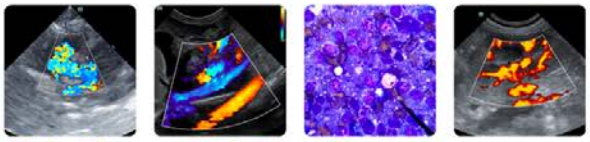

PATIENT

Kiki Carola

SPECIES

Canine

BREED

Yorkie

SEX

Spayed Female

AGE

16 Years 6 Months

WEIGHT

4.8 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

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INVOICE

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DATE

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PRESENTING CLINICAL SIGNS

AUS to further evaluate azotemia and pancreatitis. Currently hospitalized. Presented to the ER for vomiting after getting into the trash a few days ago. Possible CKD w/ AKI given weight loss over last few months and now azotemic in hospital. Having diarrhea in hospital. PMH: Left medial liver lobectomy - hepatic adenoma, HBC - pelvic Fx. Hosp mgmt: Mirtazapine, Ondansetron, Unasyn, IVF, IVF bolus.

Abnormal PE/Chem/CBC/UA Results: 3V AXR DACVR: Concern for GEC. No FBO. Decr serosal detail poss due to peritoneal effusion, peritonitis, or pancreatitis. Prev hepatic surgery. Prev b/l SI repair; questionable cranial positioning of the right SI. Prev lft FHO. Mod rt coxofemoral DJD. Prev pelvic fx ischium (left). Pubic involvement poss. Stifle DJD; cruciate pathology cannot be r/o. CBC: HCT 41.7%, MCHC 32.8, WBC 11.43, lymph 0.32, mono 0.94, neut 10.09, plt 523 Chem: Alb 2.7, ALP 116, ALT 89, Chol 260, Cr 3.1 H, Phos >15 H, Glu 166 H, tBili 0.3, BUN >140 H EPOC: Bicarb 16.8, iCa 0.83 L, Cl 103 L, Cr4.73 H, Glu 153 H, Na 130 L, pH 7.253 L, BUN >120 Idexx QPLi: 1907 H UA: USG 1.024, pH 6.5, pro neg, WBC 0-2 /hpf, RBC 0 /hpf, Cocci 15-20 /hpf, transitional cells 4+ UCS: pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a moderate amont of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. No mineral is observed. The left kidney is normal in size at 4.25 cm. Significant pyelectasia is present in the left kidney measuring 0.76 cm in the sagittal view. The right kidney is normal in size at 4.67 cm with significant pyelectasia measuring 0.60 cm in the transverse view.

Adrenal Glands

The right adrenal gland is normal in size (0.40 cm at cranial pole and 0.50 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

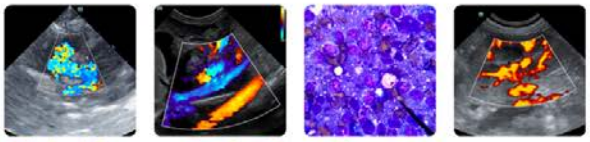
The left adrenal gland is normal in size (0.50 cm at cranial pole and 0.50 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size (1.3 cm thick at the hilus) 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 enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. The rounded enlargement and the heterogenicity is most prominent in the right caudal



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liver, where there is an almost discrete mass-like rounded area measuring approximately 4.7 cm x 6.1 cm in size. 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 visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is diffusely mildly distended with soft stool.

Pancreas

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

There is a trace amount of anechoic free fluid in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The liver changes could represent a benign process such as nodular hyperplasia, steroid or vacuolar hepatopathy, extramedullary hematopoiesis, or potentially a benign hepatoma/adenoma, although infiltrative neoplasia including primary hepatocellular neoplasia, sarcoma, round cell neoplasia, other can't be ruled out without tissue sampling.
- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs. There is no definitive ultrasonographically visible evidence of an acute process, but a mild or emerging acute pancreatitis is possible, especially given the trace free fluid in these images.
- Moderate chronic kidney disease changes bilaterally with moderate bilateral pyelectasia.
- Moderate amount of echogenic urinary bladder debris.
- The colonic changes are consistent with patient's reported history of in-hospital diarrhea.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Based on patient's history combined with these ultrasound findings, possible differentials for an acute on chronic kidney insult include an infection such as pyelonephritis versus mild flare up of chronic pancreatitis versus other. Initial recommendations include:

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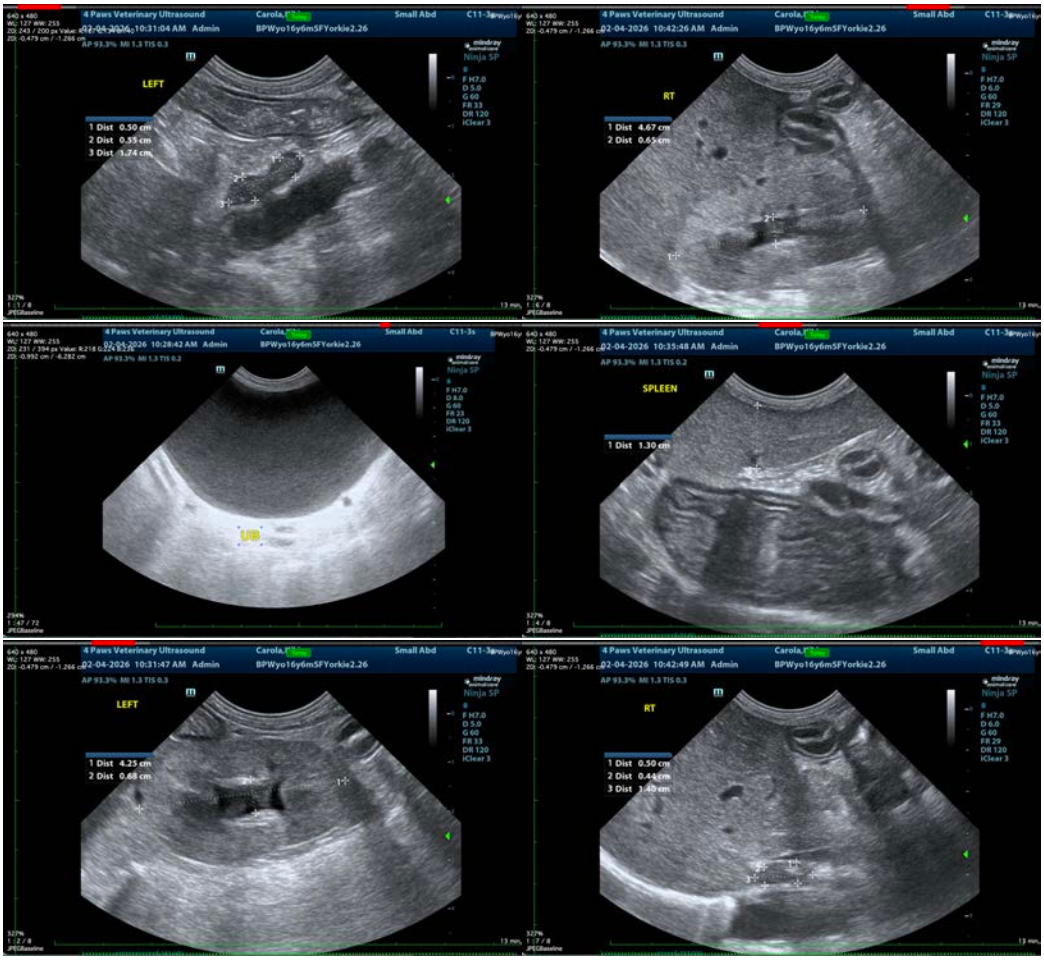
If not already evaluated, a urine culture is recommended. If pyelonephritis as the acute on chronic offense is suspected, but urinary bladder sampling isn't considered clinically significant, direct sampling of the renal pelvises could be considered if patient's coagulation status is appropriate.

In the meantime, a quantitative PLI is recommended if not already evaluated.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the right caudal liver are recommended if patient' s coagulation status is appropriate.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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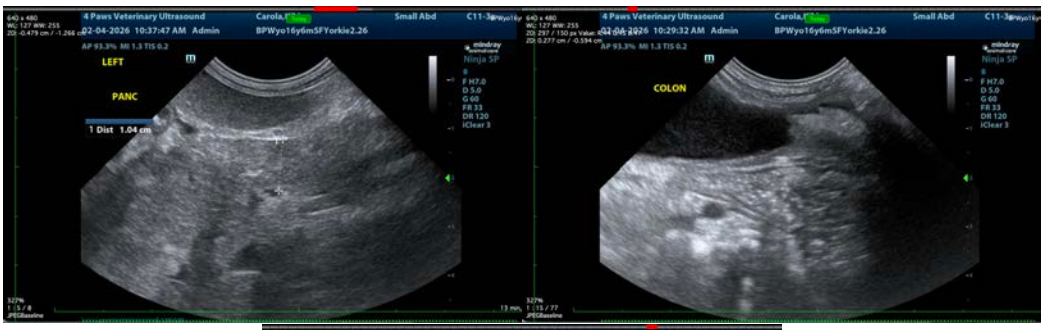

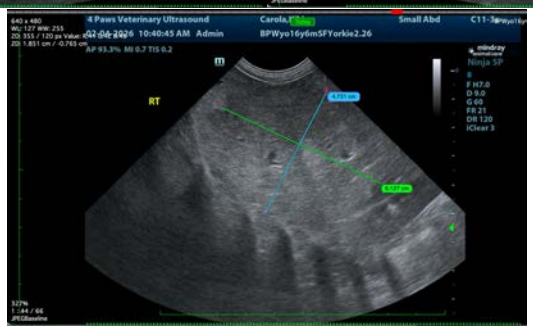

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com