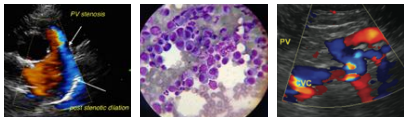
IMAGING PERFORMED BY

IntraPet.com



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DATE

9/16/22

PATIENT

Aspen Jaeger

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed female

AGE

11/2/20

WEIGHT

43 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Festival VC

REFERRING VET

Dr. Davies

INVOICE

39452

PRESENTING CLINICAL SIGNS

Urine leakage during sleep. Seems to drink more than normal dog. Symptoms started in July. Urine culture negative.
Current Medications: Proin 74mg Daily.
Lab Results: SDMA 15, Cortisol normal, USG 1.006.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Dexdomitor/Torbugesic IV.
Stat Report: Not requested.
Imaging Performed By: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately 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. At least one ureteral papilla is well visualized with a urine jet. There is no evidence of ectopic ureters noted in these images.

Left kidney is normal is size (5.55 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 (5.69 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 (2.9 cm long, 0.52 cm at cranial pole and 0.54 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (2.8 cm long, 0.72 at cranial pole and 0.68 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. 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). 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.

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 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. 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 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 free peritoneal effusion noted in these images.

Mesenteric lymphadenopathy is noted in these images as is cranial abdominal lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Cranial abdominal and mesenteric lymphadenopathy, most likely reactive especially given the patient's young age. Infiltrative neoplasia cannot be ruled out, but is considered less likely.

- There is no evidence of anatomical defects i.e. ectopic ureters in these images and the likelihood based on these images is very low, but cannot be definitively ruled out without advanced imaging.

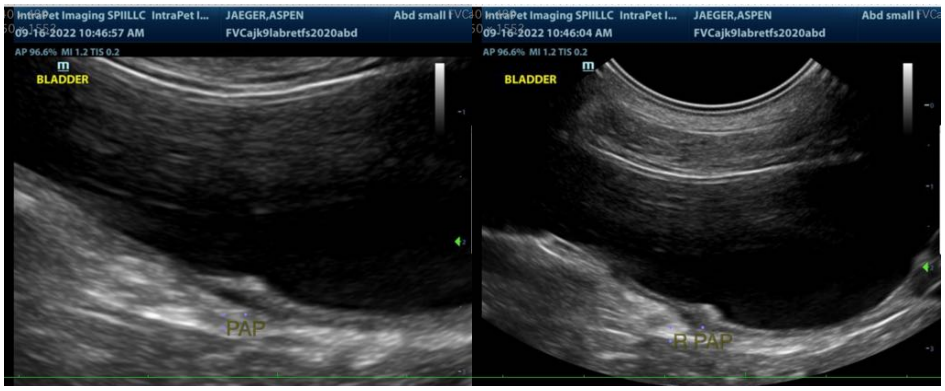
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

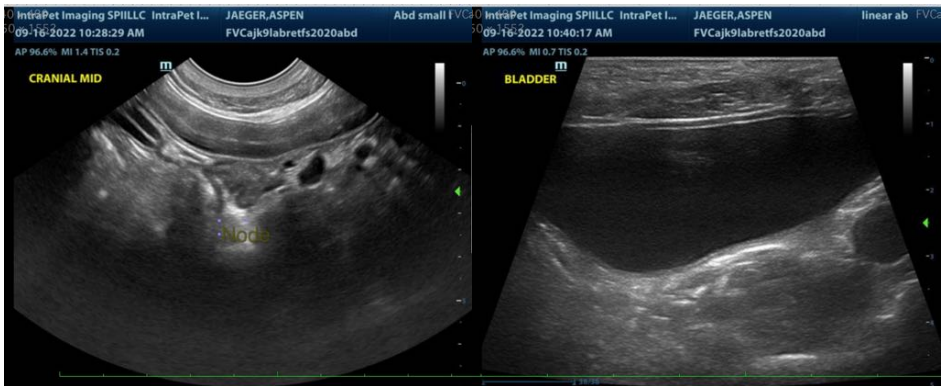
1. Given the patient's reported polydipsia the top differential for the new reported urinary incontinence is likely early or mild urethral sphincter mechanism incompetence or "spay incontinence" brought on by possible PU/PD. Therefore, recommendations are further work-up for polyuria, polydipsia followed by medical management of likely spay incontinence, as is already in place if an underlying cause for PU/PD cannot be determined and/or corrected.

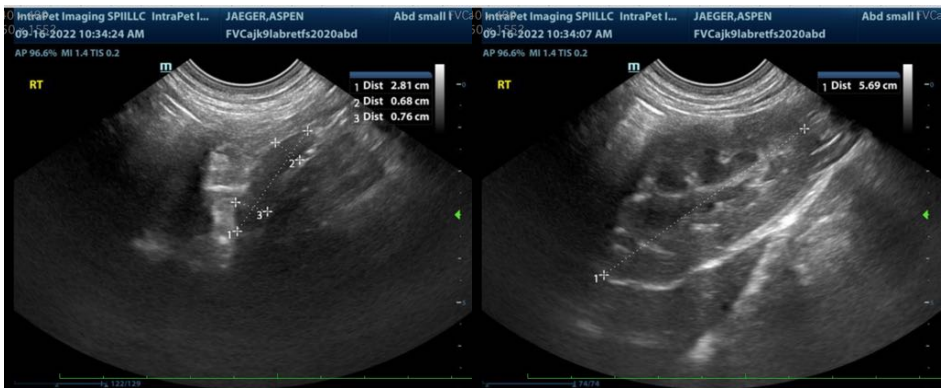
2. Given the patient's reported low blood glucose and borderline baseline cortisol a full ACTH stimulation test is recommended to rule out unlikely, but still possible in a small percentage of animals, hypoadrenocorticism with baseline cortisol of 2.

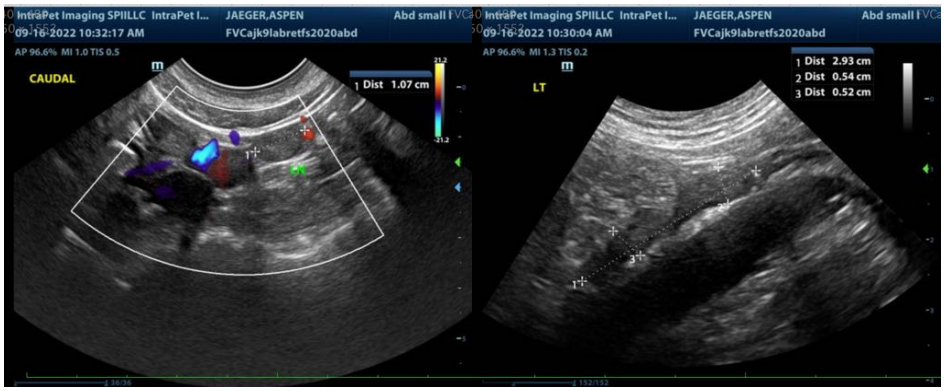
3. To further work-up the possible polyuria/polydipsia a first a.m. urine specific gravity to see if urine concentration is possible, as most animals drink less overnight is recommended as is daily water intake quantification if possible. Urine culture can be considered if not recently evaluated as could T4, bile acids, testing for Leptospirosis and/or an empirical course of antibiotics to address the possible PU/PD. If after that a diagnosis is still not obtained a more advanced work-up including water deprivation test, possible Desmopressin trial, etc. may be warranted. A cause for the incontinence other than spay incontinence including primary neuromuscular defects is possible and further evaluation with or by a neurologist can be considered; however, this likelihood is low.

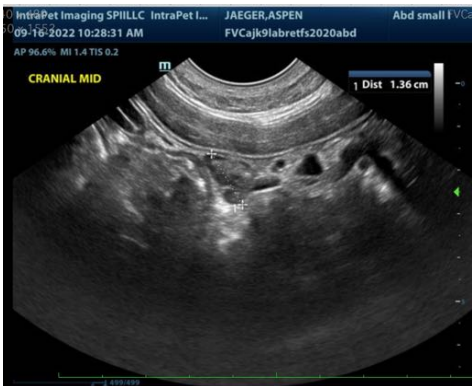
Additionally given the patient's lymphadenopathy if not recently evaluated empirical deworming with a 5 day course of Panacur is recommended.











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