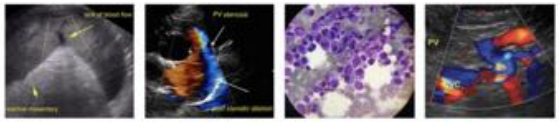


PATIENT

Max Clark

SPECIES

Canine

BREED

Terrier X

SEX

Neutered Male

AGE

08-07-2015

WEIGHT

5.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

MP Blue Pearl ER

REFERRING VET

John McFadden

INVOICE

11951

DATE

12.3.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings/HX: Max is a 5yo MN Terrier Mix presenting for vomiting, lethargy.
P has not been acting himself for the last week. He began acting lethargic on Sunday and vomited several times that day. O started him on a chicken, rice, and veggie diet. He continued to vomit a few times a day through Wednesday, then seemed to perk up. However yesterday into today he grew more lethargic. He vomited four times today. Vomit has consisted of some bile and food. No changes in diet, toxin, or FB ingestion per o.

P was seen at rDVM (Charleston Harbor) last week for wellness visit. BW was run and was WNL per o. A UA was run because p has chronic proteinuria and had been urinating more than usual. UA showed no UTI but significant proteinuria per o. P was started on Telmisartan 6mg/mL at this time. O believes this medication is causing p's GI issues.
E/d less than normal.
U more than normal, bm normal.
V several times a day, no c/s/d.
RX: Telmisartan 6mg/mL- 1mL SID
- P was previously on a 90-day trial of Benazepril (5mg, 1/2 tab BID). O claimed this was to treat his chronic proteinuria. Re o, p was taken off this roughly a month ago.
Utd vaccines, hw, flea/tick prevention.
HX: occasional mild GI upsets, chronic proteinuria

PE: Mild dehydration and mild abdominal discomfort
Abnormal lab-work values: CBC: HCT 31.8 (L), WBC 3.47 (L), Neut 2.6 (L), Lymph 0.56 (L), PLT 63 (L)
PCV/TS: 24/8
Manual PLT count: 144,000, some clumping
Current Medications: telmisartan, in clinic getting Plasmalyte, Cerenia, Protonix, Unasyn

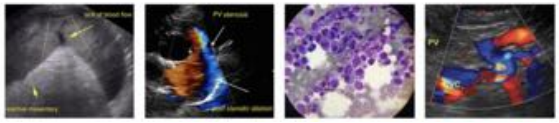
ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System
The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A scant amount of suspended, echogenic 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 (1.06 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (4.98 cm in length) with a normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Trace pyelectasia is present (0.18 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (6.98 cm in length) with a normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Mild pyelectasia is present (0.26 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.



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Adrenal Glands

The left adrenal gland is normal size (0.50 cm at cranial pole) (0.50 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 right adrenal gland is normal size (0.85 cm at cranial pole) (0.51 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.

Spleen

The spleen is normal in size (0.32 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 portal vein to caudal vena cava ratio is approximately 1: 1.

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 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 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

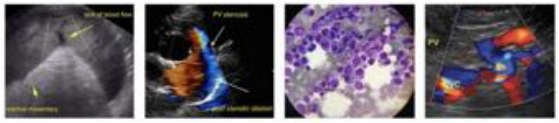
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mild bilateral non-specific chronic renal changed with mild pylectasia. Given the clinical history, acute-on-chronic renal failure is suspected.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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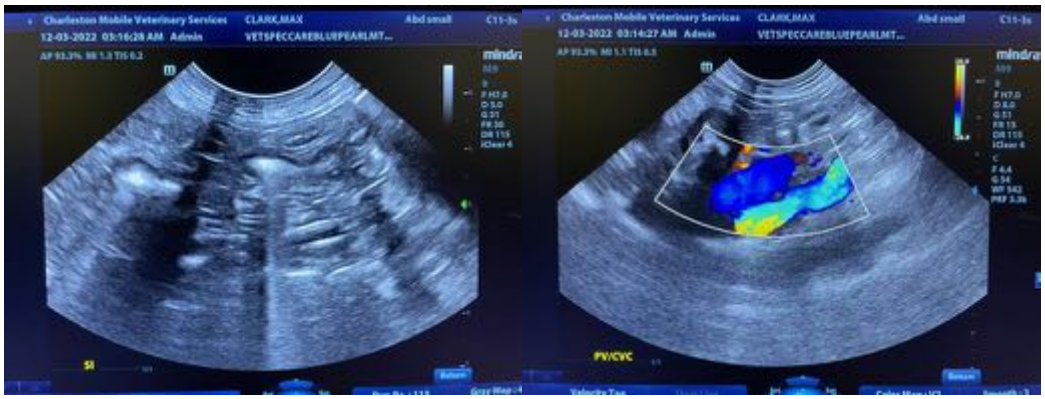
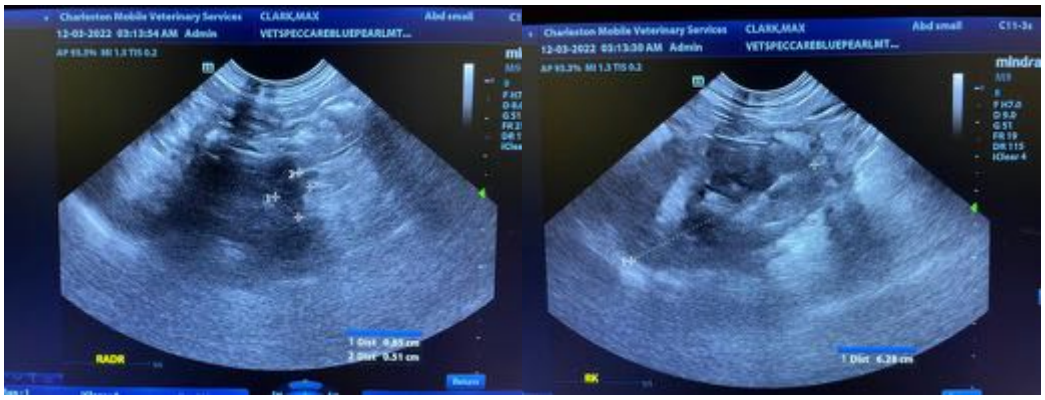
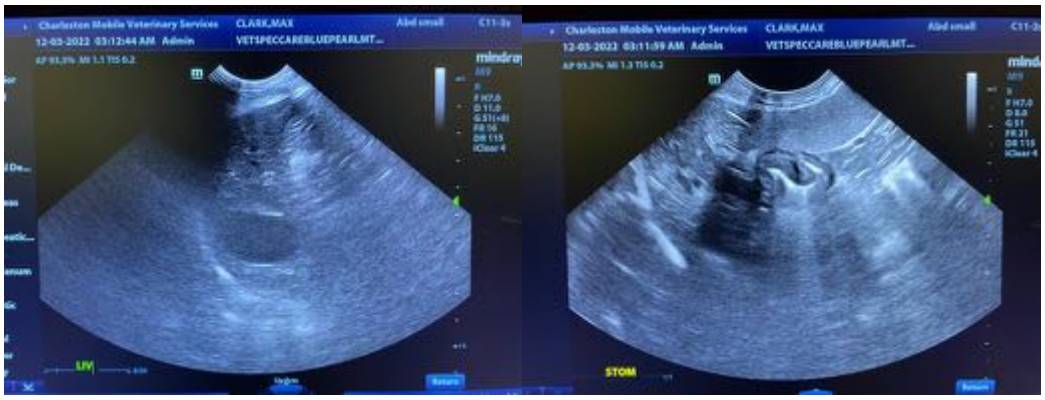
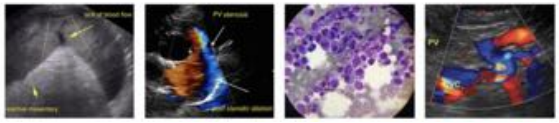
- Given the patient's azotemia, consider the following:

1. Urine culture and sensitivity
2. UPC (if proteinuria is present in the absence of infection)
3. Leptospirosis testing (i.e., blood and urine PCR, serology)
4. Lyme testing (IgM-IgG)
5. Baseline blood pressure measurement
6. Fluid therapy, supportive care and broad-spectrum antibiotics, while awaiting test results.









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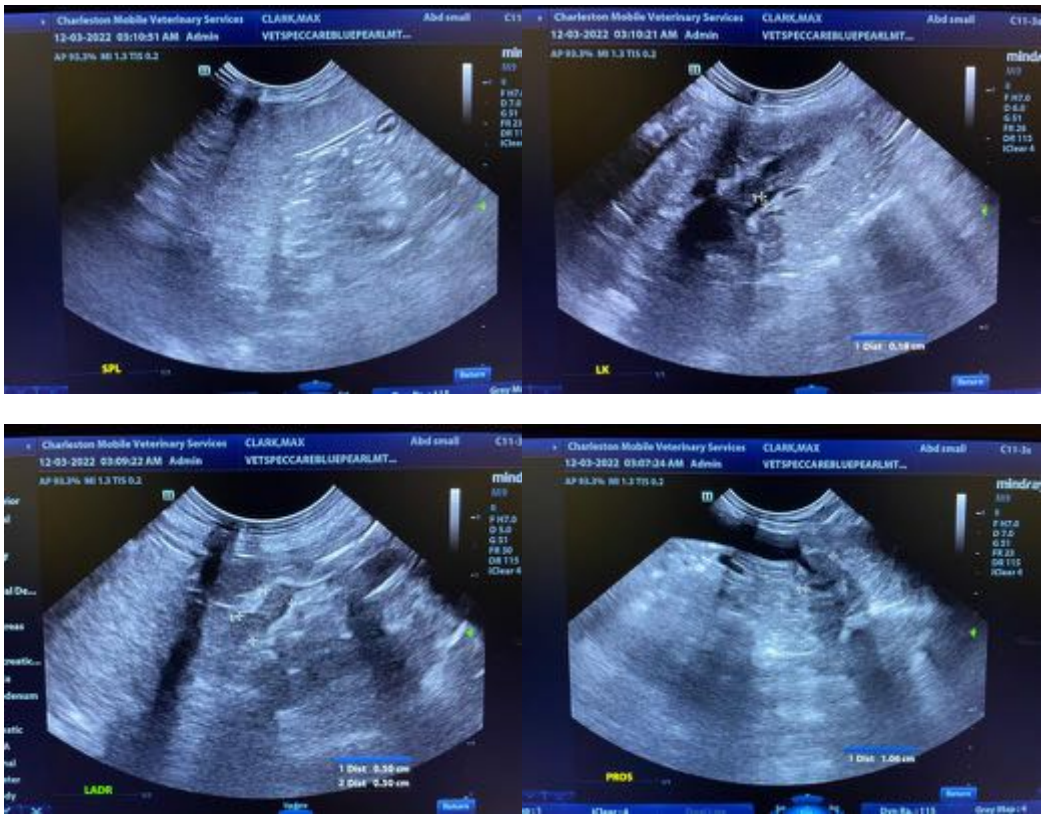

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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