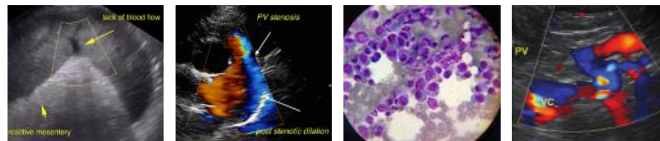
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Coco Chanel Silva/Bazzoni

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Spayed Female

AGE

10 Years

WEIGHT

6.26 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Johnson

HOSPITAL NAME

Animal Emergency Hospital Deland

REFERRING VET

Dr. Johnson

INVOICE

17539

DATE

10/2/22

PRESENTING CLINICAL SIGNS

History: P presented 10/1/2022 11am. Per O has previously be diagnosed with stage 4 kidney failure. Giving Cerenia at home and SQ fluids EOD- has been lethargic since 9/26/2022. Vomited on Monday 9/26 - intermittent anorexia (wouldn't eat the night before presentation / ate some rice and chicken the morning of presentation. Steadily losing weight per o. Presenting for lethargy and vomiting, history of azotemia.

Abnormal PE/Chem/CBC/UA Results: 10/1/2022 3p SG 1.018 / Light Yellow / clear / Protein ++ / pH 5.0 BUN 117 CRE 3.87 PHOS 10.7 10/1/2022 5:30p BUN 124.1 (single test) 10/2/2022 4:00a BUN 95 CREA 2.91 Radiograph Report: October 1, 2022 The heart and pulmonary vessels are normal in size. There is a mild diffuse bronchial pattern throughout the lungs. There is no free pleural fluid or gas. No tracheal, esophageal, or mediastinal abnormalities are seen. Incidentally, there are 14 pairs of ribs/thoracic vertebrae. There is incidental minimal spondylosis deformans ventral to a few cranial thoracic disc spaces. The stomach contains a small amount of fluid and gas, nearly empty. The small intestine is mildly distended with gas and amorphous soft tissue opaque material/frothy fluid. The colon contains gas and formed feces. Peritoneal detail is normal. The liver and spleen are normal in size and shape. The kidneys are incompletely seen due to summation of structures; visible margins on the lateral views appear normal in size/shape. The urinary bladder is moderately distended, normal in opacity and margination. Conclusion 1. Consider gastroenteritis from a variety of causes including dietary indiscretion, toxin exposure, bacterial overgrowth/dysbiosis, infectious (parasitic, viral), inflammatory bowel disease, metabolic disorders, etc. - Pancreatitis may be present without radiographic changes. 2. No overt renal changes associated with a history of azotemia. 3. Mild diffuse airway changes most likely benign age-related change. Recommendations Consider recheck blood work including CBC, chemistry panel, GI panel, (TLI, PLI, cobalamin, folate), and urinalysis for additional diagnostic information. Consider initial medical management/symptomatic treatment, as clinically indicated (fluid therapy, antinausea medication, antacids, antibiotics, pain management, fasting followed by gradual reintroduction of bland diet, etc.). Consider abdominal ultrasound for additional diagnostic information, as clinically indicated.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

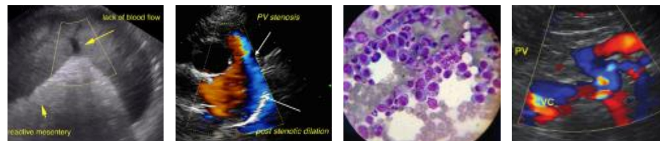
Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally uniformly enlarged/swollen (the left kidney measures 4.0 cm, the right kidney measures 5.0 cm) with an overall hyperechoic echogenicity and slight loss of corticomedullary definition. Normal smooth peripheral margination and shape are maintained. The renal pelvis are dilated with anechoic fluid and hyperechoic thickened pelvic fat. No overt evidence of neoplasia or mineral is observed. The perinephric area is enhanced by hyperechoic fat and mesentery.

Adrenal Glands

Left adrenal gland is unable to be well visualized in these images.

Right adrenal gland is plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The right adrenal gland measures 0.7 cm at the cranial pole and 0.78 cm at the caudal pole.



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Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

The visible small intestines are normal in wall thickness and layering. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

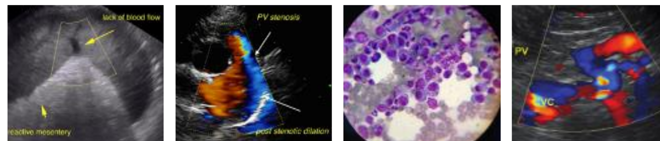
There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Pyelonephritis – These changes are most consistent with chronic pyelonephritis. Chronic scarring and fibrosis and/or chronic nephrolith passage can also result in these pelvic dilation changes. Early infiltrative disease cannot be ruled out but is considered less likely.

- Gastritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.

- Mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.



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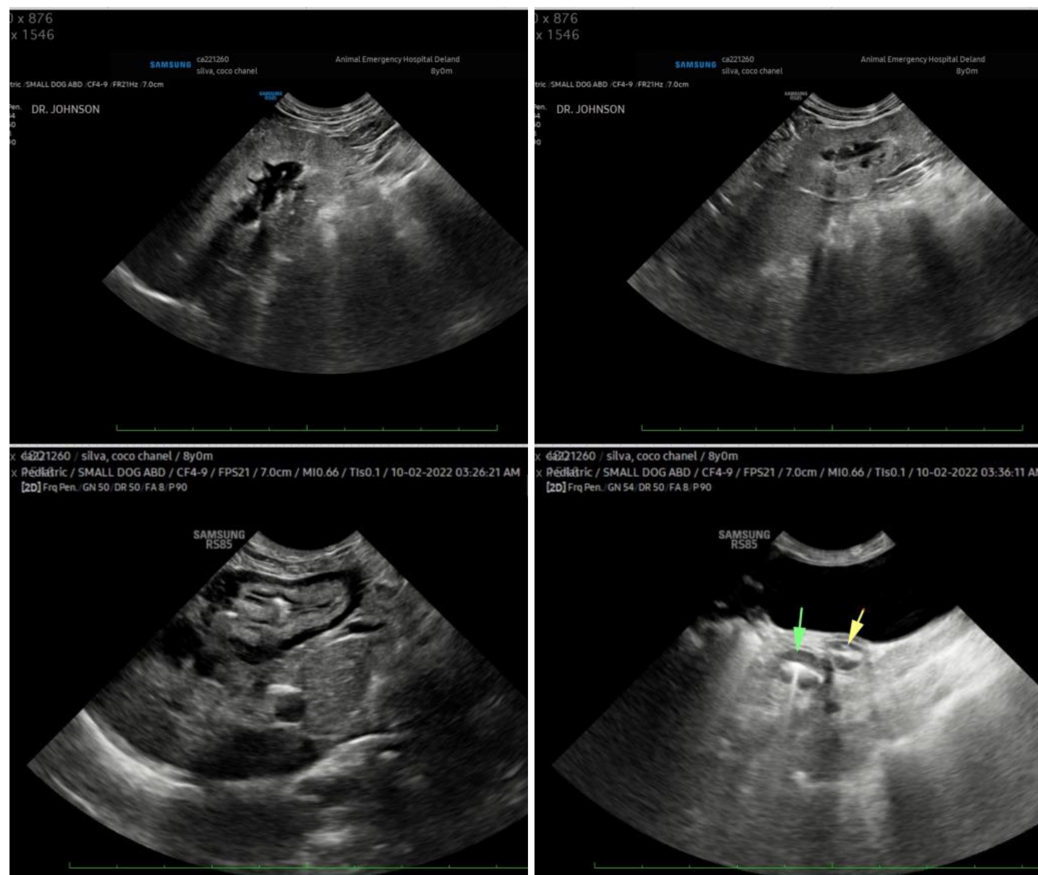
- Right adrenomegaly- consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism vs stress or normal variant. Interpret in combination with clinical signs of hyperadrenocorticism.

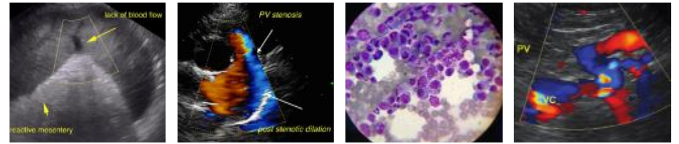
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urine culture is recommended if not recently evaluated, and if patient is not already on antibiotics given the suspicion for possible pyelonephritis. If patient is already on antibiotics, recommendations include checking a urine culture a week to 10 days after completing the current course. A blood pressure is recommended if not recently evaluated.

Given the suspicion for possible gastrointestinal disease, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

In the meantime, supportive/symptomatic medical management of acute on chronic kidney disease, possible pyelonephritis and gastroenteritis with antiemetics, gastroprotectants/antacid therapy, appetite stimulants (if necessary), broad spectrum antibiotics and fluid therapy is recommended. Empirical deworming with a 5-day course of Panacur could also be considered.





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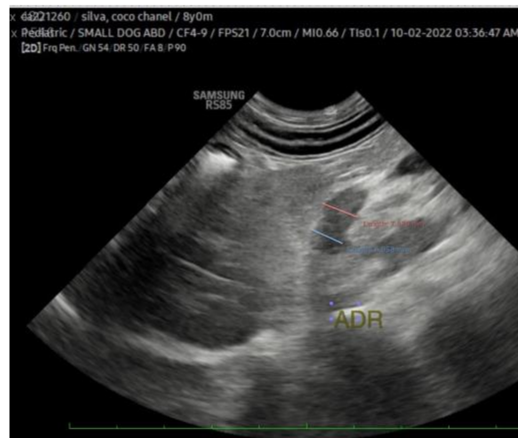

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com