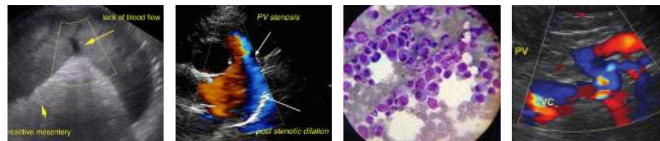
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Cooper Miller

SPECIES

Canine

BREED

Yorkie

SEX

Neutered Male

AGE

8 Years

WEIGHT

5.1 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Lupole

INVOICE

16652

DATE

8/2/22

PRESENTING CLINICAL SIGNS

History: Patient started vomiting this afternoon. O noticed that his urine was pink then bloody. Previous Health Concerns: UTI last year Current Medications/Supplements/OTC: none Appetite/When did they eat last: ate this am-patient is a grazer Diet: RC for yorkies Vomiting/Diarrhea: yes/no Coughing/Sneezing: no/no Urination: blood in urine Indoor/Outdoor: indoor/ outdoor supervised Any changes in their environment: no Vaccines up to Date: yes HW/Flea/Tick Prevention: no

Abnormal PE/Chem/CBC/UA Results: Level of Pain: (0-4)1 BCS (0-5): 3 Oral-Nasal-Throat: dental disease/ halitosis; Respiratory: increased BV sounds Abdominal: tender cranially Musculoskeletal: mild lumbar discomfort In talking to owner, she says dog has always drank a lot of water; Results of Diagnostics: RAETC- alb 4.3(H) amylase 1614(h) lipase >1000 (H) iCa+ 1.12(L) cl- 113(L) hct 62% (H) Rads- no obvious fb/ obstruction/ effusion/ stones, etc. UA- (+++) blood) (++) cocci (++++) glucose; sp gravity 1022 cPL=abnormal Lepto witness test-negative Flex 4- negative UA strip this morning:Pro-trace, Glu- ++, pH- 7, Blood- +.SG:1.020., all other values WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses or inflammatory changes are observed. A 0.35 cm dependent cystolith was present. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (4.07 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 (4.09 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 (1.58 cm long x 0.48 cm at cranial pole and 0.58 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

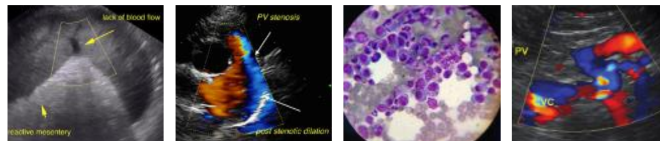
The area of the right adrenal gland is examined without evident pathology.

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.



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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

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

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.

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

Pancreas

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

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

ULTRASONOGRAPHIC FINDINGS

- Gastritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.
- Urinary bladder cystolith (0.35 cm in diameter)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urine culture is recommended, followed by management of the suspected urinary tract infection, based on culture and sensitivity results with monitoring of the cystolith during and following treatment of the urinary tract infection. If the cystolith does not dissolve/shrink, etc., removal may be necessary to prevent future urinary tract infections. Transition to a stone dissolution/crystal prevention urinary bladder health diet could be considered if this is a chronic problem.

In the meantime, prior to that diet, symptomatic supportive management of gastritis and GI signs, with antiemetics and gastroprotectants, as well as a low fat bland, easy to digest diet, short term is indicated.

If GI signs persist beyond management of the urinary tract infection and acute gastritis, further evaluation recommendations include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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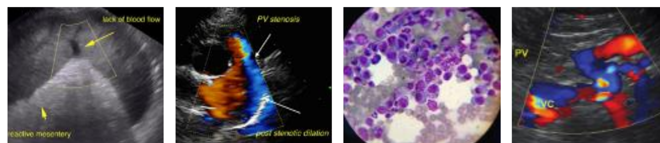

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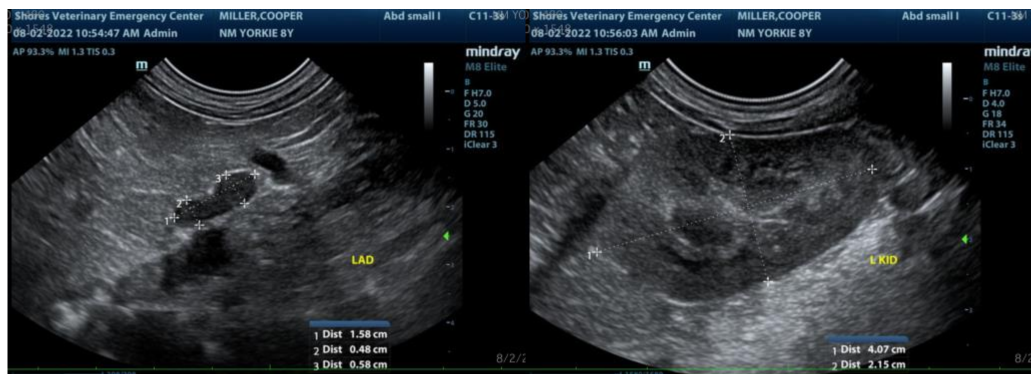

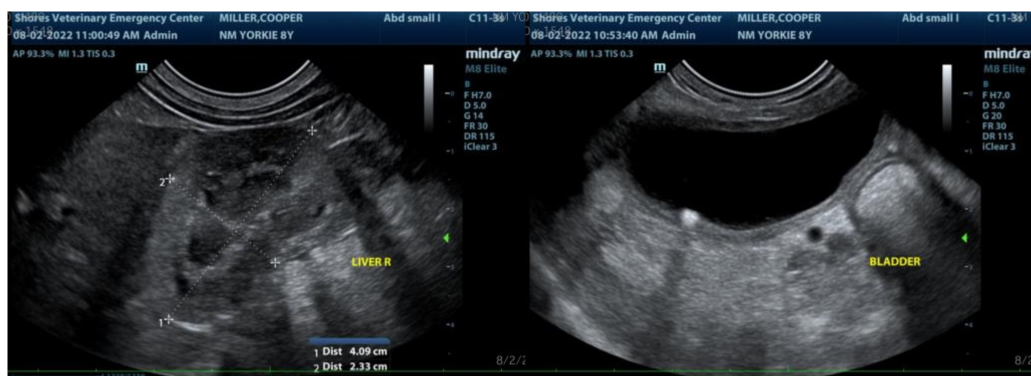

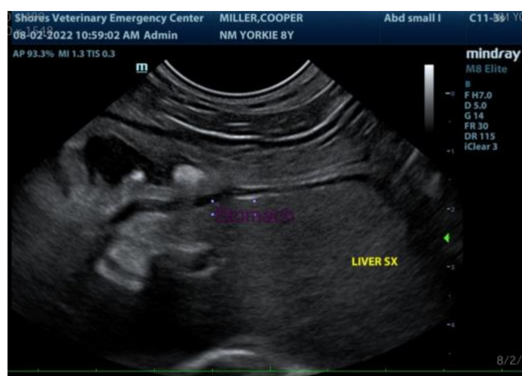

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

Beth.Johnson@SonoPath.com