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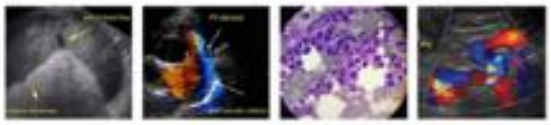


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Kaia Bulkeley

SPECIES

Canine

BREED

Austr Shepherd

SEX

Female Spayed

AGE

7 years, 5 mos

WEIGHT

29 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView AH

REFERRING VET

Laurie Bulkeley DVM

INVOICE

12710

DATE

4.6.23

PRESENTING CLINICAL SIGNS

History: No sedation, panting and tense abdomen- History * She has food allergies and GERD She has anxiety She is mildly PU/PD Working diagnosis Kaia has had non azotemic, mild proteinuria , and her cholesterol has been elevated for years, her SDMA is 15 concern for nephrotic syndrome vs early renal disease MEDS: Sertraline 50 mg am, 25 mg pm Zylkene 450 mg 1 cap q 24 h Metoclopramide 10 mg 1 T PO BID For vomiting GERD Starting Benazepril 10 mg 1.5 T PO q 24h Omega 3 FA and a renal diet

Abnormal PE/Chem/CBC/UA Results: 3/23 SDMA 15, Cr 1.0, BUN 22, UPC 2.3, USG 1.017 with 1+ hyaline and granular casts, Cholesterol 468, albumin 2.3, T4 1.2, 4 DX neg, Trigylcerides 91 4/22 Cortisol 2.8 4/22 UPC 1.38 3/22 PCV 57.9, Alt 16, Cholesterol 467, USG 1.017,T4 1.8, SDMA 9, Cr 1.0 1/22 Cholesterol 399, SDMA 27, USG 1.013 , Cr 1.2, T4 1.6 9/2021 Cr 1.1, USG 1.027, Cholesterol 436, 2+ proteinuria, T4 1.5 1/ 20 USG 1.022 2+ proteinuria 7 /2019 Cholesterol 358, Cr 0.9, trace proteinuria, USG 1.019 T4 1.5 8 /2018 Cr 1.0, SDMA 12

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. 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 2 cm, are normal.

The left kidney is normal in size (6.74 cm in length) with a slightly irregular shape. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A few tiny cortical cysts are seen. Trace pyelectasia is present. There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.60 cm in length) with a slightly irregular shape. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A few tiny cortical cysts are seen. There is no evidence of pyelectasia or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.56 cm at cranial pole) (0.52 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 in length (0.56 cm at cranial pole) (0.47 cm at caudal pole) (3.17 cm in length) with a flattened contour. 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 (1.76 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. No pathological hepatic lymphadenopathy observed.

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.

Gastrointestinal

The lumen is not distended. 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 colonic wall is 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 evidence of free fluid. A few prominent mesenteric lymph nodes are visualized (the largest measuring 3.36 cm in length). The nodes are normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral chronic nephropathy. Given the patient's clinical history, a protein-losing nephropathy is suspected. Most cases are idiopathic. However, can occasionally be secondary to inflammatory/infectious disease or neoplasia.

Secondary Findings

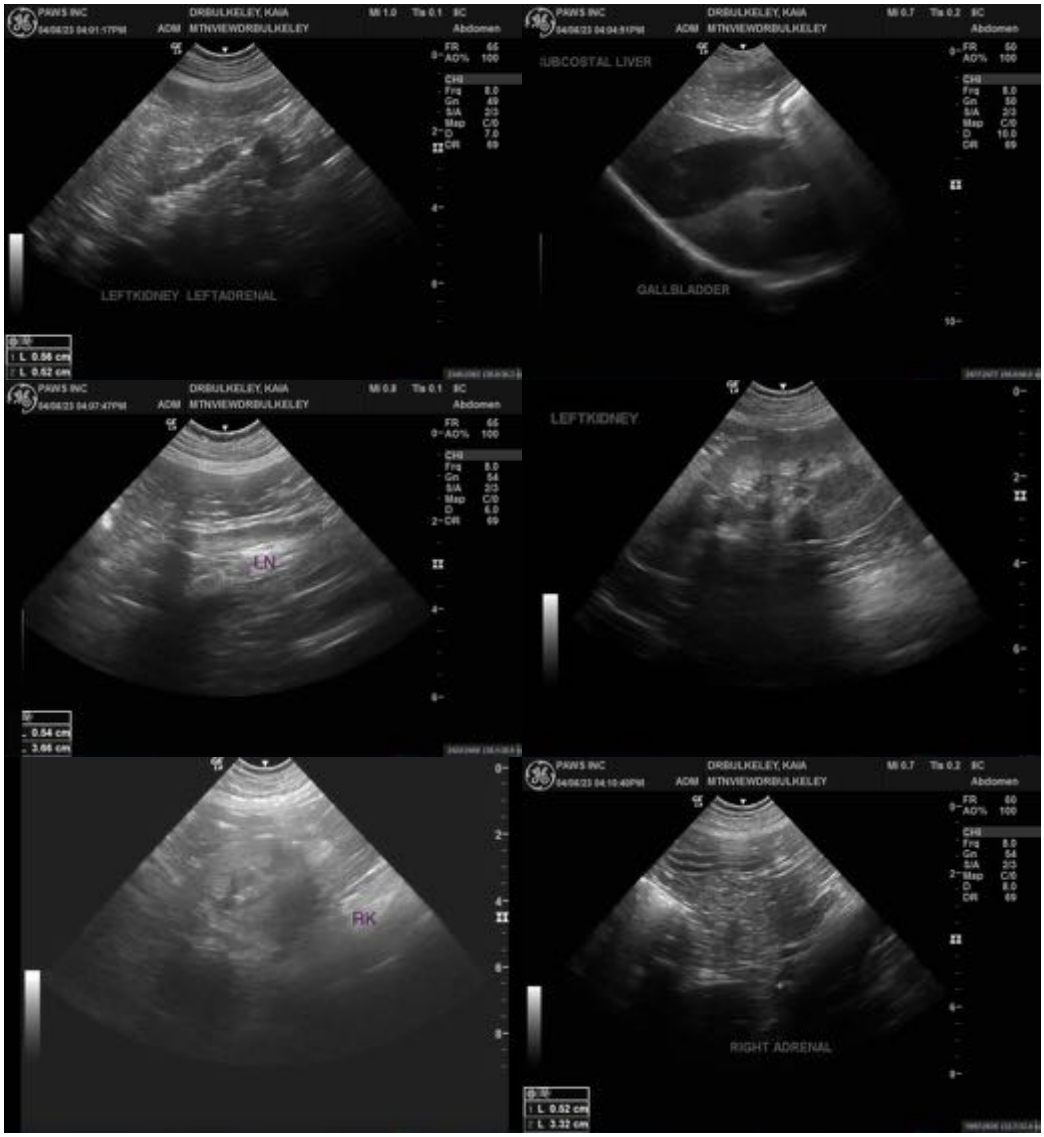
- The flattened right adrenal gland is most likely a normal variant for this patient, given the normal resting cortisol level.

- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the likelihood of a protein-losing nephropathy, consider the following:

    1. Further testing for neoplasia and infectious diseases (i.e., thoracic radiographs, heartworm testing, comprehensive tick panel).
    2. Baseline blood pressure measurement
    3. If the ACE inhibitor fails to reduce the UPC, consider initiation of an angiotensin receptor blocker (i.e., losartan, telmisartan)
    4. Also consider initiation of an anti-thrombotic agent (i.e., clopidogrel).
    5. Continuation of the omega 3 fatty acids and renal diet is recommended.
    6. Serial monitoring of the patient's renal values, UPC and blood pressure is recommended to assess for progression of disease.



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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