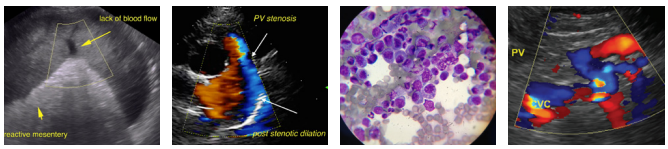
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Tanner Davis

SPECIES
Canine

BREED
Brittany Spaniel

SEX
Neutered Male

AGE
8 Years 9 Months

WEIGHT
39 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Leal

HOSPITAL NAME
Blairstown AH

REFERRING VET
Dr. Clegg

INVOICE
35360

DATE
2/1/22

PRESENTING CLINICAL SIGNS

Dog presented with polyuria/polydipsia. UA shows specific gravity 1.012 Protein negative. Clinically dog doing well. Blood pressure not obtainable. Current on lepto vaccine
Abnormal PE/Chem/CBC/UA Results: Chemistry creatine - 1.0 BUN - 17 Albumin - 3.3 Rest all WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is mildly to moderately distended with anechoic contents. Apical urinary bladder wall is diffusely thick (0.5 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

Prostate (neutered) is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal in size (4.9 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. A hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal in size (5.3 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. A hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

The right adrenal gland is normal in size (1.7 cm long x 1.3 cm at the cranial pole and 0.45 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (2.4 cm long x 0.38 cm at the cranial pole and 0.52 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The 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.

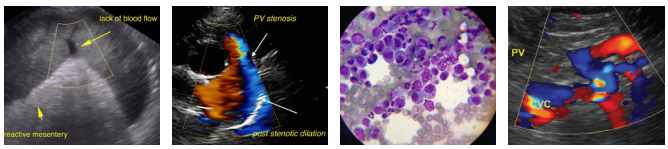
Liver

The 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.

The 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

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. 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 appreciable lymphadenopathy in these images.

ULTRASONOGRAPHIC FINDINGS

- Chronic Cystitis – Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.

- Medullary Rim Sign - of unknown clinical significance and can be a normal variant. Medullary rim sign(s) should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Polyuria/polydipsia – Differentials are vast and include, but are not limited to, primary polyuria caused by chronic kidney disease, pyelonephritis, liver disease, diabetes mellitus, hyperthyroidism, hypercalcemia, hyperadrenocorticism, hypoadrenocorticism, E.coli infectious ie) pyometra in females, polycythemia, central diabetes insipidus or primary nephrogenic diabetes insipidus or primary polydipsia caused by psychogenic polydipsia, fever, pain or central nervous system disease.

Most causes of PU/PD can be diagnosed with a comprehensive history and physical exam, a first AM urine specific gravity to see if urine concentration is possible (as most animals drink less overnight) followed by a comprehensive CBC, serum chemistry panel, electrolytes and urinalysis. If not, next step(s) should include a urine culture, low dose dexamethasone suppression test, T4, bile acids, Leptospirosis testing and/or an empirical course of antibiotics. If a diagnosis is still not obtained, a more advanced work-up is recommended.

For this patient specifically, initial recommendations include a urine culture and testing for Leptospirosis, as patients can still acquire Leptospirosis despite vaccination. Pending the results, an empirical course of antibiotics could be tried. If clinical signs persist, then pursuing the additional diagnostics mentioned above is recommended.

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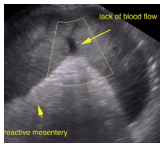

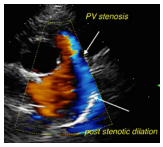

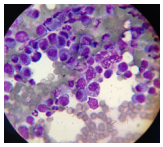
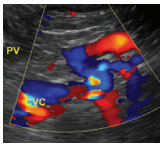

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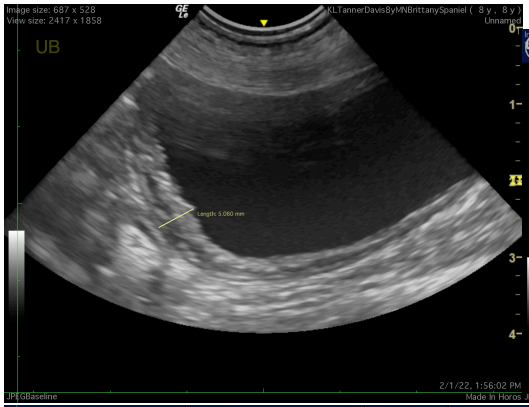

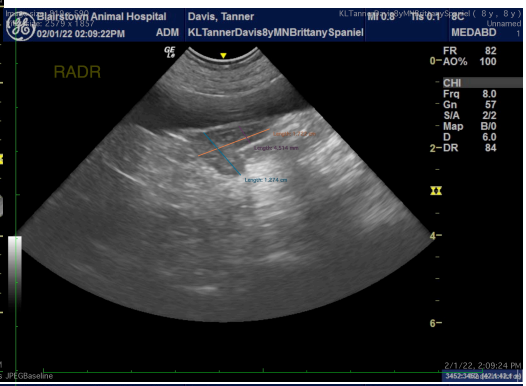

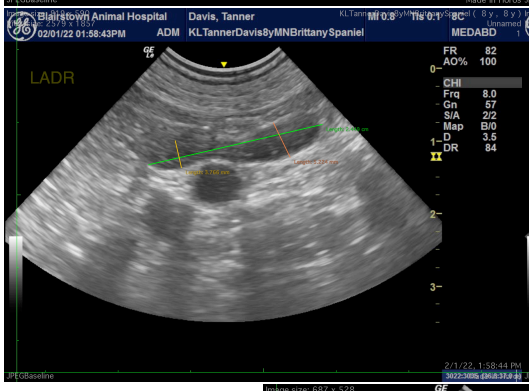

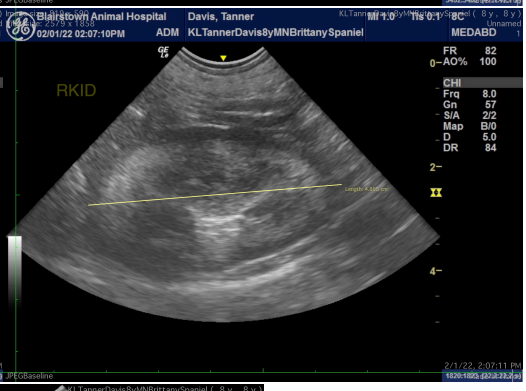

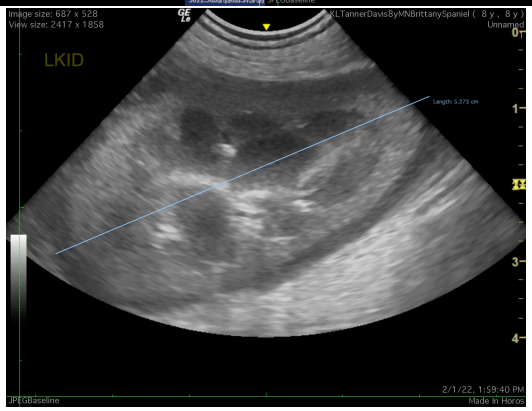

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com