



PATIENT PRESENTING CLINICAL SIGNS

Blanca Puigdorfila

SPECIES

Canine

BREED

German Shepherd

SEX

Female, spayed

AGE

14 Yrs.

WEIGHT

60 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ferrer

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. Biello

INVOICE

15077

DATE

6/21/23

History: Presented today for abdominal ultrasound. The patient was brought for HW treatment on 5/17/2023, BW 60 lbs. HX of arthritis, and Ehrlichia. Patient received diroban and was discharged on Prednisone 10 mg PO BID for 7 days, then tapered. Patient was brought in on 5/25/2023 for excessive panting. Blood work performed: CBC mild thrombocytopenia of 105. Ca (7.9-12.0)7.6, TP 4.5 (5.8-8.2), Alb 2.0 (2.2-3.9) ALT 244 (10-125), Amylase 369 (500-1500). Patient was discharged on gabapentin and famotidine. Owner had been giving Rimadyl at same time as pred. Informed owner to stop giving both medications. Patient returned again on 6/7/2023 for Marked pain and unable to use left hind limb. Patient was discharged adequan, and rimadyl. Re-check on on 6/13/2023 patient has been doing extremely well but due to multiple rechecks it was postponed. 6/16/2023 presented recumbent with marked pain and unable to get up. Rimadyl administered as previously but the response. Some edema noted on front limbs. The patient was started on IV fluids: WBC elevated with lymphocytosis and monocytosis. Blood glucose 63 mg/dl BUN 47, Creatinine 2.0, Alb 1.8, Tbil 1.0 mg/dl. UA: Specific Gravity of 1.041 NO WBC, NO Bacteria, Creatine >26.4, Ptrotein/creatinine >=0.5 tp <2.0, Bilirubin +2.33. The patient was started on Ampicillin and doxycycline due to Elevation in WBC and decrease in platelets. concerned for recurrence of Ehrlichia signs 6/18/2013 remained with no urine production. Abdomen scanned bladder present moderated size. Urinary catheter was attempted but was unable to due to the small vulva. Chemistry: Hypoglycemia despite dextrose fluids, BUN increased to 73, Creatine 3.3, Alb 1.8, TP 5.0, Tbil 1.0. Fluids increased to 80 ml/hr with dextrose at 2%. The patient was started on Dex SP 4 mg/ml 1.0 ml SQ SID and Ampillicin discontinued and started on Enrofloxacin @ 5 mg/kg, Cerenia, famotidine and force feeding slurry. Today, edema has worsened. Bladder expressed. Urine is more clear UA SG 1.025 all other wnl, SDMA 48

Abnormal PE/Chem/CBC/UA Results: CBC: RBC 5.36 M/ μ L 5.65 - 8.87 LOW HCT 33.6 % 37.3 - 61.7 LOW HGB 12.6 g/dL 13.1 - 20.5 LOW WBC 28.42 K/ μ L 5.05 - 16.76 HIGH NEU * 23.21 K/ μ L 2.95 - 11.64 HIGH MONO * 1.87 K/ μ L 0.16 - 1.12 HIGH PLT 100 K/ μ L 148 - 484 LOW PCT 0.13 % 0.14 - 0.46 LOW CHEM: GLU 57 mg/dL 70 - 143 LOW CREA 3.3 mg/dL 0.5 - 1.8 HIGH BUN 73 mg/dL 7 - 27 HIGH PHOS 12.0 mg/dL 2.5 - 6.8 HIGH TP 5.0 g/dL 5.2 - 8.2 LOW ALB 1.8 g/dL 2.2 - 3.9 LOW TBIL 1.0 mg/dL 0.0 - 0.9 HIGH SDMA 48 μ g/dL 0 - 14 HIGH

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. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (7.37 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Mild pyelectasia is present (0.37 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter.

The right kidney is normal size (6.52 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.44 cm at cranial pole) (0.59 cm at caudal pole) (2.66 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.



PATIENT

Blanca Puigdorfila

The right adrenal gland is normal size (0.58 cm at cranial pole) (0.58 cm at caudal pole) (3.03 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.

SPECIES

Canine

Spleen

The spleen is normal in size (2.33 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.

BREED

German Shepherd

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 amount of suspended echogenic debris is observed within the lumen. 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 colonic wall is normal. There is no evidence of an obstructive pattern.

WEIGHT

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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

The mesentery in the cranial to mid-abdomen is hyperechoic and slightly irregular in appearance. A small amount of anechoic free fluid is present. The abdominal lymph nodes are normal/not visible.

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ULTRASONOGRAPHIC FINDINGS

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- Bilateral non-specific chronic renal changes. Based on the patient's clinical history, acute on-chronic renal failure is suspected.
- Diffuse peritonitis is present. Sterile vs septic causes should be considered.

REFERRING VET

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*An obvious cause for the patient's clinical signs and lab work abnormalities is not definitively identified in this study. Considerations include infectious disease (i.e., Leptospirosis, tick-borne), protein-losing nephropathy, protein-losing enteropathy, hypoadrenocorticism, hepatic dysfunction (less likely), occult neoplasia, other.

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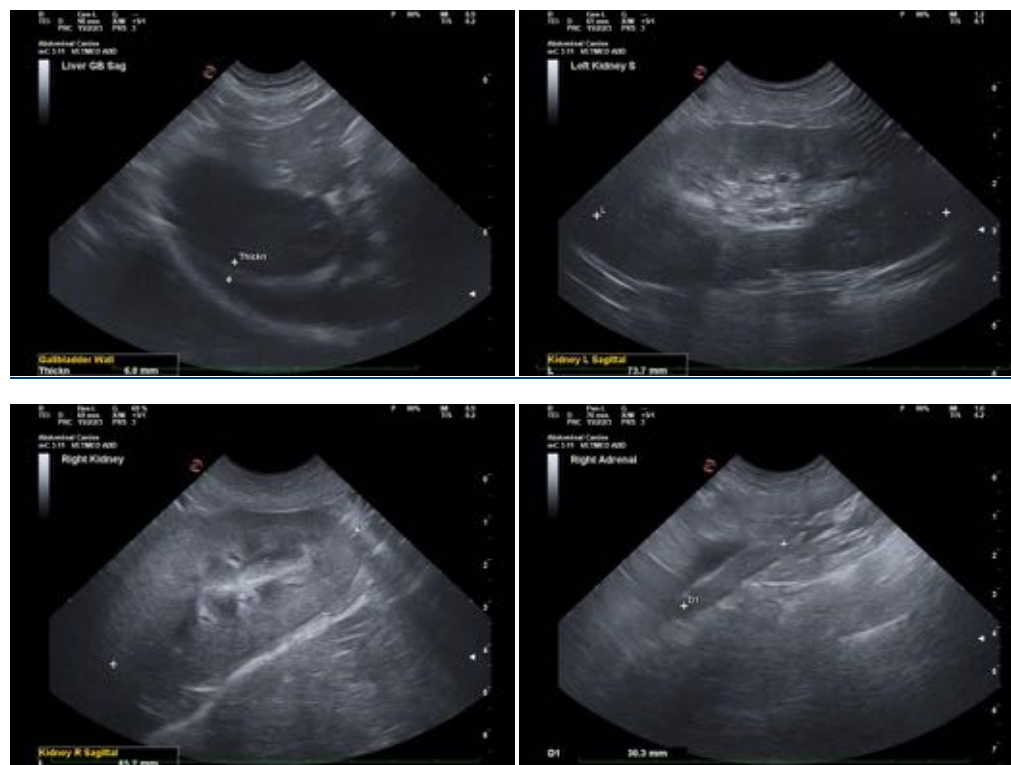
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Urine culture and sensitivity
- UPC, if proteinuria is present in the absence of infection
- Baseline blood pressure measurement
- Leptospirosis testing (i.e., blood and urine PCR, serology)
- Comprehensive tick panel
- A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
- Consider fluid analysis and cytologic evaluation of the abdominal fluid if aspiration can be performed safely.
- Pre and post prandial serum bile acids are also a consideration to assess hepatic function.
- Thoracic radiographs are recommended to assess cardiopulmonary status, particularly given the presence of hypoalbuminemia and the risk of pleural effusion.
- While awaiting test results, continued supportive measures are recommended. Consider administration of albumin or other colloid to improve oncotic pressure.





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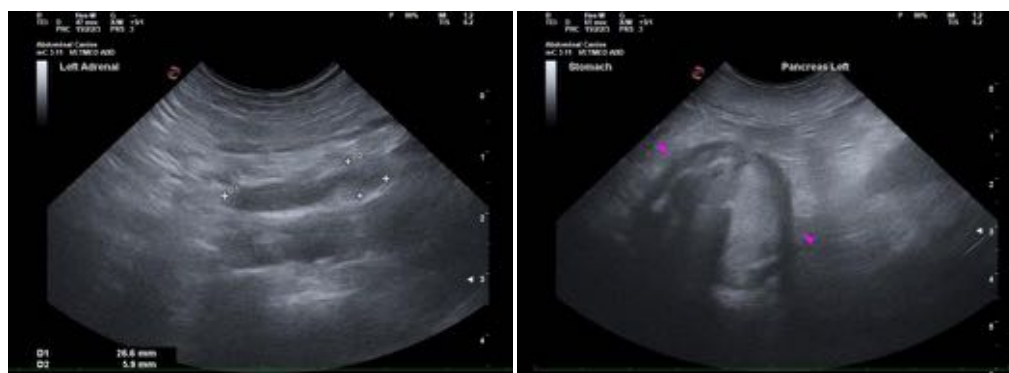
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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