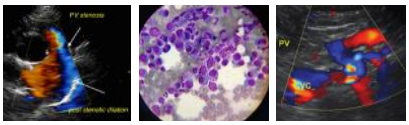
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE
1/6/22

PATIENT
Dazzle Constantine

SPECIES
Canine

BREED
Yorkiepoo

SEX
Spayed Female

AGE
8/7/12

WEIGHT
13.9 Lbs.

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

HOSPITAL NAME
Perry Hall AH

REFERRING VET
Dr. Baer

INVOICE
1/6/22

PRESENTING CLINICAL SIGNS

History: History of hypertension and protein losing nephropathy since 08/21, suspect glomerulonephritis. Grade 2/6 holosystolic cardiac murmur diagnosed 12/15/21. BP on 12/28 160, 156, 160 right lateral LF size 3 cuff. Current diet Hill's k/d.

Current Medications: 8/30-current Enalapril 5mg 1 tab am and 1/2-tab pm. 08/30-current clopidogrel 7mg 1 PO SID.

Lab Results: 12/28: Free-catch UA USG 1.028, Protein 5+, 12/16: USG 1.026, protein 4+, 8/25/21: USG 1.028, protein 3+. Date of Previous IntraPet Ultrasound: No previous IntraPet scans. Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Stephanie Pearce RDCS, RVT

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 lumen is moderately distended with mostly anechoic urine. 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 left kidney is normal size (4.62 cm in length); with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Moderate pyelectasia is present (0.44 cm in the transverse plane). A cortical infarct is present at the lateral aspect. There is no evidence nephroliths or hydroureter. Renal vasculature is normal.

The left kidney is normal size (5.08 cm in length); with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Trace pyelectasia is present (0.415 cm in the longitudinal plane). There is no evidence nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (0.56 cm at cranial pole) (0.73 cm at caudal pole) (2.43 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 (0.91 cm at cranial pole) (0.66 cm at caudal pole) (2.04 cm in length); with a normal shape and smooth peripheral contours. The parenchyma is subtly heterogenous with sudden loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively prominent in size (1.61 cm in width at the level of the hilus) with swollen peripheral contours. Using the high-frequency probe, a light micronodular pattern is observed all throughout the parenchyma. No distinct focal lesions are observed. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively enlarged with swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and homogenous in appearance. No focal lesions are observed. Hepatic vasculature and

intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of echogenic debris is observed within the lumen, most of which is partially dependent and some of which is suspended. The cystic and common bile ducts are normal.

Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. 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 right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic 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 nephropathy with pyelectasia and a left cortical infarct

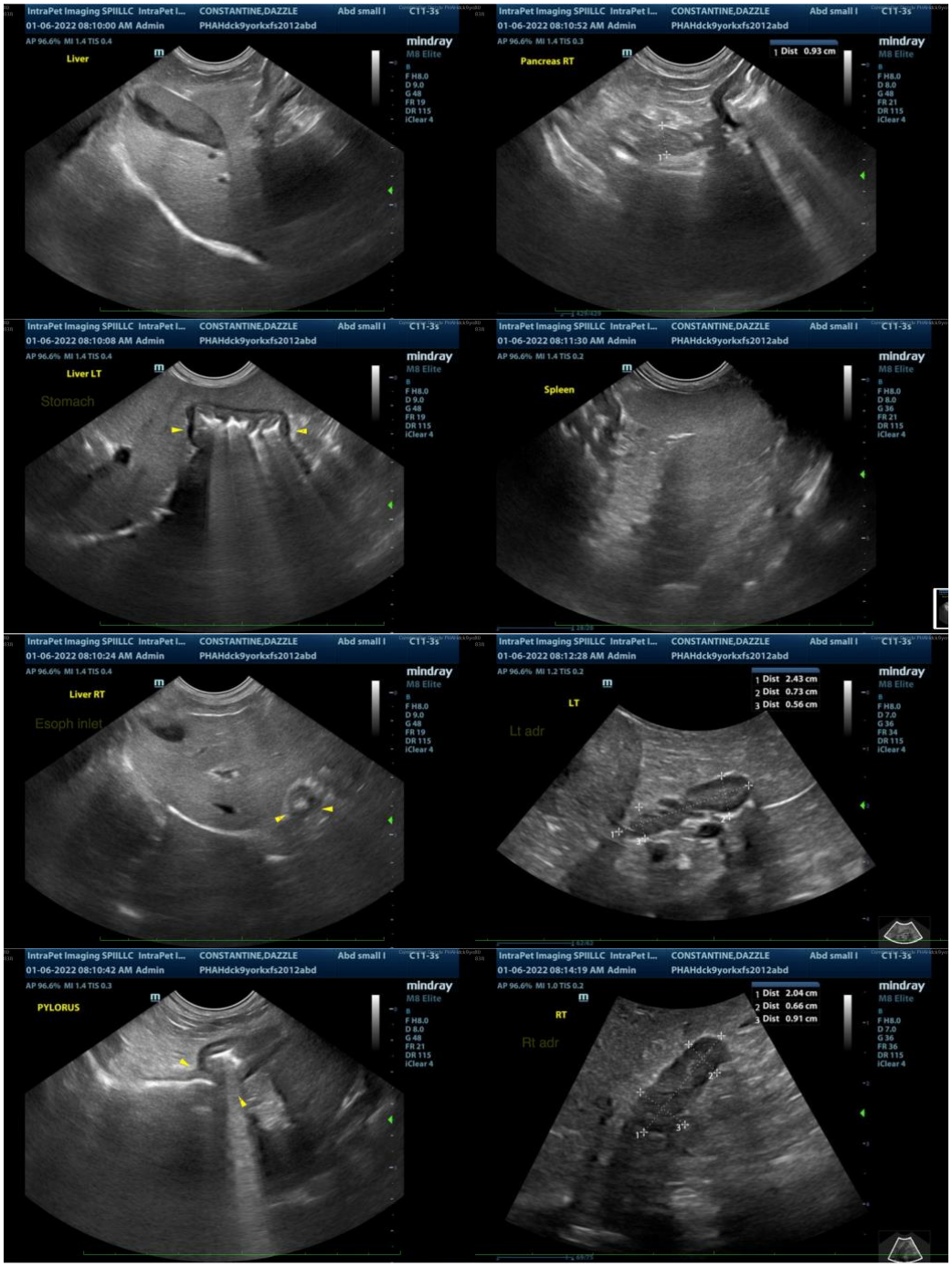
Secondary Findings

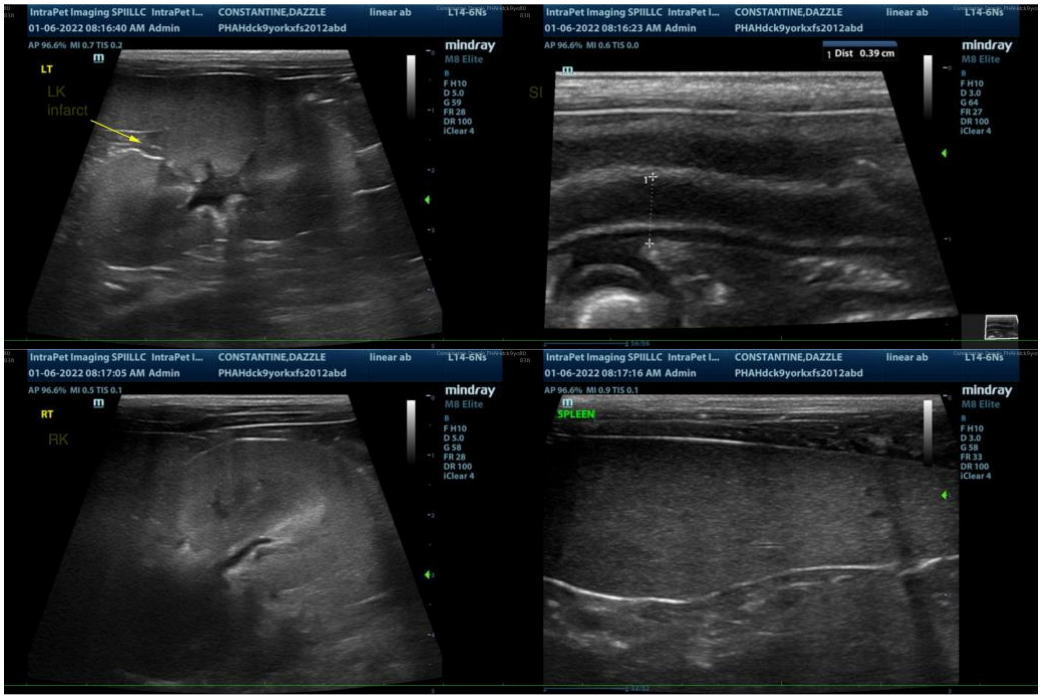
- Mild bilateral adrenomegaly
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- Gall bladder debris, non-mucocele
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If the patient is exhibiting clinical signs of Cushings disease, consider further testing (i.e., lotus dexamethasone suppression test) or ACTH stimulation test.
- Regarding the protein-losing nephropathy, a UPC is recommended if not already performed. This will help to determine if adjustments in the medication regimen is needed. Consider initiation of

Omega 3 fatty acids and a prescription renal diet, if the patient will tolerate it.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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)
info@SonoPath.com