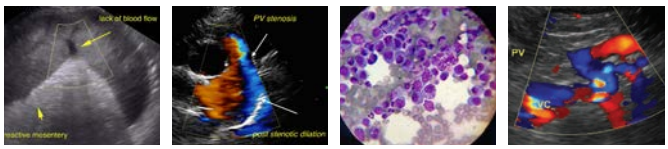
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

**PATIENT**

Tony El Tigre Kennedy

**SPECIES**

Canine

**BREED**

Terrier X

**SEX**

Neutered Male

**AGE**

2 Years

**WEIGHT**

4.3 Pounds

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Dr. Mychajlonka

**HOSPITAL NAME**

Craig Road AH

**REFERRING VET**

Dr. Mychajlonka

**INVOICE**

40728

**DATE**

8/25/22

## PRESENTING CLINICAL SIGNS

Lethargic, crossing back leg, dehydrated
Abnormal PE/Chem/CBC/UA Results: TOTAL PROTEIN 9.6g/dL 5.0-7.4 HIGH ALBUMIN 5.7g/dL 2.7-4.4 HIGH GLOBULIN 3.9g/dL 1.6-3.6 HIGH AST (SGOT) 288IU/L 15-66 HIGH GGT 1-12 Comment: ********** The quantity of the sample submitted was not sufficient to run this test. BUN/CREAT RATIO 33 4-27 HIGH PHOSPHORUS 6.9MG/DL 2.5-6.0 HIGH Glucose <10MG/DL 70-138 LOW Comment: The low glucose can be best verified by submitting a fresh sample in a completely spun and separated SST, or a RTT with the serum removed and placed in a separate tube. MAGNESIUM 4.8mEq/L. 1.5-2.5 HIGH SODIUM 138MEQ/L 139-154 LOW POTASSIUM 6.6MEQ/L 3.6-5.5HIGH NA/K RATIO 21 27-38 LOW CHLORIDE 96MEQ/L 102-120 LOW CHOLESTEROL 339MG/DL 92-324 HIGH CPK 924IU/L 59-895 HIGH Sample Conditions CPK may be falsely elevated due to a Hemolysis 4+ and could be in the Normal Range. AST may be lower than reported due to a Hemolysis 4+, but is still abnormal. Comment(s) Sample run on dilution because sample volume insufficient for tests requested. Electrolyte values may be affected. RBC 12.41000000/UL 4.8- 9.3 HIGH HGB 28.3G/DL 12.1-20.3 HIGH HCT 86% 36-60 HIGH Platelet Count 141X1000/UL LOW Comment: Platelet count reflects the minimum number due to platelet clumping. Platelet Estimate Adequate Comment Blood smear reviewed by technologist. Monocytes 864 /UL HIGH Basophils 324 /UL HIGH Protein 4+ NEGATIVE HIGH Comment: Urine protein:creatinine ratio testing is recommended (if the sediment is inactive) to help determine the clinical significance of proteinuria. RBC 4-10HPF 0-3HIGH

## 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 area of the prostate is examined without evident pathology.

The right kidney is normal in size (3.5 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 (3.3 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*

The right adrenal gland is normal in size (0.42 cm at the cranial pole and 0.46 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 (0.36 cm at the cranial pole and 0.41 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

### *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.

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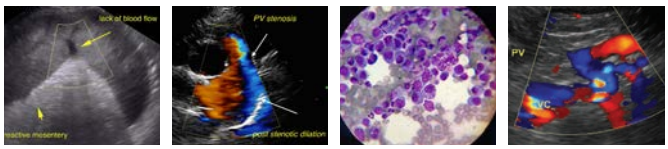

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### *Liver*

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 visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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.

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.

There is no apparent lymphadenopathy noted in these images.

## ULTRASONOGRAPHIC FINDINGS

- Normal/unremarkable abdomen

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Differentials for this patient's reported pelvic limb paraparesis/ataxia include a spinal problem such as intervertebral disc disease versus other, or potentially a stroke like event brought on by polycythemia, proteinuria, hypertension, or even hypoadrenocorticism, given this patient's laboratory changes and history. Therefore, recommendations include:

- A baseline cortisol. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.
- A urine protein to creatinine ratio is recommended.
- A blood pressure is recommended if not recently evaluated.

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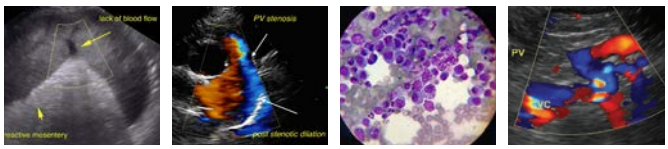

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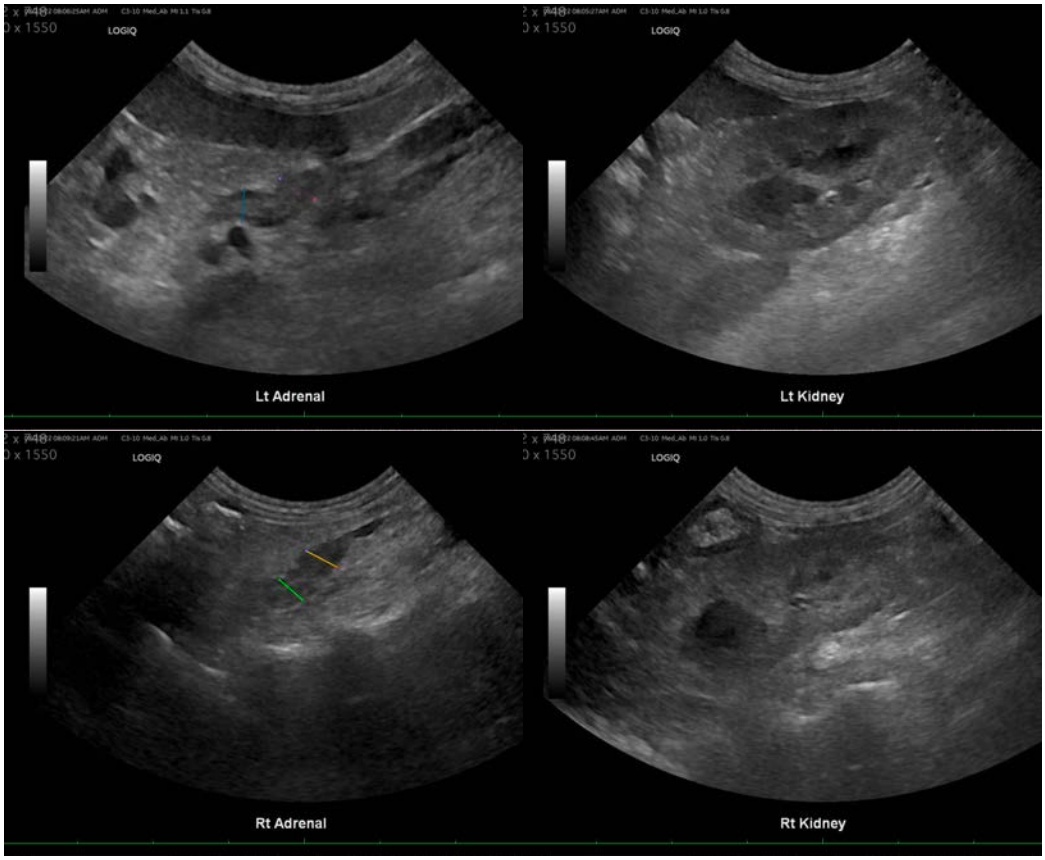
Given this patient's dehydration, recommendations include fully rehydrating this patient and rechecking the red blood cell count. If polycythemia is still present at that time, further workup of polycythemia would be recommended to try to determine the underlying cause. Next steps would include thoracic radiographs and an echocardiogram if patient remains polycythemic.

In the meantime, following rehydration, if the red blood cell count is still high, a therapeutic phlebotomy procedure followed by replacement of crystalloid fluids could be considered to offer relief.




**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