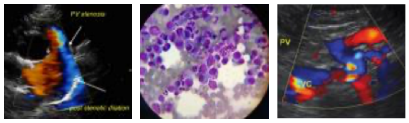
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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

DATE

10.17.2022

PATIENT

Lady Bug Otterbein

SPECIES

Canine

BREED

Poodle

SEX

Intact Female

AGE

3/26/2020

WEIGHT

15.51kg

INTERPRETED BY

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

HOSPITAL NAME

Banfield Towson

REFERRING VET

Dr. Mike

INVOICE

11840

PRESENTING CLINICAL SIGNS

9-10 d history of lethargy, inappetence, and changes with urination. Seen at urgent care 10/15 - wbc 27.8, neutrophils 22.6 cre 1.9, bun normal at 25, increased glob at 4.8, cysto u/a - sg 1.012, rods present; 17 wbc/hpf
urine culture from urgent care pending. Abd rads urgent care listed as overall unremarkable, last heat ~ 1 m ago. Sent home from urgent care with baytril 126 mg 1 po q 14 d &gabapentin 100 mg 1 po 12 hr # 10

Current Medications: sent home from urgent care with baytril 126 mg 1 po q 14 d &gabapentin 100 mg 1 po 12 hr # 10
Lab Results: 10/17/22 bun 23, cre 1.6; wbc 21.1, nuetrophils 16.68
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with 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 subjectively small in size (4.52 cm in length) and is severely misshapen. The cortex is variably thickened. There is poor corticomedullary distinction. Moderate pyelectasia is present (0.45 cm in the longitudinal plane). A 1. 50 cm cortical cyst is observed at the cranial pole. There is no evidence of nephroliths or hydroureter.

The **right kidney** is normal size (5.93 cm in length); with an irregular shape. The cortex is variably thickened. There is poor corticomedullary distinction. Moderate pyelectasia is present (0.55 cm in the longitudinal plane). There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.50 cm at cranial pole) (0.60 cm at caudal pole) (2.71 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 normal size (0.68 cm at cranial pole) (0.65 cm at caudal pole) (1.99 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

The **spleen** is normal in size (1.31 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.

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. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is mildly to moderately distended with ingesta. The gastric wall and pylorus are normal in thickness with a 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. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

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.

Other

The **left ovary** is subjectively normal in size (1.42 x 1.13 cm) with a normal shape. A 1.05 cm cystic area is observed within the parenchyma. No obvious other parenchymal abnormalities are seen.

The **right ovary** is subjectively normal in size (1.92 x 1.46 cm) with a normal shape. A 1.35 cm cystic area is observed within the parenchyma. No obvious other parenchymal abnormalities are seen.

The **uterine body** is prominent in size (1.23 cm in diameter) with diffusely thickened walls (up to 0.41 cm). The lumen is not overtly dilated with fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The bilateral kidney changes are most concerning for renal dysplasia.
- The bilateral pyelectasia may be secondary architectural remodeling, pyelonephritis, PU/PD or some combination thereof.

Secondary Findings

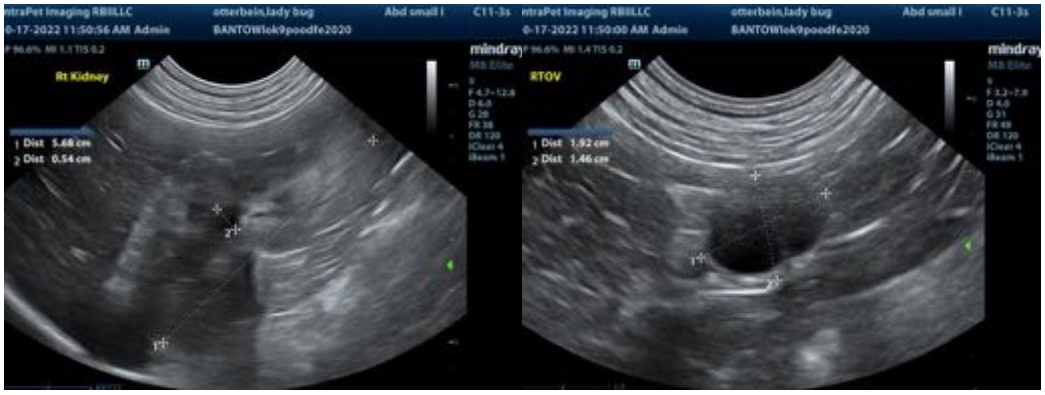
- Visible uterus and ovaries.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the azotemia, consider the following:

1. Urine culture and sensitivity, preferably on a pre-antibiotic sample or 5-7 days after the last dose of antibiotics.
2. UPC (if proteinuria is present in the absence of a urinary tract infection)
3. Baseline blood pressure measurement
4. Prescription renal diet

5. Serial monitoring of the patient's renal values to assess for progression of disease
6. Consider a resting cortisol level to screen for hypoadrenocorticism, although peritoneal disease is suspected in this patient.



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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com