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Clinical Sonography & Telecytology
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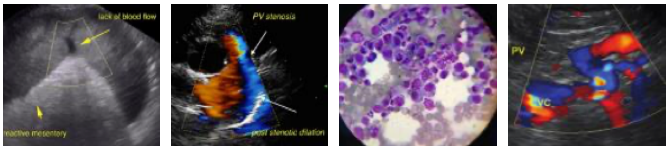

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Maggie Thomson

SPECIES
Canine

BREED
Whippet

SEX
Female, spayed

AGE
12 Yrs.

WEIGHT
35 lbs.

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

IMAGING PERFORMED BY
Sorbo

HOSPITAL NAME
Black Bay VC

REFERRING VET
Dr. Sager-Gellerman

INVOICE
13024

DATE
2/22/22

PRESENTING CLINICAL SIGNS

History: started urinating in the house around the time of the blizzard. Stopped 5 days after and started back up again 7 days ago. No straining No blood in urine. Not licking vulva. no redness or swelling around vulva. appetite and energy is normal. urinating in the same spot (near the door, where she used to urinate when she was on steroids) at the same times (8pm and overnight) Historical ITP (in remission)
Abnormal PE/Chem/CBC/UA Results: 2/20/22: UA: 3+ proteinuria --> UPC = 3.5, 2+ fine granular casts 2/21/22: Renal panel (pending)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder sits in a pelvic location. The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed.

The left kidney is normal size (6.54 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (6.40 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.44 cm at cranial pole) (0.45 cm at caudal pole) (2.87 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 (xxx cm at cranial pole) (0.48 cm at caudal pole) (2.62 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 subjectively enlarged (1.90 cm in width at the level of the hilus) with rounding of the cranial pole. The 3.5 cm hyperechoic to heterogeneous mass effect is observed approximately mid-spleen and just caudal to the hilus. Other ill-defined hyperechoic nodules are also observed throughout the organ. Splenic vasculature appears normal with no evidence of thrombosis.

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 gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

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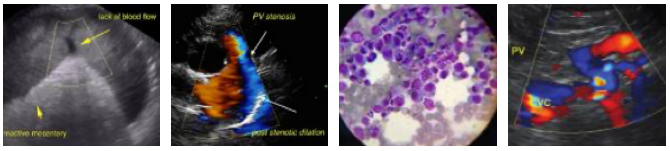

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Gastrointestinal

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 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 disease is noted.

Pancreas

The left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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:

- The splenic mass effect and other hyperechoic nodules trend toward the benign (i.e., myelolipomas). However, emerging neoplasia cannot be excluded.

Secondary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include renal disease, urinary tract infection, behavioral, other.

*Given the elevated UPC, a protein-losing nephropathy is suspected. Protein losing nephropathies are often idiopathic but can sometimes be secondary to infections (i.e., tick borne, heartworm disease), neoplasia or inflammatory processes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Urine culture and sensitivity.
- Regarding the elevated UPC, consider the following:

1. Comprehensive tick panel and heartworm testing
2. Three-view thoracic radiographs are recommended to evaluate for occult neoplasia
3. Angiotensin II receptor blocker (e.g., Telmisartan)
4. Antithrombotic (e.g., Clopidogrel at 2.5 mg/kg PO q 24 hours)
5. Omega-3 fatty acids (65 mg/kg of DHA and EPA combined daily)
6. Prescription renal diet
7. Baseline blood pressure measurement with serial monitoring thereafter
8. Routine monitoring of UPC and bloodwork (CBC, chemistry panel) to assess for progressive disease

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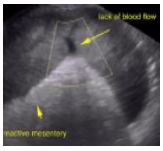
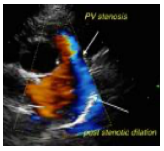
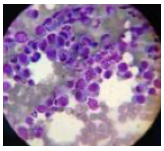
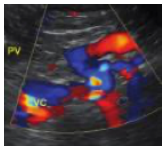

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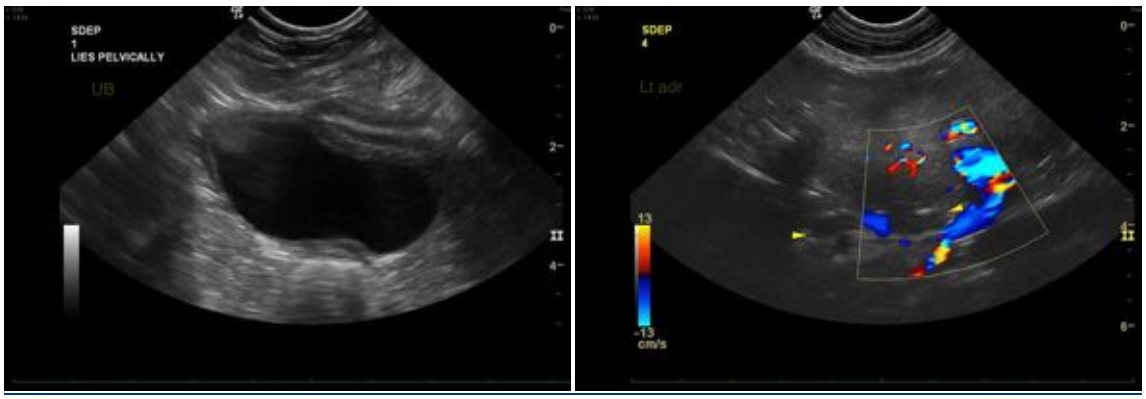
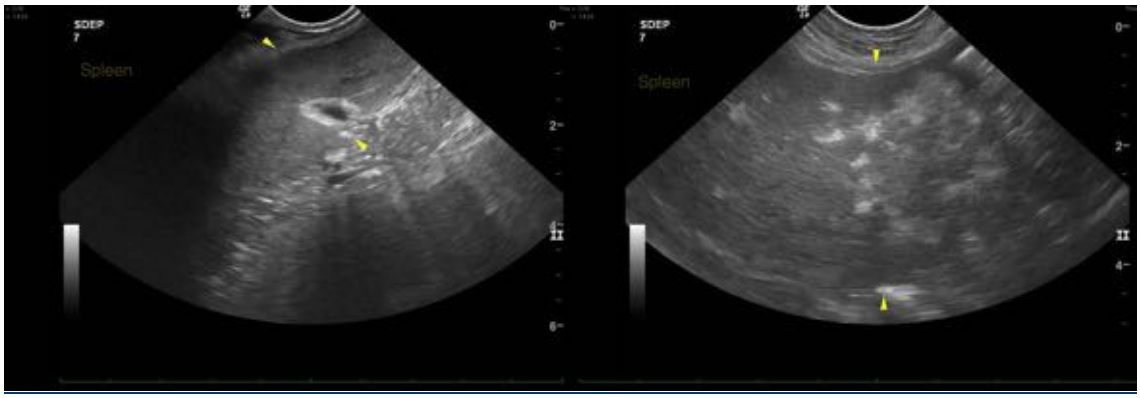
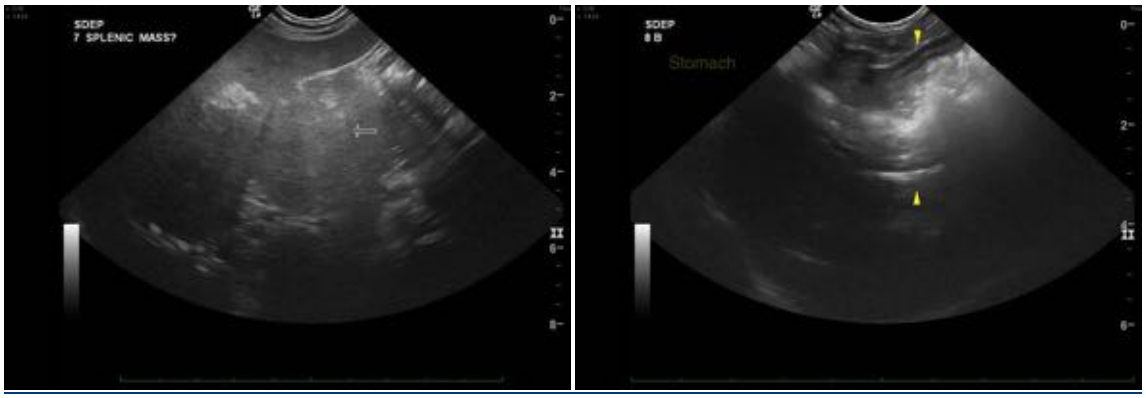
- Regarding the splenic mass effect, consider a fine needle aspirate, if clotting status is appropriate.







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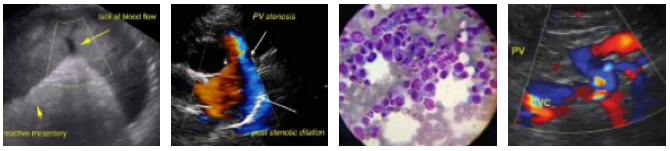

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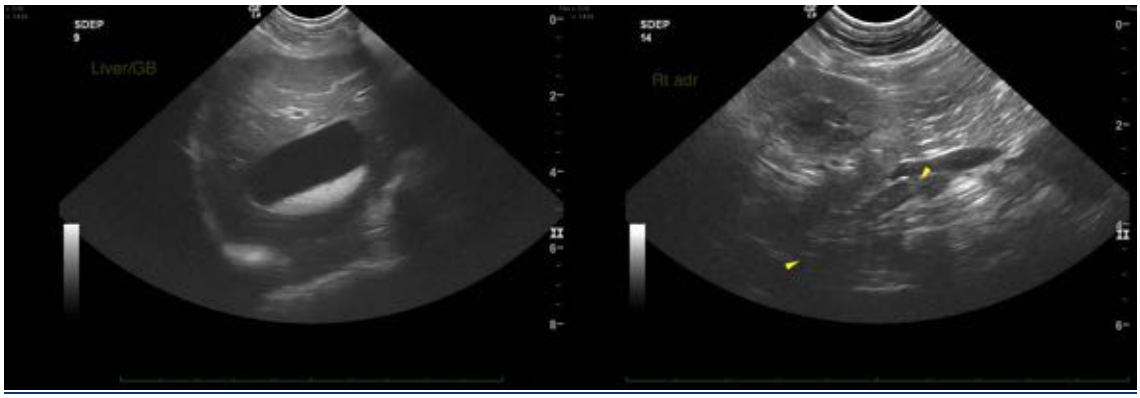

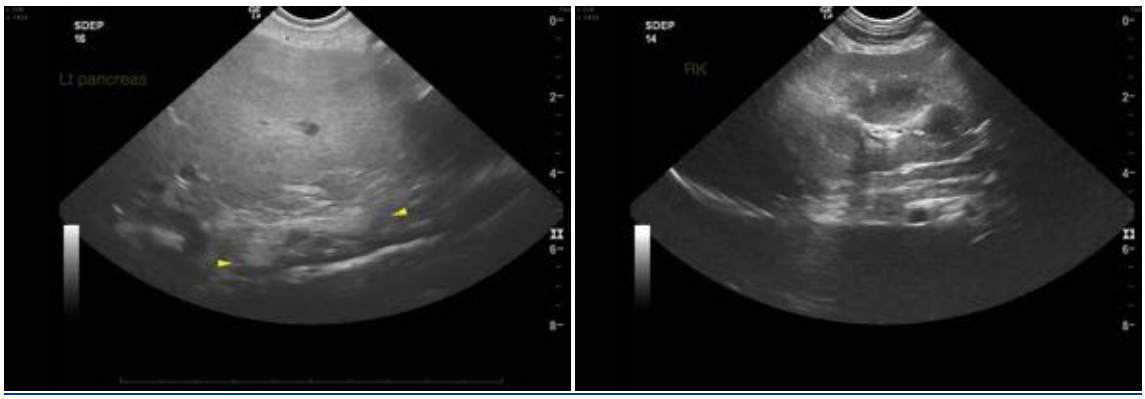

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 ACVIM (*Small Animal Internal Medicine*)

Andrea.nicastro@sonopath.com