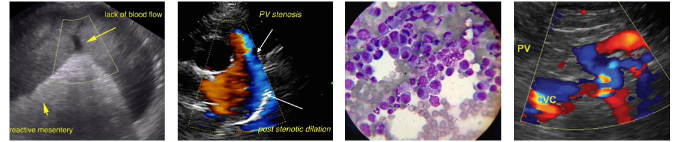


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Evi Boisvert

SPECIES

Canine

BREED

Border Collie

SEX

Spayed Female

AGE

14 Years

WEIGHT

20.7 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Nigel Gumley

HOSPITAL NAME

Cedarview AH

REFERRING VET

Dr. Nigel Gumley

INVOICE

35881

DATE

3/3/22

PRESENTING CLINICAL SIGNS

Recently diagnosed and treated for a urinary tract infection (hematuria and polyuria). On Vetmedin for valvular disease.
Abnormal PE/Chem/CBC/UA Results: Elevated creat, urea, SDMA (all mild), urine sp gr = 1.013. After therapy, sp gr increased to 1.025, SDMA improved to normal but urea still elevated. Hct = 31%, mild low RBCs and Hb. Systolic BP 147 mmHg.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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.

The right kidney is normal in size (4.6 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.

The left kidney is normal in size (4.05 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Pyelectasia is noted measuring 0.4 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.40 cm at the cranial pole and 0.36 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 (0.42 cm at the cranial pole and 0.44 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. 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). Multifocal well-demarcated hyperechoic homogenous nodules are present. Splenic vasculature appears normal.

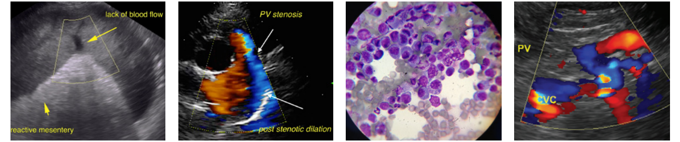
Liver

Liver is subjectively enlarged with rounded margins. Parenchyma is heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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 (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. Mild medial iliac lymphadenopathy is noted. Lymph nodes maintain a normal shape.

PRIMARY FINDINGS

- Pyelectasia of the left kidney - Differentials for pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.

- Heterogenous liver – Differentials for hepatic changes include both benign steroid (vacuolar) hepatopathy or extramedullary hematopoiesis as well as infiltrative round cell or metastatic neoplasia.

SECONDARY FINDINGS

- 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.

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are less likely.

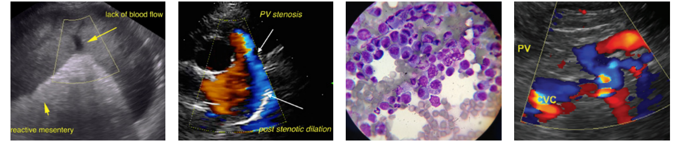
- Reactive medial iliac lymphadenopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the mild pyelectasia in the left kidney, pyelonephritis could be considered, and recommendations include a recheck follow up urine culture a week to 10 days after finishing antibiotics to be sure that the infection has fully cleared.

Other considerations for the mild anemia and mildly increased BUN include a possible occult gastrointestinal bleed. Recommendations include assessment of stool for possible blood, and empirical deworming with a 5-day course of Panacur as well as gastroprotectants including an antacid +/- sucralfate with monitoring of the BUN and hematocrit for improvement while on that therapy to help rule in/out an occult GI bleed.

A fine needle aspirate of the liver could be considered if patient's coagulation status is appropriate.



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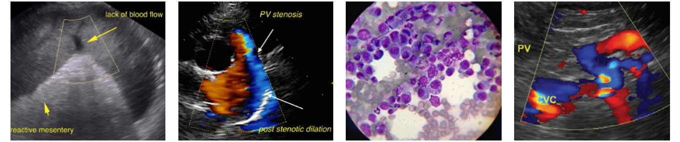
However, the liver changes are considered incidental and likely benign, given the reported history and laboratory changes.



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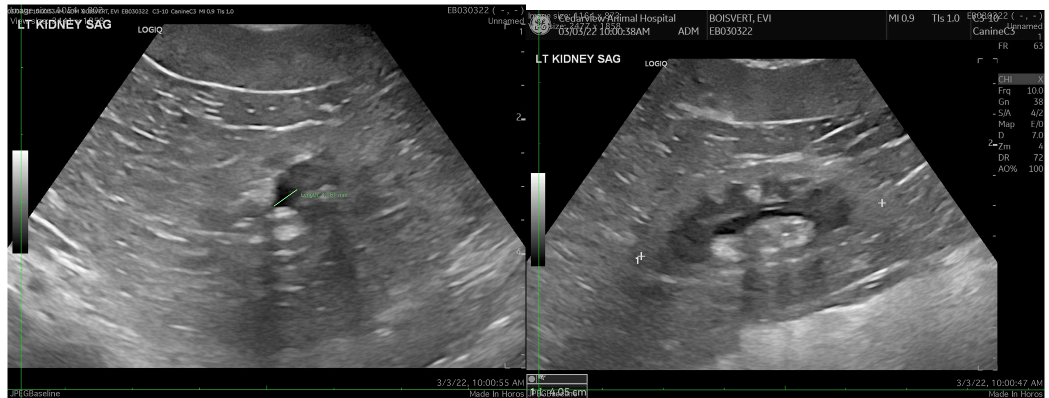

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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