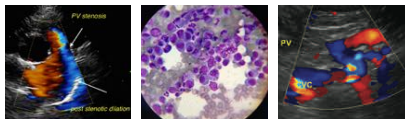
IMAGING PERFORMED BY

IntraPet.com



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DATE
2/14/22

PATIENT
Jack Roberts

SPECIES
Canine

BREED
Dachshund

SEX
Neutered male

AGE
11/29/06

WEIGHT
10.08 lbs

INTERPRETED BY
Beth Johnson, DVM DACVIM

HOSPITAL NAME
Jacksonville AH

REFERRING VET
Dr. Burk

INVOICE
96048

PRESENTING CLINICAL SIGNS

History: Polydipsia Polyuria. Large and small amounts of urine; accidents in house. Appetite normal. Systolic murmur 3-4/6; lungs clear. Abdomen organomegaly cranial- mid abdomen- dorsal. Rectal NSF. Cataracts OU.
Lab Results: CBC WNL, SUPERCHEM WNL, U/A: sg 1.020, pH 5.0, protein/glucose/ketones/bile/blood-negative.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is minimally distended with anechoic contents. It has normal uniform wall thickness (< 0.2 cm). No masses or cystoliths are observed.

The prostate is normal for a neutered dog.

Left kidney is large in size (8.4 cm) due to the presence of a large, 7.5 x 6.0 cm anechoic, thin walled structure off of the cranial pole of the kidney. This is consistent with a cortical cyst. The remaining caudal kidney appears hyperechoic with loss of normal architecture. This is likely due to the presence of the cyst. There is no evidence of pyelectasia, mineral, or infarcts observed.

Right kidney is normal in size (3.35 cm), shape and echogenicity. It has smooth peripheral margination and appropriate corticomedullary distinction. There is no pyelectasia noted. No mineral is observed.

Adrenal Glands

Left adrenal gland is normal in size (2.02 x 0.61 cm at the cranial pole and 0.5 cm at caudal pole), shape and contour. Corticomedullary structure is unremarkable.

Right adrenal gland is normal in size (1.94 cm x 0.61 cm at cranial pole and 0.53 cm at caudal pole), shape and contour. Corticomedullary structure is unremarkable.

Spleen

Spleen is subjectively normal in size with normal smooth margins. Parenchyma is normal in echogenicity and echotexture. There is a 0.8 cm, round, hypoechoic, non-capsule disrupting nodule near the tail of the spleen. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size. Margins are sharp and smooth. It has normal homogenous echotexture and normal echogenicity. No focal lesions are observed. Visible vasculature appears normal. GB is moderately distended with anechoic bile and gravity dependent echogenic sediment. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible gastric wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm). The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of

obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.
The small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). There are no luminal contents noted within small intestines.

Colon is normal in wall thickness (< 0.2 cm) and layering.

Pancreas
Pancreas has normal homogenous echotexture and is normal in echogenicity and smooth margination. There is no evidence of peripancreatic inflammation.

Free Abdomen
Lymph nodes are normal with no observed enlargement.

Heart
Rapid view of the heart revealed no evidence of pathology.

ULTRASONOGRAPHIC FINDINGS
PRIMARY FINDINGS:

- Hypoechoic splenic nodule, most consistent with benign nodular hyperplasia or extramedullary hematopoiesis versus infiltrative neoplasia, which can mimic benign lesions and cannot be ruled out, but is considered less likely.

- Gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

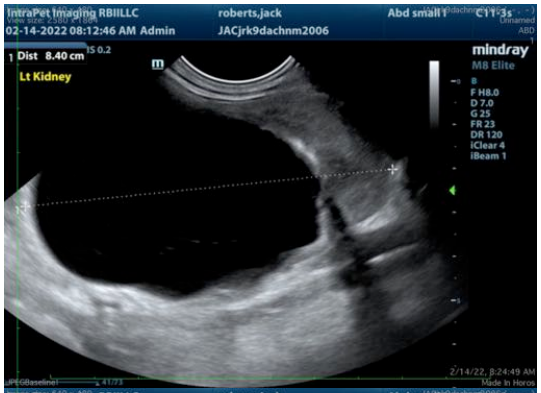
- A large, left renal cortical cyst off the cranial pole of the left kidney with concurrent loss of normal architecture of the remaining left renal parenchyma.

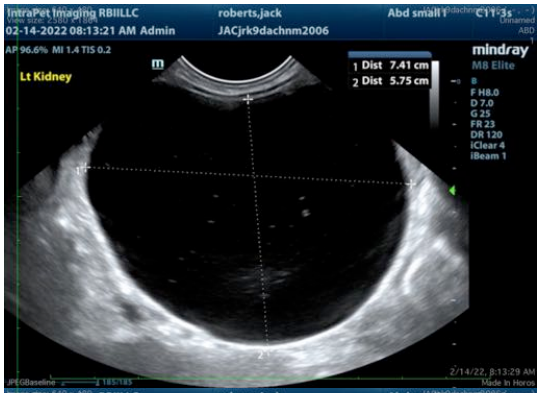
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS
Polyuria/polydipsia – Differentials are vast and include, but are not limited to, primary polyuria caused by chronic kidney disease, pyelonephritis, liver disease, diabetes mellitus, hyperthyroidism, hypercalcemia, hyperadrenocorticism, hypoadrenocorticism, 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.

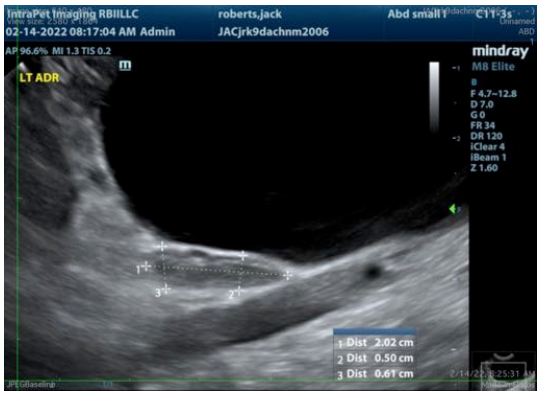
Most causes of PU/PD can be diagnosed with a comprehensive history and physical exam, a first AM urine specific gravity to see if urine concentration is possible (as most animals drink less overnight) followed by a comprehensive CBC, serum chemistry panel, electrolytes and urinalysis. If not, next step(s) 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.

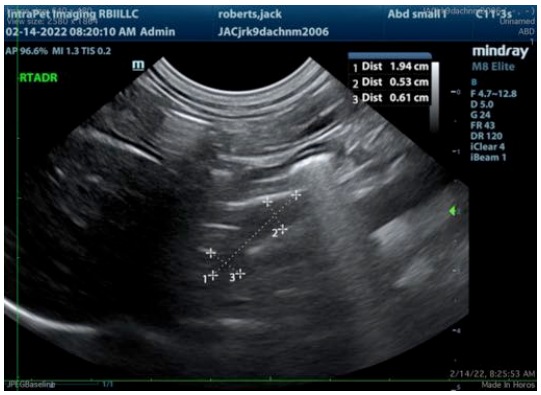
For this patient specifically recommendations include drainage of the left renal cortical cyst with submission of fluid for culture and cytology. If drainage of the cyst does not result in improvement of the clinical signs then proceeding with a PU/PD work-up as described above is recommended.

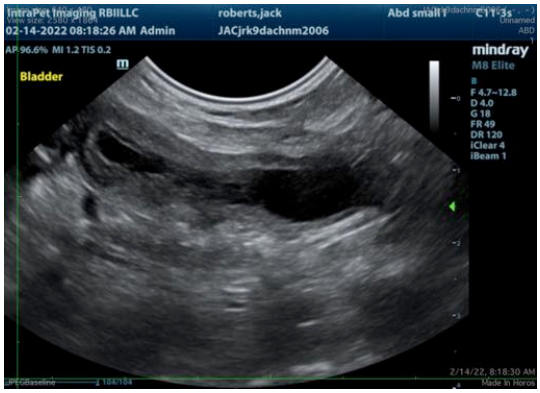
Given the reported heart murmur an echocardiogram is also recommended as are three view thoracic radiographs if not recently performed.

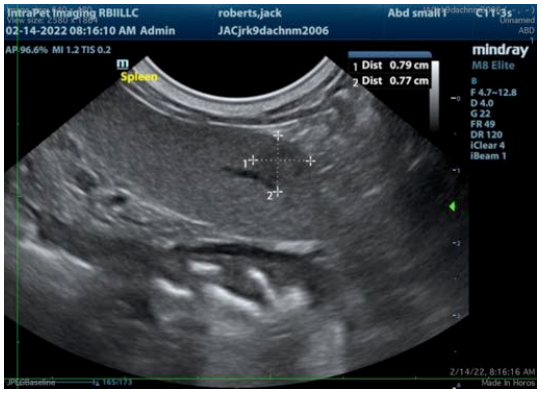












The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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