

**DATE PRESENTING CLINICAL SIGNS**

7/19/22

On Friday P was lethargic and O realized the piece of the couch was gone. O gave P 3 doses of Flagyl, a depository, and catlax. P started to do fine until Sunday where P vomited every couple of hours and has not eaten since Sunday. P went to rDVM today and the rDVM is suspicious for FB. The bloodwork: - BUN >130 - Creatinine - needed dilution - Phosphorus elevated - WBC increased

PATIENT

Sparky Young

Current Medications: None listed.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

SPECIES

Canine

BREED

Borzoi

SEX

Intact Male

AGE

6/10/21

WEIGHT

53.5 Pounds

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING PERFORMED BY**

Rachel Brilhart RDMS

HOSPITAL NAMEAnimal Emergency
Hospital**REFERRING VET**

Dr. Roper

INVOICE

39655

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder is moderately distended with anechoic contents. A foley catheter is in place. 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 prostate is unable to be well visualized in these areas due to a pelvic position.

Kidneys are normal in size and contour. A relatively uniform hyperechogenicity is observed with mildly decreased corticomedullary distinction. There is no pyelectasia noted and no mineral is observed. No overt masses/nodules are observed. The left kidney measures 7.75 cm. The right kidney measures 8.5 cm.

Adrenal Glands

Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measures 3.01 cm long x 0.59 cm at the cranial pole and 0.74 cm at the caudal pole. The right adrenal gland measures 3.43 cm long x 0.72 cm at the cranial pole and 0.74 cm at the caudal pole.

Spleen

The 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

The 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.

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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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 (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. However, some gas is noted.

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 free peritoneal effusion noted in these images.

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

No testicular pathology noted.

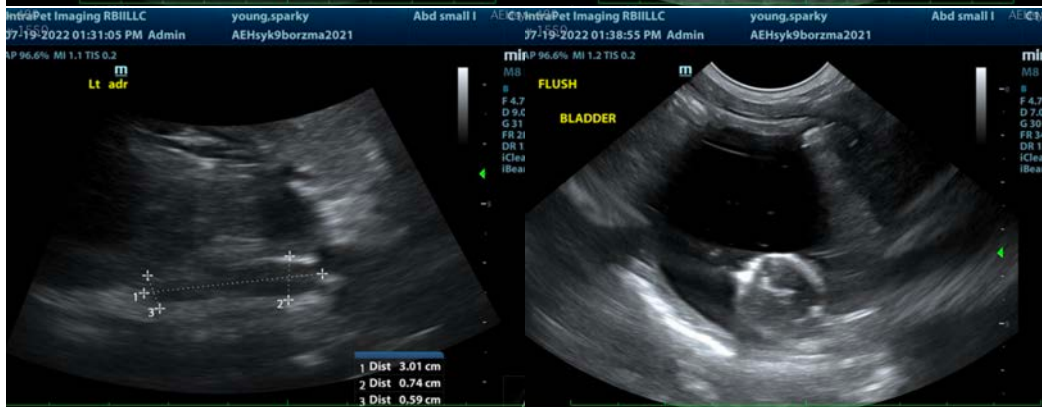
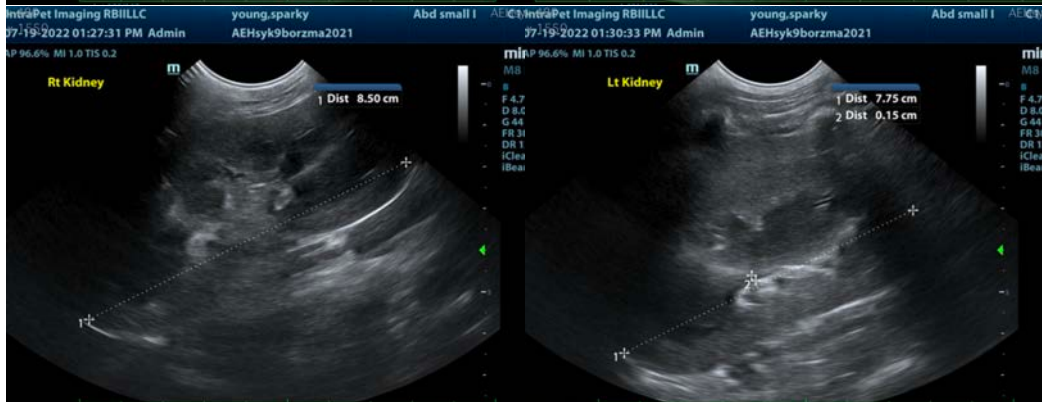
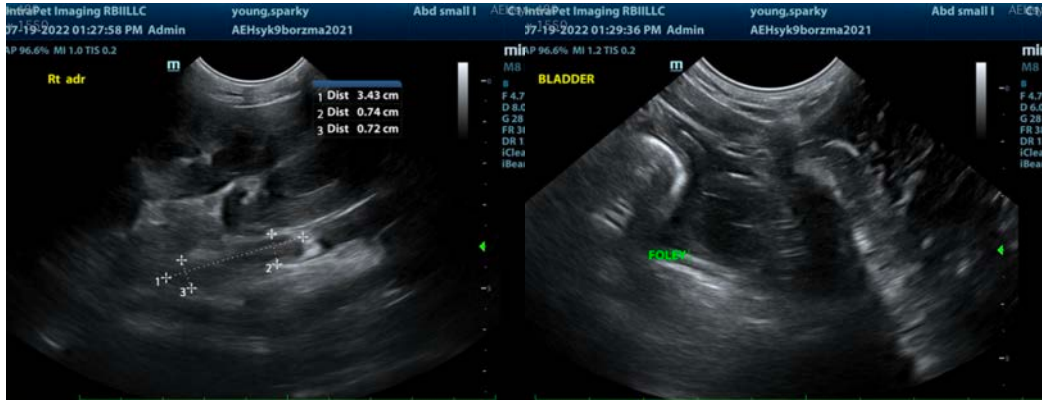
ULTRASONOGRAPHIC FINDINGS

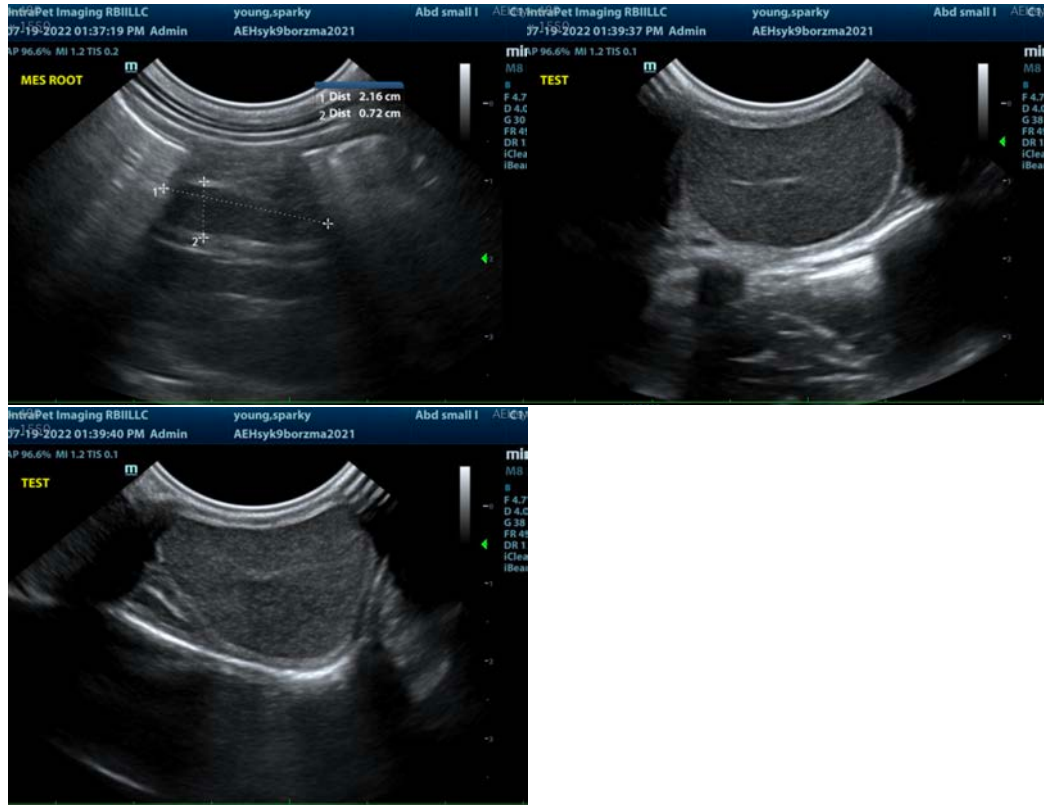
- **Nephritis** – This appearance can be consistent with chronic interstitial nephritis or glomerulonephritis. Toxic insult and/or infectious disease (pyelonephritis, Leptospirosis, etc.) cannot be ruled out. This finding should be interpreted in combination with suspicion for renal disease and/or supporting laboratory or urinalysis changes.
- **Flat adrenal glands** – This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.
- **Reactive lymph nodes** – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations include:

- Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.
- Blood pressure is recommended if not recently evaluated.
- A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.
- The appearance of the kidneys is more consistent with a possible acute insult such as toxin, infectious, other, versus chronic dysplasia, etc. Therefore, testing for Leptospirosis should be considered if not recently evaluated.
- Ultimately, if this patient is not responding or does not respond to diuresis and supportive symptomatic care, broad-spectrum antibiotics, etc., referral for dialysis could be discussed/considered.





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