



**PATIENT**

Oscar Weis

**SPECIES**

Canine

**BREED**

Yorkshire Terrier

**SEX**

Neutered Male

**AGE**

9 Years 6 Months

**WEIGHT**

5.6 kgs

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Dr. Lavigne

**HOSPITAL NAME**

Kings VH

**REFERRING VET**

Dr. Lavigne

**INVOICE**

21226

**DATE**

2/20/23

**PRESENTING CLINICAL SIGNS**

History: Vomiting, diarrhea, decreased appet. History: O states that Oscar has been vomiting for 3 days, he is not eating hardly at all and his appetite is decreased drastically from normal. O states that P simply cannot keep food down. The vomit has been bright yellow and foamy, like bile. P does not seem to be hungry at all. O states that there was no new introduction of food, treat, etc. prior to these symptoms. O states water intake is normal, U/BM have been normal as well. BM have slowed down but normal when produced. P is UTD on vaccines and prevention. Who is the Primary Care Veterinarian/Clinic? Mason Family Pet Hospital Any history of major illness/surgery/chronic conditions? Hx of diarrhea problems, tylen powder resolved this. Current medications: Tulane Powder

Abnormal PE/Chem/CBC/UA Results: Dehydration, heart murmur, dental disease, painful cranial abdomen. CBC: HCT 56, Chem: creat 5.7, BUN 134, phos 8.6, alb 4.2, UA: USG 1.014, 1 + protein. snap CPL abnormal. Urine P:C ration, urine culture, PLI, blood pressure pending.

**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 normal in size and contour. A relatively uniform hyperechogenicity is observed with mildly decreased corticomedullary distinction. Multiple tiny nonobstructive nephroliths are noted bilaterally, and pyelectasia is noted bilaterally. No overt masses/nodules are observed. The left kidney measures 3.23 cm. The right kidney measures 4.02 cm.

**Adrenal Glands**

Left adrenal gland is normal in size (0.39 cm at cranial pole and 0.46 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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

**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 moderately distended with anechoic bile as well as mild to moderate suspended and gravity dependent echogenic debris. 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**



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The visible stomach wall is normal in thickness and layering. 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.

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The visible small intestines are normal in wall thickness and layering. 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.

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

**Pancreas**

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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**

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

**ULTRASONOGRAPHIC FINDINGS**

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- Nephritis with bilateral pyelectasia and multiple small nonobstructive bilateral nephroliths – This appearance can be consistent with chronic interstitial nephritis or glomerulonephritis. Toxic insult and/or infectious disease (pyelonephritis, Leptospirosis, etc.) cannot be ruled out. This finding should be interpreted in combination with suspicion for renal disease and/or supporting laboratory or urinalysis changes. Differentials for pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.
- Mild to moderate 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.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

As is reportedly already pending, a urine culture, as well as, if the culture is negative, a urine protein to creatinine ratio and blood pressure are recommended.

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Additionally, testing for leptospirosis is recommended, as well as a baseline cortisol. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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In the meantime, supportive/symptomatic medical management of clinical signs, as well as management of possible pyelonephritis vs other is recommended with antiemetics, gastroprotectants, appetite stimulants (if necessary), broad spectrum antibiotics and fluid therapy/diuresis until kidney values either normalize or plateau, at which time potentially a transition to subcutaneous fluid therapy could be considered.

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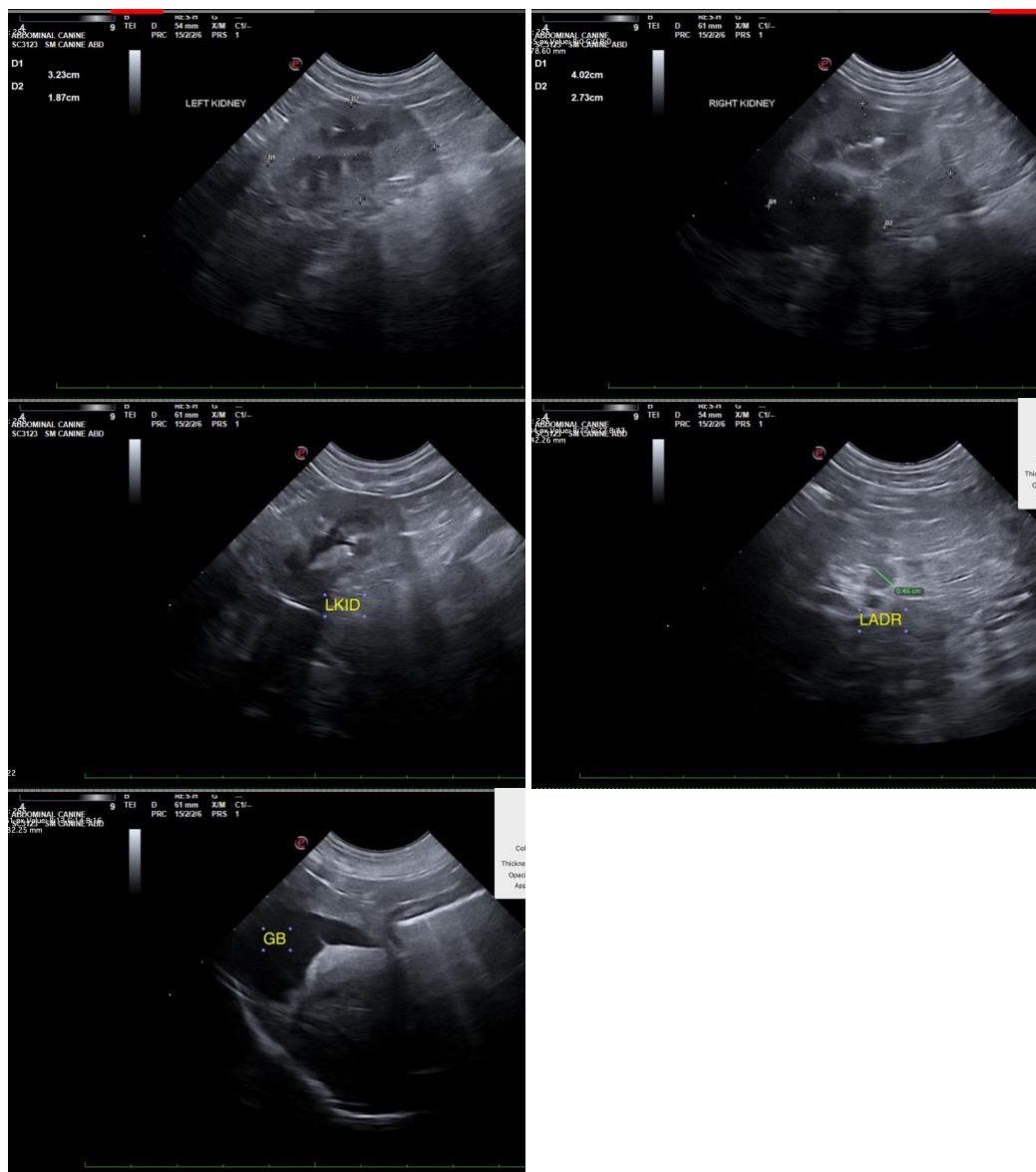
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**

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