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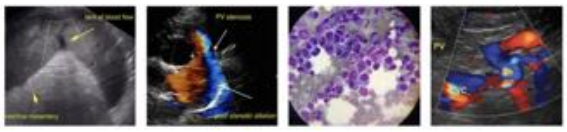


Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Winnie Cobbs

SPECIES

Canine

BREED

Chinese Crested

SEX

Female Spayed

AGE

10/8/2017

WEIGHT

9.4 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

Southside AH

REFERRING VET

Dr. Michael Forcier

INVOICE

12304

DATE

3.2.23

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: SARDS historically
Current medications Entyce, omeprazole, Enrofloxacin, aluminum hydroxide, doxycycline and Gabapentin.

February 9th @ SAH: Lethargy, decreased appetite, increased thirst.
PE FINDS - Abd tense with cranial splinting on palpation. Pale.
BUN >130, Cr 6.1, Phos 8.7, HCT 36.7
Transferred to CVRC.

Five days hospitalized @ CVRC:
IVF therapy, tick titers submitted, US unremarkable.
Patient diagnosed with IMHA, in addition to treatment for AKD, Glomerulonephritis.
Blood transfusion (no match).
Discharged: SC Fluids, Enrofloxacin, Entyce, Omeprazole, preniSOLOne.

Recheck SAH. 2/17/23: No improvement (But PCV rising. Withdrawal of Steroid initiated)
Additional meds dispensed for hyperphosphatemia. Doxy dispensed with titers pending. Patient appetite remains poor.

Follow-up SAH 2/21/23 - Patient remains lethargic, poor appetite, emerging anemia, azotemia more severe. Rising hepatic enzymes,
Offered abdominal ultrasound based on minimal diagnostic value of the previous ultrasound. Owner declined. Offered transfer to ER. Declined.
The Cobbs (myself as well) were curious as to why no internal medicine involvement was not recommended during ER visit.

2/28/23 - Perkier in appearance. Still diminished appetite. Patient appears pale.
Gave SC fluids, Cerenia, start pepcid (stopped Omeprazole), start Gabapentin.
Scheduled US with Dr Nicastro.
HCT 26.9%.
BUN 92, Cr 6.2, Phos 8.3
ALKP 1348 (increased), ALT 540 (decreased), GGT 45 (increased).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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 region of the trigone and the proximal urethra (visible to a depth of 2-3 cm) are normal.

The left kidney is normal in size (4.31 cm in length) with smooth curvilinear peripheral contours. The cortex is diffusely thickened and hyperechoic. There is moderate loss of corticomedullary distinction. Small focus of mineralization are visualized. Mild pyelectasia is present (0.22 cm in the transverse plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.74 cm in length) with smooth curvilinear peripheral contours. The cortex is diffusely thickened and hyperechoic. There is moderate loss of corticomedullary distinction. Small foci of mineralization are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands
The left adrenal gland is normal in size (0.42 cm at cranial pole) (0.42 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 in normal size (0.99 cm at cranial pole) (0.39 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 (0.81 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 enlarged with slightly swollen 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 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 segmentally dilated with gas and chyme (mild). 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
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. On to two prominent mesenteric lymph nodes are visualized (the largest measuring 1.13 cm in length).

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The bilateral wall changes are consistent with chronic interstitial nephrosis/nephritis, with nonobstructive nephrocalcinosis and trace pyelectasia.

- The hepatic parenchymal changes could be consistent with steroid hepatopathy, infectious/inflammatory disease (i.e., bacterial cholangiohepatitis, Leptospirosis), hepatotoxicosis (i.e., copper), infiltrative neoplasia (i.e., lymphoma (less likely)), or some combination thereof.

Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

  *Based on the patient's clinical history, glomerulonephritis and possible immune-mediated hemolytic anemia are suspected. An underlying autoimmune or infectious cause may be present but has not been identified. Systemic lupus erythematosus (SLE) is a consideration.

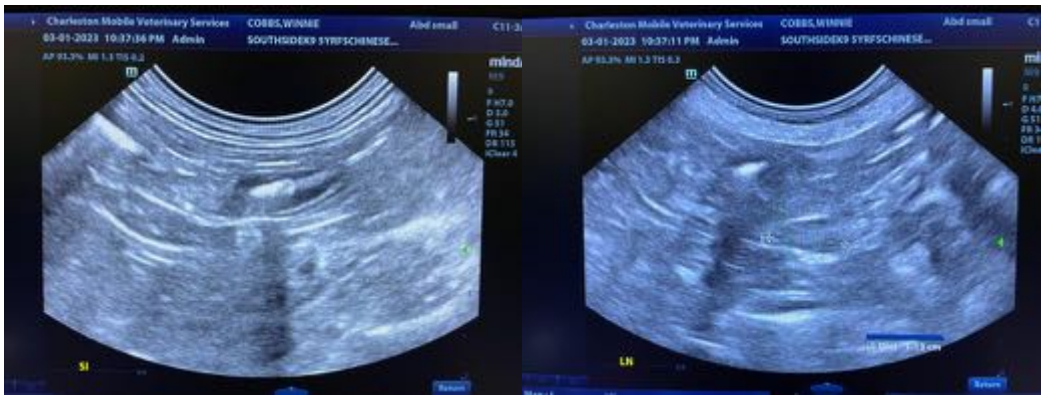
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

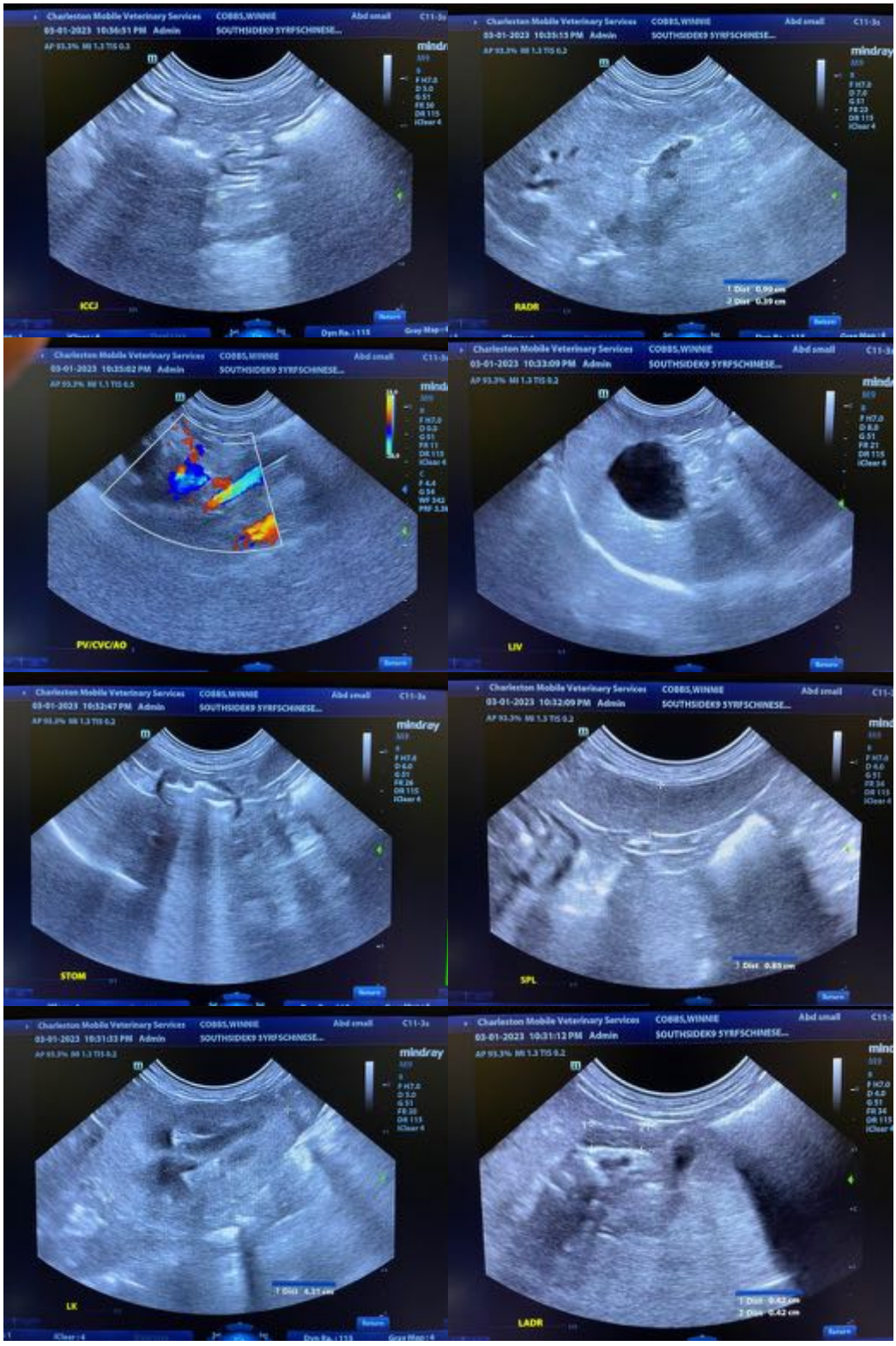
- Recheck PCV and slide agglutination, as well as a urinalysis, UPC and baseline blood pressure measurement. Based on these results, we can decide if treatment for protein-losing nephropathy and IMHA need to be instituted/reinstituted. We will discuss the results further when they are available.

- Also consider performing an antinuclear antibody (ANA) test +/- LE prep on blood to further evaluate for SLE.

- Consider discontinuation of doxycycline due to poor appetite and negative 4Dx.

- Given the substantially elevated ALT, consider empirical treatment for bacterial cholangiohepatitis (i.e., amoxicillin-clavulanic acid).




Charleston Mobile Veterinary Services
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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)
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