

PATIENT

Frank Donnelly

SPECIES

Canine

BREED

Fox Hound

SEX

Neutered Male

AGE

10 Years 11 Months

WEIGHT

70.1 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Ay Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Dr. Cullen

INVOICE

21045

DATE

2/6/23

PRESENTING CLINICAL SIGNS

History: PU/PD with open assessment for 2 years. Hematuria.

Abnormal PE/Chem/CBC/UA Results: Low BUN, low USG. **Please see attached.

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.

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

Left kidney is normal is size (7.96 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.

Right kidney is normal is size (7.68 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.

Adrenal Glands

Left adrenal gland is normal in size (0.75 cm at cranial pole and 0.68 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.55 cm at cranial pole and 0.77 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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 enlarged with mildly irregular margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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

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 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.

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Free Abdomen

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

SEX

Neutered Male

- Heterogenous liver- These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This is a relatively unremarkable abdomen without an ultrasonographically visible explanation of the reported PU/PD and/or hematuria. Differentials for PU/PD are vast and include, but are not limited to primary polyuria, caused by chronic kidney disease, pyelonephritis, liver disease, diabetes mellitus, hypercalcemia, hyperadrenocorticism, hypoadrenocorticism, E.coli infections, polycythemia, central diabetes insipidus or primary nephrogenic diabetes insipidus vs primary polydipsia, caused by psychogenic polydipsia, fever, pain or central nervous system disease. Most causes can be diagnosed with a comprehensive history, physical exam, a first morning 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 steps often include urine culture, low dose dexamethasone suppression test, T4, bile acids, Leptospirosis testing and/or an empirical course of antibiotics. At that time, if a diagnosis is still not obtained, a more advanced work up, including things like desmopressin trials and/or water deprivation tests are recommended.

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In this patient specifically, given the new hematuria, a urine culture is recommended to rule out an occult urinary tract infection and testing for Leptospirosis is recommended. Additionally, while the low BUN is likely secondary to the chronic PU/PD, bile acids testing is recommended to rule out liver disease as a cause. Beyond that, an empirical course of antibiotics could be considered and if that doesn't help, then more advanced diagnostics, as mentioned above may be warranted.

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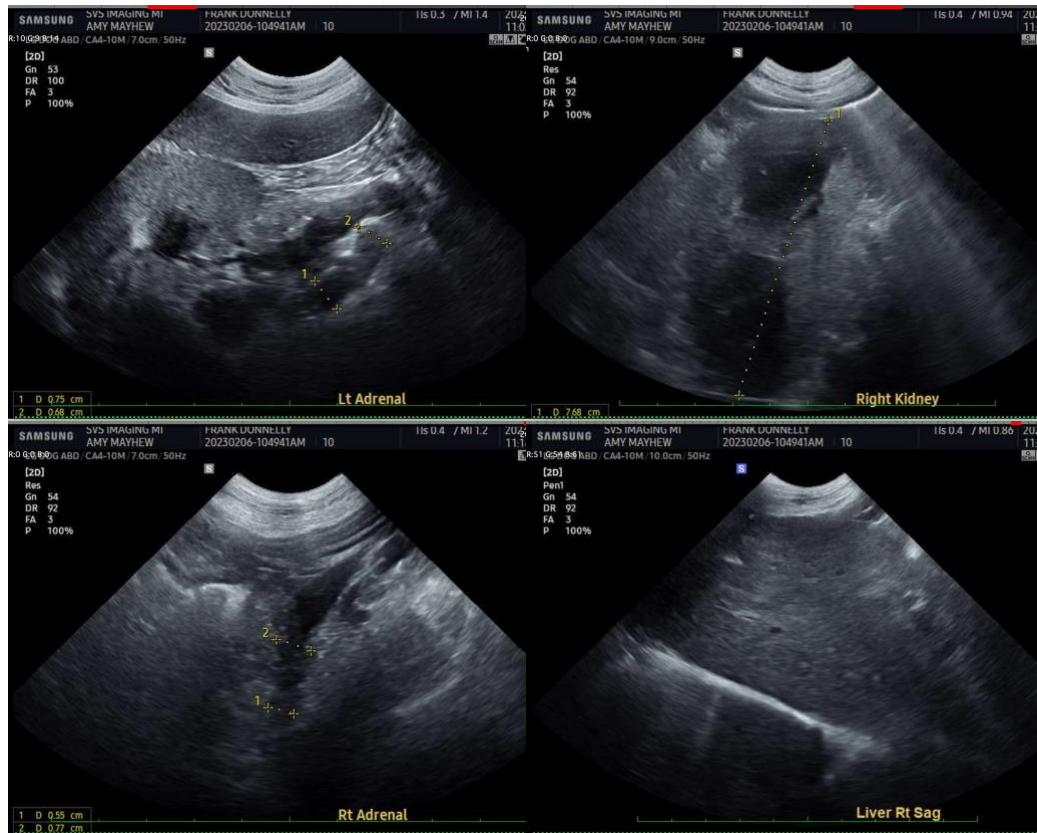
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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