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Clinical Sonography & Telecytology
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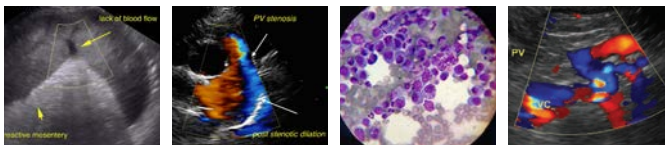


PATIENT
Carrie Misitano

SPECIES
Canine

BREED
Mini Poodle X

SEX
Spayed Female

AGE
17 Years

WEIGHT
2 kg

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Erin Wicks

HOSPITAL NAME
Shores VEC

REFERRING VET
Dr. Slenbaker

INVOICE
41639

DATE
9/25/22

PRESENTING CLINICAL SIGNS

Presented at our hospital for similar symptoms from June. Weakness in back legs, falling over, shaking, described symptoms of posturing and possible seizure. Previous Health Concerns: pancreatitis, chronic kidney Current Medications: Entyce, cerenia PRN, SubQ – 400 ml weekly, phosbind – discontinued, Adequan – recently started Appetite/When did they eat last: decreased eating – can be normal

Abnormal PE/Chem/CBC/UA Results: Cardiovascular: gr 1/5 systolic L>R; weak femoral pulses Respiratory: increased BV sounds Neurological: ataxia(generalized) turns head to right and over shoulder(also seen at home- seizure??) rad- no obvious masses/ fb/effusions; general lack of detail abdomen(very thin) Renal panel- BUN 67.5(H) (last 102 9/7/220 Cr 1.5(H) (last 3.3) IP- 3.1(N) (last 8.8) EPOC- BUN 60 (H) Cr 1.42(N) HCt 18%(last 25%) cPl abnormal (strong) Rad- no obvious effusion/masses/etc.

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 bilaterally small, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no mineral observed. Mild pyelectasia noted bilaterally. The left kidney measures 2.56 cm. The right kidney measures 2.71 cm.

Adrenal Glands

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

The left adrenal gland is normal in size (1.5 cm long x 0.40 cm at the cranial pole and 0.40 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.

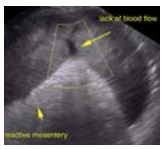
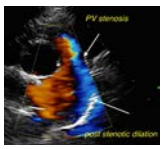
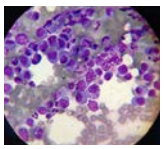
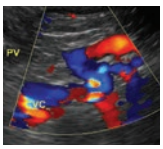
Liver

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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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.

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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 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

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

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

- **Chronic active pancreatitis** – Mild acute flare up can't be ruled out, but there is no ultrasonographically visible evidence of active peripancreatic inflammation at this time.
- **Chronic Kidney Disease –** This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.
- **Pyelectasia –** Differentials for pyelectasia include pyelonephritis, diuresis, congenital malformation or ureteral or lower urinary tract obstruction.
- **Gallbladder debris -** Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's chronic history, disease, and reported neurologic signs, if not recently evaluated, a urinalysis, and if indicated based on urinalysis results, a UPC is recommended to rule out proteinuria could have led to stroke-like event. Similarly, if not recently evaluated, a blood pressure is recommended.

In the meantime, supportive/symptomatic medical management of possible mild pancreatitis versus mild gastroenteritis secondary to kidney disease, etc. with antiemetics, gastroprotectants, appetite stimulants, or nutritional support as needed, broad-spectrum antibiotics, and fluid therapy, etc. is recommended.

If an underlying cause for the seizures cannot be determined, and neurologic signs continue, advanced imaging in the form of an MRI may be warranted.

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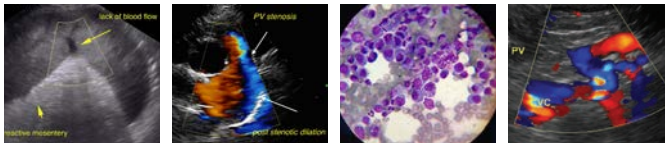

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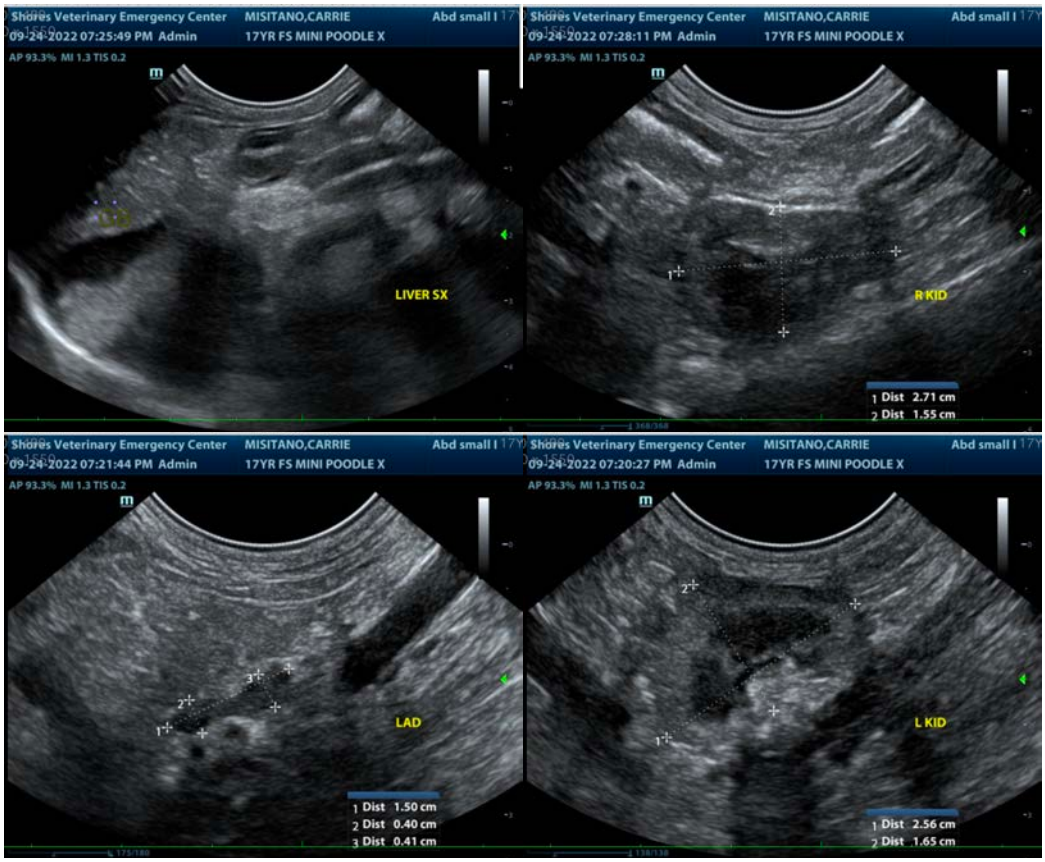

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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