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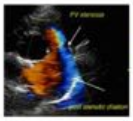
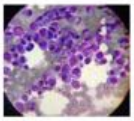
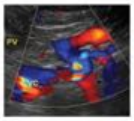

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PATIENT

Mocha Schieve
32706A

SPECIES

Canine

BREED

Shih Tzu

SEX

Spayed Female

AGE

10 years, 7 mos

WEIGHT

7.27 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison Veterinary Specialists-Dr. Patton

INVOICE

12297

DATE

2.27.23

PRESENTING CLINICAL SIGNS

History: Mocha presented to the MVS Emergency Service on Feb 26, 2023, at 7:20p, for evaluation of stranguria. Last time she urinated was last night prior to 8pm. Owners let her out before bedtime and noticed at 8pm that she took an unusual amount of time to come back inside and are unsure if she urinated at that time. This morning she was noted to have stranguria with frequent urges to urinate. Inappetent, not wanting to drink water, is able to defecate Hx: pancreatitis, anal gland mass removal, frequent UTI, uroliths (2/2022, retropulsed into bladder and was able to pass on her own).

Abnormal PE/Chem/CBC/UA Results: Phos 7.9 ALT 160 WBC 15.96 (5.05-16.76)0 Neu 12.53 Mono 1.27

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended following installation of 20 ml of saline via a Foley catheter, which is observed in the region of the trigone. The wall is of appropriate thickness for the level of repletion. The mucosal surface is slightly irregular. A small amount of gravity dependent mineralized sand +/- tiny calculi is observed within the lumen. The region of the trigone is normal. There is suspected mineralized sand within the proximal urethral lumen.

The left kidney is normal in size (4.33 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The right kidney is normal in size (4.63 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

Adrenal Glands

The left adrenal gland is enlarged (0.36 cm at cranial pole) (0.49 cm at caudal pole) with a normal shape and 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 (1.36 cm at cranial pole) (0.54 cm at caudal pole) with a slightly irregular shape. A 1.45 x 0.94 cm hyperechoic to heterogenous nodule is observed at the cranial to mid-aspect. Glandular echogenicity and detail at the caudal aspect are normal. Surrounding vasculature appears normal.

Spleen

The spleen is normal in size (1.48 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 curvilinear peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of gravity dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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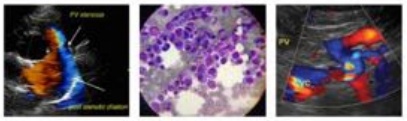

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Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are 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
There is no obvious evidence free fluid. A 1.30 cm mesenteric lymph node is visualized. In addition, a 1.16 cm medial iliac lymph node is seen. The nodes are normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Urinary bladder sand +/- tiny calculi

Secondary Findings

- Bilateral chronic renal changes with subtle dystrophic mineralization
- The right adrenal nodule could be consistent with benign nodular hyperplasia or an emerging tumor (i.e., adenoma, adenocarcinoma, pheochromocytoma).
- The hepatic parenchymal changes are most consistent with vacuolar hepatopathy (i.e., idiopathic/endocrine). However, inflammatory disease, hepatotoxicity, fibrosis, infiltrative neoplasia or other hepatopathies are also possible.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider abdominal radiographs to further assess for discreet cystic calculi.
- A urinalysis with a culture and sensitivity are also recommended.
- Consider initiation of a prescription urinary diet.
- Consider a follow-up ultrasound in 3-4 weeks to reassess for discreet cystic calculi.
- While awaiting test results, consider initiation of empirical antibiotics therapy for urinary tract infection.
- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If values continue to increase, a repeat abdomen ultrasound +/- a more advanced hepatic work-up (i.e., tissue sampling) may be warranted.

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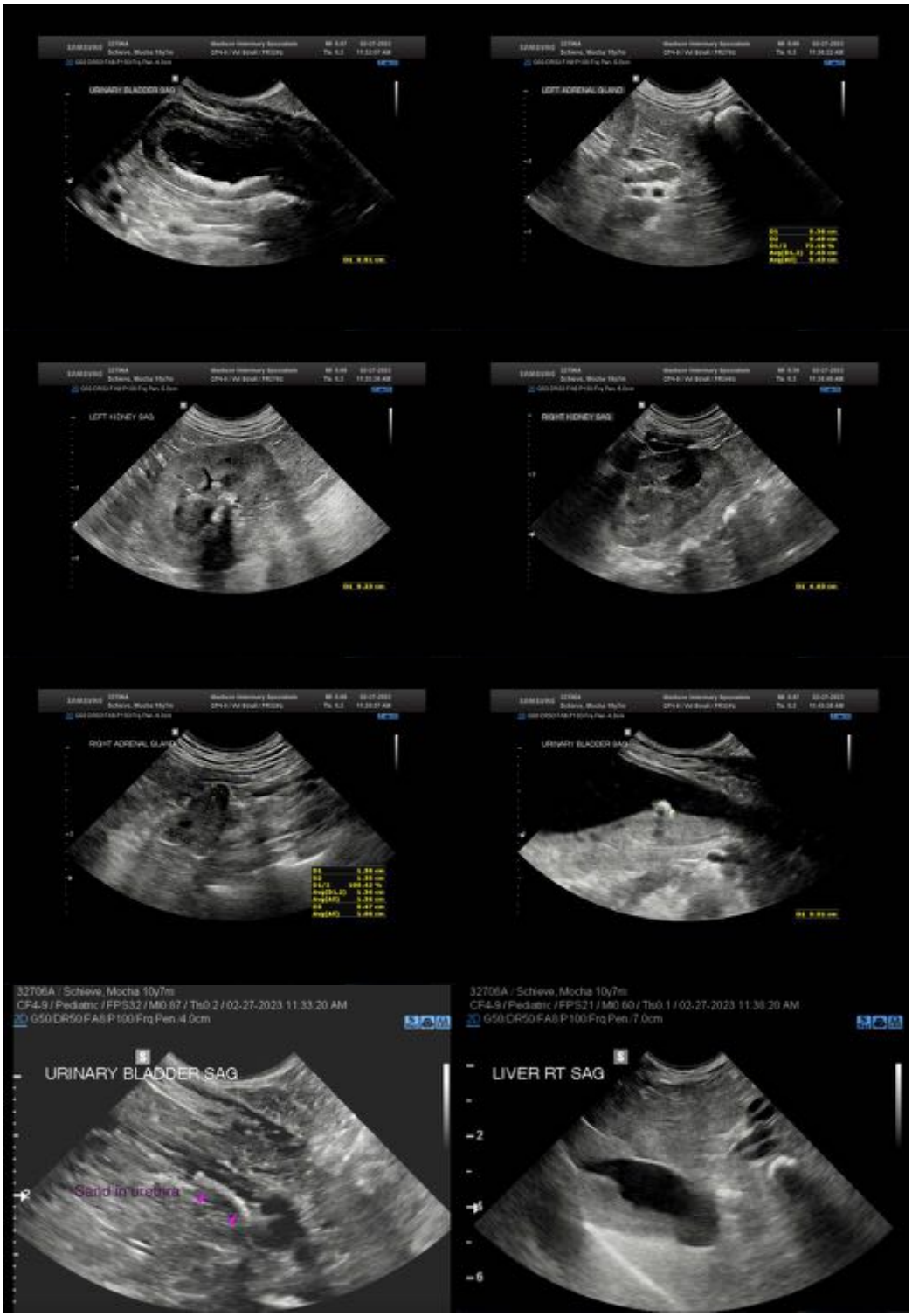

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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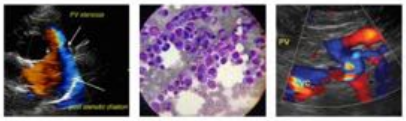

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