Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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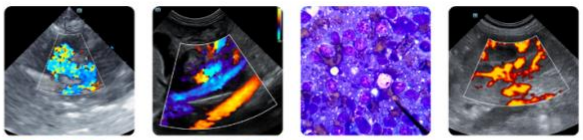

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Otis Cuccherini

SPECIES

Canine

BREED

Golden Retriever

SEX

Male Neutered

AGE

12/28/2018

WEIGHT

65

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

AH Of South Carolina

REFERRING VET

Dr. Matthew Stone

INVOICE

22707

DATE

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Uncomfortable mid abdomen, skin tenting, tacky mm, V+
Abnormal lab-work values: BW- elevated kidney values, all else within normal limits emailed BUN 43. Creatinine 3.2.
Current Medications: Marbofloxacin 100mg x7days
Radiographic Findings: None

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface in the region of the apex is slightly irregular. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 5 cm, are normal.

The prostate is mildly enlarged (2.12 cm in width) with smooth peripheral contours. The parenchyma is minimally heterogenous. No distinct focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (5.95 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild- to moderate loss of corticomedullary distinction. At least two cortical cysts are seen (the largest measuring 0.84 cm in diameter). Mild- to moderate pyelectasia is present (0.37 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.58 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild- to moderate loss of corticomedullary distinction. Mild pyelectasia is present (0.31 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.66 cm at cranial pole) (0.84 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 normal in size (0.76 cm at cranial pole) (0.62 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.

Spleen

The spleen is normal in size (1.30 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. The portal vein to caudal vena cava ratio is approximately 1: 1.

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/not seen.

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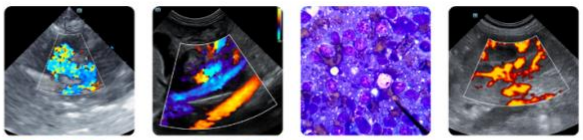

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Gastrointestinal
The gastric lumen is minimally distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness 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.

Lymph Nodes
The abdominal lymph nodes are normal/not visible.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral nonspecific chronic renal changes with left cortical cysts. The bilateral pyelectasia may be secondary to pyelonephritis, parenchymal remodeling, PU/PD (if applicable), or some combination thereof.

Secondary Findings

- Mild left adrenomegaly
- The mild prostatomegaly could be consistent with late-in-life neutering (if applicable), prostatitis, hyperplasia, or emerging neoplasia. Correlation with the patient's clinical history and urinalysis findings is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the azotemia, consider the following:

  1. Urinalysis with culture and sensitivity
  2. UPC if proteinuria is present in the absence of infection
  3. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
  4. Leptospirosis testing (i.e., blood and urine PCR, serology), particularly if clinical suspicion for disease is high
  5. Baseline blood pressure measurement
  6. Serial monitoring of the patient's renal values to assess progression of the azotemia.

- Regarding the prostate changes, consider a urine BRAF test to further evaluate for lower urinary tract neoplasia, if clinical suspicion for disease is high.

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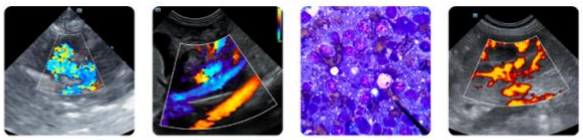

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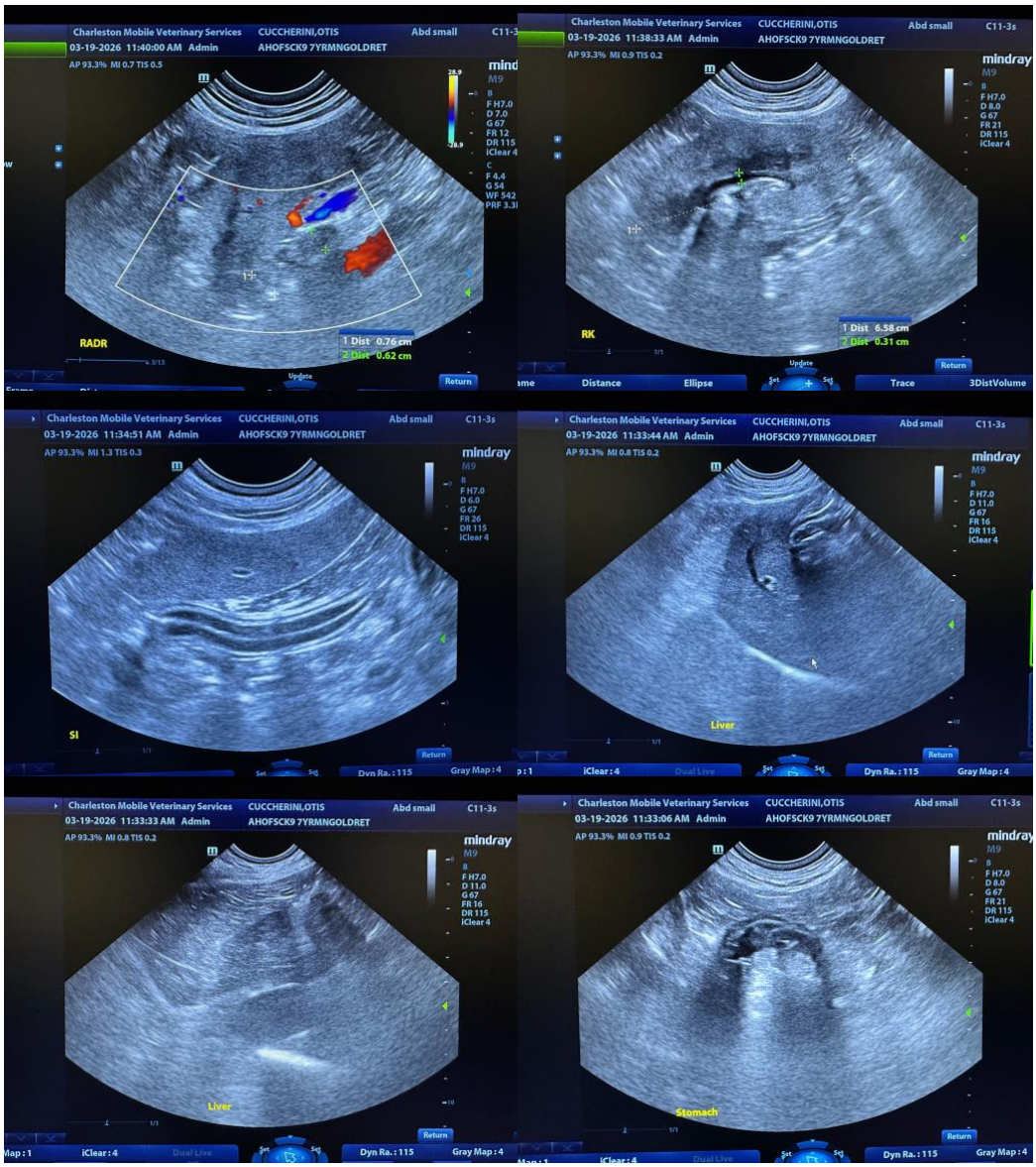

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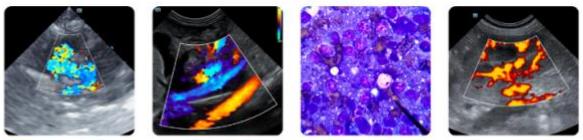

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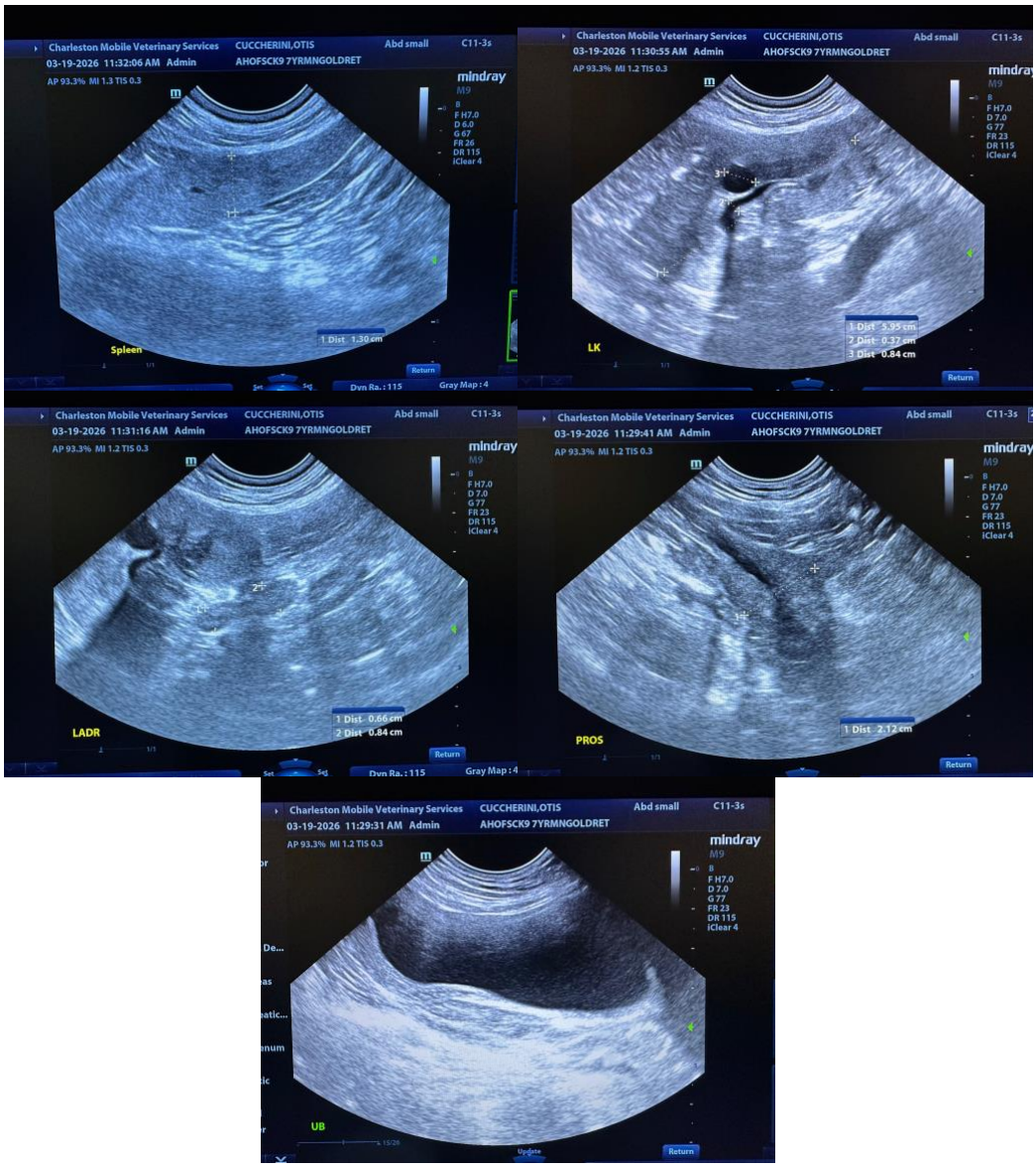

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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