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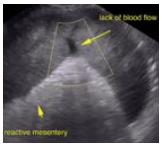
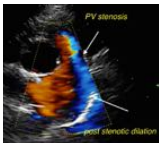
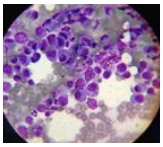
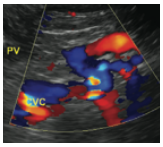
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Skutch Ryba

SPECIES
Canine

BREED
Australian Terrier

SEX
Neutered male

AGE
12 years

WEIGHT
13.8 lbs

INTERPRETED BY
Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY
Melissa DaSilva

HOSPITAL NAME
Pocono Peak VC

REFERRING VET
Dr. Coyle

INVOICE
76299

DATE
7/31/23

PRESENTING CLINICAL SIGNS

History: Patient presented 6/26 for three days of hematuria, otherwise is acting normally. Finished 30-day doxycycline dose in the beginning of June for Lyme & Anaplasma infection on 4/14. Last received Pro Heart12 on 4/14. Started Hepato Trubenefits & Clavamox x 14 on 6/26.
Abnormal PE/Chem/CBC/UA Results: 6/26: Elevated: RBC 8.93, ALT 266, ALKP 281 UA- SG 1.018, PRO 0.3, BLD 250, RBCs and Cocci visualized on manual UA Decreased: Retic-HGB 20.9, CREA 0.3, BUN 4, AMYL 317 7/24: Elevated: RDW 21.9%, ALT 238, ALKP 382 Decreased: Retic-HGB 21.0, CREA 0.4, BUN 6

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with complete loss of corticomedullary definition. No evidence of pelvic dilation was present. The left kidney contains a spherical anechoic fluid accumulation consistent with cortical cyst. Pinpoint areas of cortical mineralization bilaterally. The left kidney measured 5.11 cm and the right kidney measured 5.31 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized. Both were subjectively prominent and hypoechoic with no specific masses or nodules seen. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 1.59 cm in length and 0.69 cm at the caudal pole and 0.57 cm at the cranial pole. The right adrenal gland measured 2.47 cm in length and 0.79 cm at the caudal pole and 0.72 cm at the cranial pole.

Spleen

The spleen was normal with a smooth homogeneous parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with homogenous hyperechoic parenchyma with no specific nodules or masses. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally

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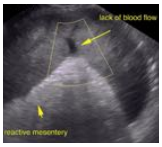
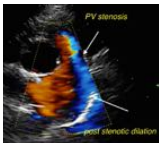
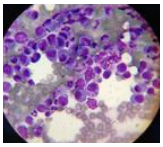
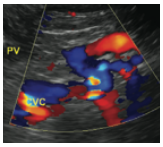

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Gastrointestinal

The stomach contains minimal luminal contents. It appears of normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

1. Hyperechoic liver
2. Significant degenerative renal changes
3. Bilateral adrenomegaly
4. Normal urinary bladder
5. Prostate not visualized

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An apparent cause of hematuria is not present in this study. A current urinalysis and urine culture are recommended. Advanced renal degeneration makes renal hematuria a differential and immediate evaluation of fresh urine for renal casts may provide further insight as this as a possibility. Prostate was not visualized in this study, likely due to intrapelvic location and/or colonic shadowing obstructing the view. This makes significant prostatic disease unlikely, but follow up sonogram to further investigate the prostate may be considered if clinically warranted. Rectal examination will also help clarify likelihood of prostatic disease.

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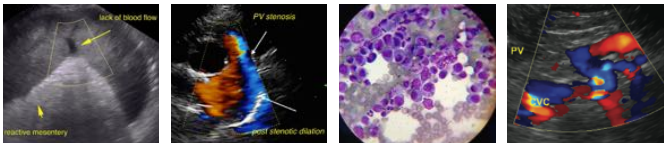

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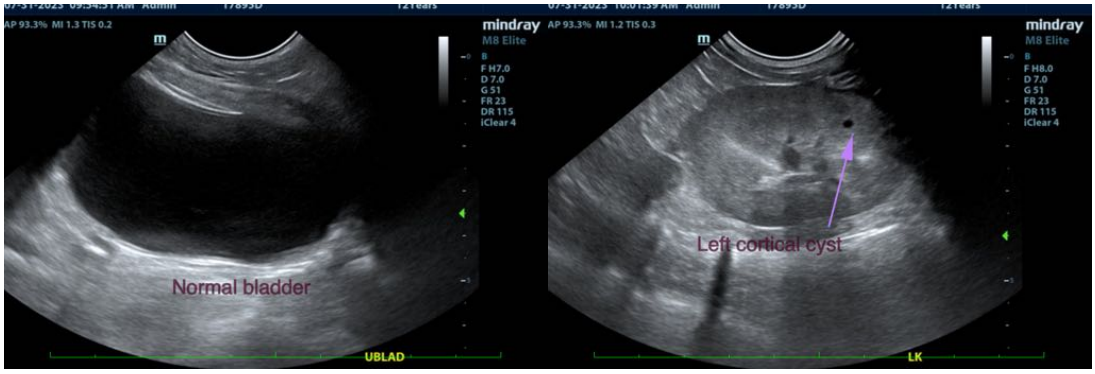
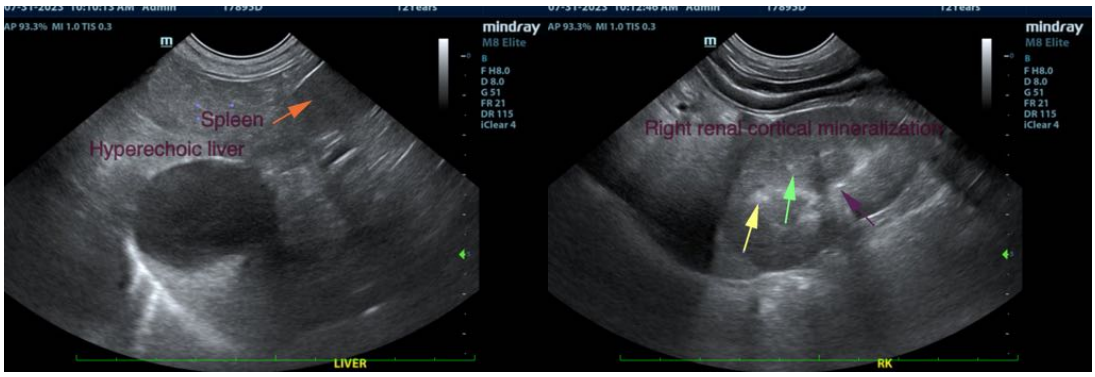
Adrenomegaly is bilateral and may represent stressful illness or hormonal stimulation as is seen with pituitary dependent hyperadrenocorticism. If corresponding clinical signs are present, testing for hyperadrenocorticism should be considered (ACTH stimulation test vs LDDST).

Hepatic parenchymal changes are a common finding in the face of endocrinopathies, infectious or inflammatory hepatitis (bacterial, viral, auto-immune other), and neoplasia among other things. As elevated liver enzymes are present, fine needle aspirate is recommended to further define. Ultimately liver biopsy may be required for more definitive diagnosis.





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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
info@SonoPath.com