



**PATIENT**

Manon Medina

**SPECIES**

Canine

**BREED**

Borzoi

**SEX**

Intact Female

**AGE**

10 mos

**WEIGHT**

46 lbs

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Dr. Gabriel Ferrer, DVM

**HOSPITAL NAME**

Paseos VC

**REFERRING VET**

Dr. Gabriel Ferrer, DVM

**INVOICE**

10439

**DATE**

2/24/22

**PRESENTING CLINICAL SIGNS**

History: Patient presented as a third opinion for evaluation of Abdominal distention with ascites, inappetence, vomiting, diarrhea, depression, weight loss, and azotemia. All this started on Feb16th when patient developed vomiting and diarrhea. Presented to first clinic and BW showed azotemia. Antibiotics were started and IV fluids was started. Pt did not seem to improved. Presented to another clinic and was hospitalized but not much improvement has been seen and started to developed ascites. On Feb 23rd. Removed 2 liters of seems to be modified transudate.

Abnormal PE/Chem/CBC/UA Results: PE: on Feb 23rd Depression, lethargic and pale pink MM with tacky MM. PT is lateral and not moving much. Moderate abdominal distention with fluid wave (abdominal effusion). P:130 R: 50 Low grade 2-3 /systolic HM Fever of 104.4F BW: Done on Feb 22  
CBC: MCV 58 (61-75) WBC: 18 (5-16) Neutrophils 12.3 (2-11.64) CHEM: Creatinine: 4.3 (0.5-1.8)  
BUN:45 (7-27) TP:4.9 (5.2-8.2) Albumin: 1.9 (2.3-4.5) Urine: USG: 1.025 Protein 1+

**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 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 1 cm, are normal.

The left kidney is normal size (6.56 cm in length); with a normal shape and smooth peripheral contours. The cortex is hyperechoic with a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A medullary rim sign is present. There is mild pyelectasia (0.23 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (6.18 cm in length); with a normal shape and smooth peripheral contours. The cortex is hyperechoic with a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A medullary rim sign is present. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

**Adrenal Glands**

The region of the left adrenal gland is evaluated. No obvious pathology is observed in this region.

The right adrenal gland is normal size (1.01 cm at cranial pole) (0.55 cm at caudal pole) (1.92 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 (1.24 cm in width at the level of the hilus) with a normal capsular contour. A light micronodular pattern is present throughout the parenchyma. No focal lesions are observed. Splenic vasculature is normal.



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**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.

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The gall bladder is moderately distended. The wall is slightly thickened (up to 0.20 cm), and hyperechoic. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

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**Gastrointestinal**

The gastric lumen is mildly distended with ingesta. The gastric wall is 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 ileocecolic junction and colonic wall are normal. The colonic lumen contains granular-appearing fecal material. There is no evidence of an obstructive pattern.

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**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.

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**Free Abdomen**

A moderate to large amount of echogenic free fluid is present within the abdomen. The mesentery throughout the abdomen is hyperechoic. Several prominent mesenteric and caudal abdominal lymph nodes are visualized. The largest mesenteric node measures 1.32 cm in length. The largest caudal abdominal lymph node measures 3.75 cm in length.

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Medicine)

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- The bilateral renal changes could be consistent with infection (i.e., Leptospirosis), nephrotoxicity (i.e., ethylene glycol), lymphoma (less likely), or other nephropathy.
- The diffuse ascites (with subsequent peritonitis), may be secondary to low oncotic pressure, increased hydrostatic pressure (i.e., due to fluid overload), increased vascular permeability, or some combination thereof.

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**Secondary Findings**

- The splenic parenchymal changes are non-specific and may be secondary to a benign process such as antigenic stimulation, lymphoid hyperplasia, extramedullary hematopoiesis, or splenitis. Infiltrative neoplasia is possible but considered less likely.
- The abdominal lymphadenopathy could be consistent with immunologic immaturity or reactive change. Infiltrative neoplasia is possible but considered less likely.
- The mild gall bladder wall thickening may be a normal variant for this patient or may represent cholecystitis.

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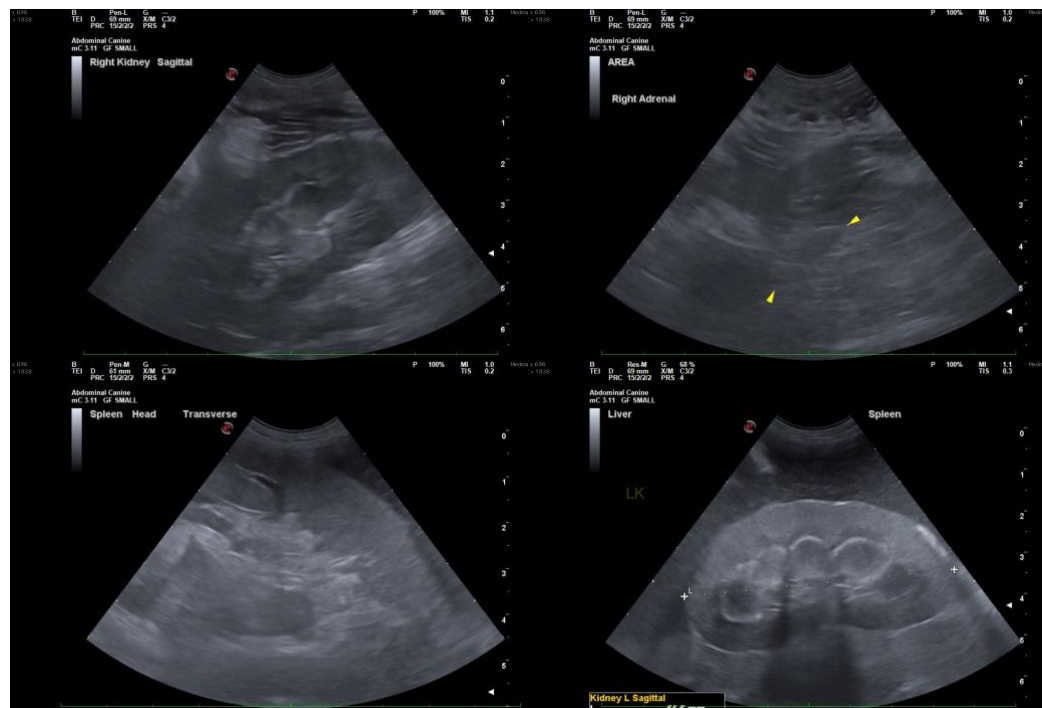
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Leptospirosis testing (i.e., blood and urine PCR, serology)
- Urine culture and sensitivity
- UPC
- Baseline blood pressure measurement
- Ethylene glycol testing (if the clinical suspicion is high and potential exposure is recent).
- Three-view thoracic radiographs +/- an echocardiogram are recommended to assess for fluid overload/congestive heart failure.
- A renal aspirate can be considered if clotting status and blood pressure are normal. However, cytology results may be non-specific.
- While awaiting test results, IV fluid diuresis, supportive care and broad-spectrum antibiotic therapy are recommended.





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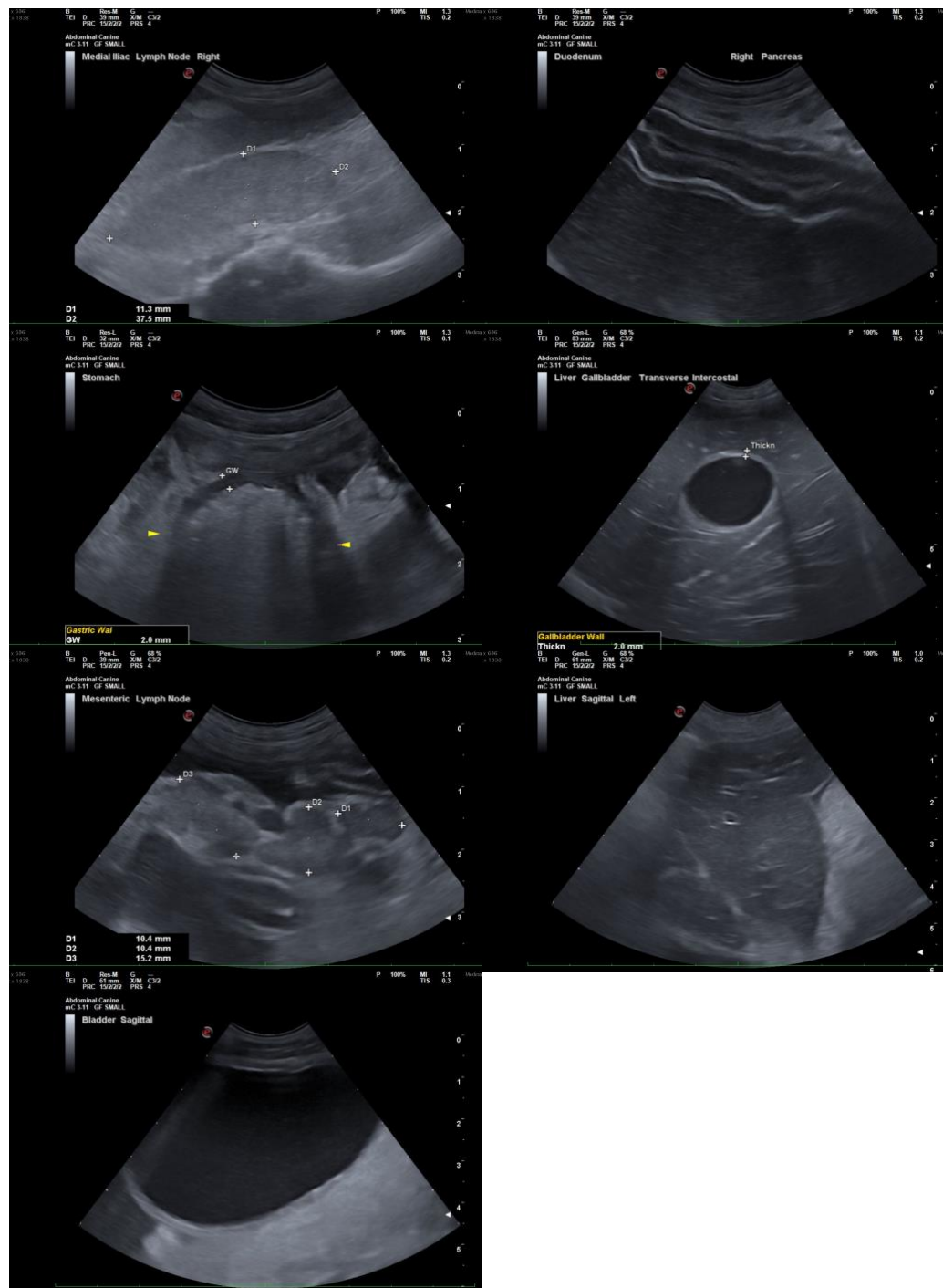
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.



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