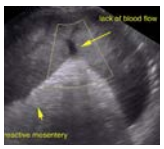
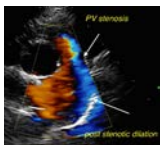
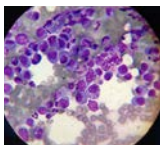
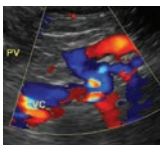





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Georgia McNamara

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

14 Years

WEIGHT

41 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Scott

HOSPITAL NAME

Ho-Ho-Kus VH

REFERRING VET

Dr. Scott

INVOICE

40183

DATE

8/5/22

PRESENTING CLINICAL SIGNS

came in for weight loss and decreased app . Found azotemia and hospitalized/treated for lyme and pyelo . Doing better now app increased but bw pretty much unchanged.
Abnormal PE/Chem/CBC/UA Results: 7/21: HCt 37%, non regen, PLT 30-50K, Creat 4.3, BUN 104, Alb 2.4, Phos 14 Lepto vaccinated but overdue (Ab positive, but PCR blood and urine negative), Lyme + and Qunat C6 91, urine culture + staph speud. Pet was hospitalized on fluids and IV antibiotics and antinausea for a few days and then sent home on doxy and clavamox for 3 weeks 8/3: HCT 31%, PLT 10-30K, creat 4.0, BUN 125, Phos 15, ALb 2.4 Urine sample planning to be obtained 10 days after finishing Antibiotics

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.

Kidneys are normal in size and contour. A relatively uniform hyperechogenicity is observed with mildly decreased corticomedullary distinction. There is no pyelectasia noted. No overt masses/nodules are observed. The left kidney measured 7.3 cm. The right kidney measured 6.8 cm. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted in both kidneys.

Adrenal Glands

The right adrenal gland is normal in size (0.95 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.70 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is generally normal in size and shape with a smooth capsular contour. Parenchyma is diffusely nodular in appearance characterized by small discrete hypoechoic nodules combined with multifocal well demarcated, hyperechoic, homogeneous nodules. Splenic vasculature appears normal.

Liver

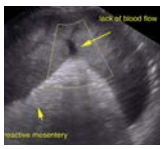
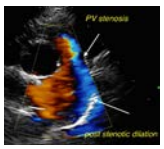
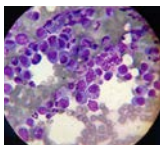
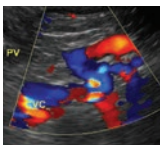
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal 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 visible stomach wall is normal in thickness 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.

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 mildly distended with echogenic

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non-shadowing luminal contents and gas consistent with normal ingesta. There is 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

- **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.

- **Splenic micronodular hyperplasia pattern –** This nodular change is often associated with benign aging nodular hyperplasia. Infiltrative neoplasia, however, including both early hemangiosarcoma as well as round cell neoplasia cannot be ruled out.

- **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 considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

At the time of the reportedly planned urine recheck, if culture is negative and sediment is otherwise quiet, a urine protein to creatinine ratio is recommended, if there is protein in the urine, to help determine whether or not an ACE inhibitor such as Benazepril may be helpful.

A blood pressure is recommended if not recently evaluated.

If this patient is clinically improving, then the addition of at-home subcutaneous fluid therapy daily could be considered to see if that helps the azotemia. if not, rehospitalization on IV fluids may be necessary until the azotemia plateaus, followed by subcutaneous fluid therapy at home at that point until this patient's infectious diseases have been fully cleared.

The appearance of the kidneys is most consistent with acute change, and the positive infectious disease diagnoses support acute nephritis. However, it is possible that chronic kidney disease will persist beyond management of the infectious diseases, in which case transition to a renal diet may also be warranted.

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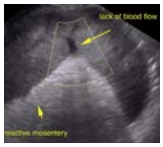
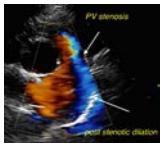
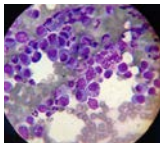
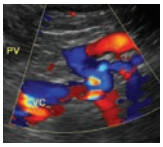

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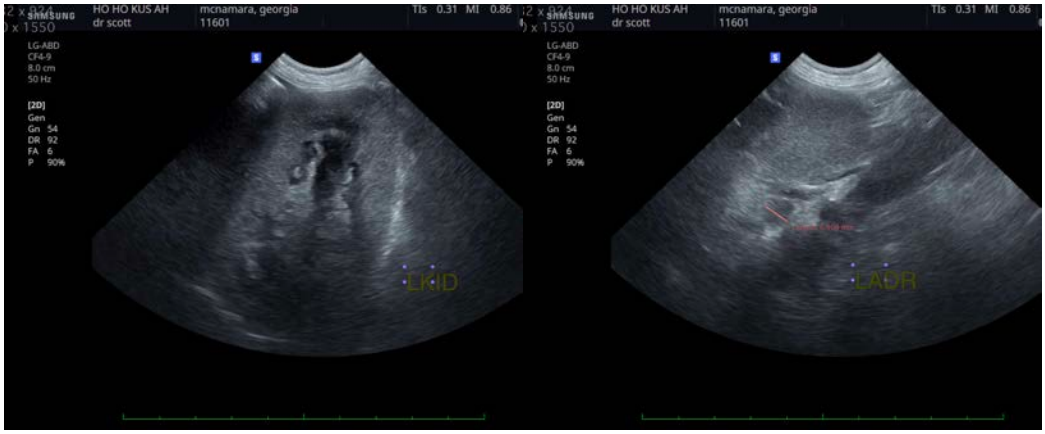

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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