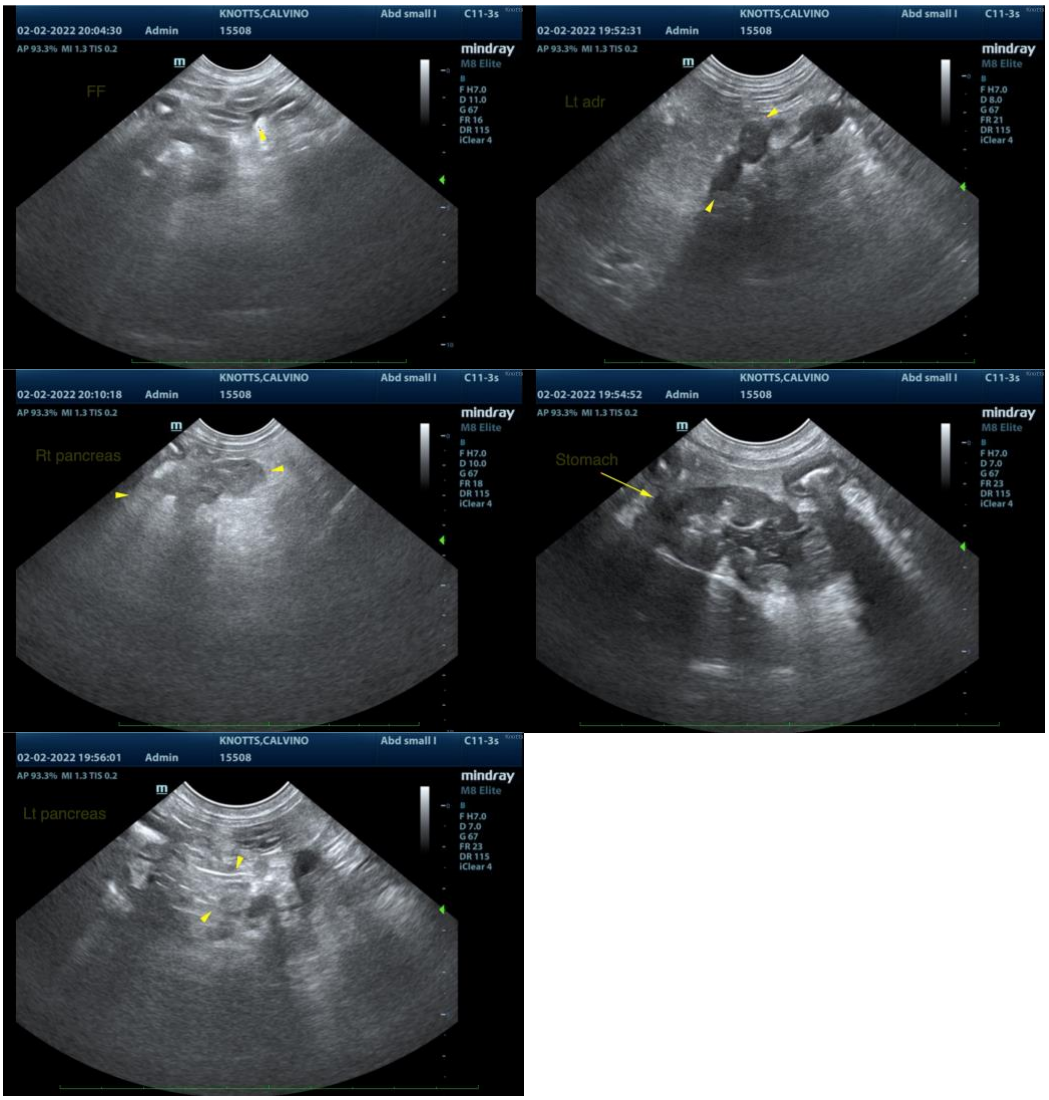

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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