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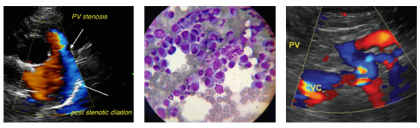

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Jasmine Wasko

SPECIES

Canine

BREED

Weimaraner

SEX

Spayed Female

AGE

15 Years

WEIGHT

64.5 Pounds

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Jessica Fishbaugher

INVOICE

36104

DATE

3/10/22

PRESENTING CLINICAL SIGNS

History of UTI's in the past. Last UTI was resistant to all antibiotics except for Nitrofurantoin. Treated with Nitrofurantoin but again developed hematuria with large amount of debris present. Dribbles urine a lot.
Abnormal PE/Chem/CBC/UA Results: Diagnosed with systemic hypertension at a previous vet. Currently on amlodipine, enalapril, carprofen, gabapentin.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** and visible pelvic urethra were unremarkable for the level of repletion presented. The urine, however, did present some mildly echogenic debris consistent with mucous, exfoliated cells from renal or bladder origin, and/or blood clots as these echogenic changes can all present similarly. This is often related to urinary tract infection but may represent simple evidence of exfoliated debris or sterile inflammation. Dependent and suspended debris noted entering into the cystourethral junction and proximal urethral. No evidence of calculi or masses. Mild edematous bladder wall noted. Cystocentesis, urinalysis, +/- culture would be recommended to rule out and define any UTI. The pelvic urethra was imaged 3.0 cm beyond the cystourethral junction. Subjectively poor urethral tone.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The right kidney measured 7.0 cm. The left kidney measured 8.02 cm.

Adrenal Glands

The **adrenal glands** appeared slightly enlarged and swollen. No evidence of focal capsular expansion or invasion into the phrenic veins were noted. No overt suspicion of neoplasia was noted. This is considered likely a hyperplastic change associated with stress or adrenal endocrinopathy (PDH). If isosthenuria is persistently present and the patient morphologically suggests Cushing's disease then ACTH testing would be indicated. The right adrenal gland measured 4.27 cm x 2.63 cm at the cranial pole and 0.77 cm at the caudal pole. The left adrenal gland measured 3.56 cm x 0.78 cm at the cranial pole and 0.77 cm at the caudal pole.

Spleen

The **spleen** revealed a complex mass measuring 5.0 cm with microcavitation and necrosis pattern. Other heterogeneous splenic changes noted.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable. Lobar biliary calculi noted, non-obstructive. Minor gallbladder sand present, non-obstructive.

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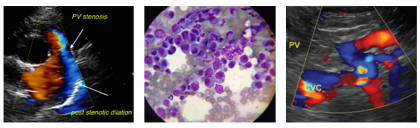

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Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

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

ULTRASONOGRAPHIC FINDINGS

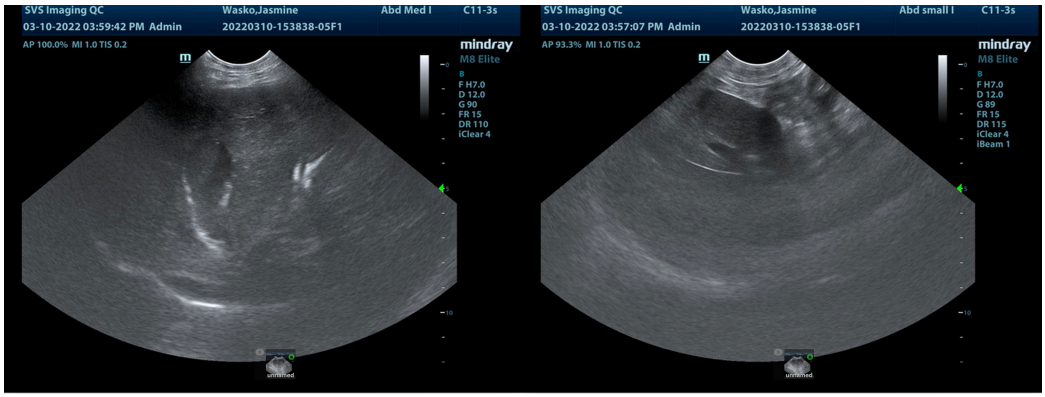
- Chronic UTI pattern with poor urethral tone
- Bilateral adrenal enlargement
- Splenic mass – differentials include round cell neoplasia, hemangiosarcoma, less likely but possible abscessation or hyperplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of metastatic disease. Echocardiogram and 3-view chest radiographs warranted followed by splenectomy. Urine culture and sensitivity recommended. Pulse therapy likely necessary in this patient as well as enhancing sphincter tone with Phenylpropanolamine. Ursodiol therapy could be considered in an attempt to dissolve the biliary mineralization. However, this is highly variable in effectiveness patient to patient.

Chronic UTI Protocol

I recommend **Enrofloxacin** (5-10 mg/kg SID PO) (In patients > 1 year of age) in late pm after urination to maximize urinary concentrations overnight. This assumes that culture supports this use. Repeat **culture** at 3-4 weeks and continue treatment at least 7-10 days post negative urinary sediment and negative culture. *Note: Negative culture does not necessarily mean lack of UTI.* Other favorite antibiotics for chronic UTI include third generation Cefa (Ceftiafur or similar s.i.d. injectable) or Clavamox. If suspicion of occult urinary incontinence is present then **phenylpropanolamine (PPA)** (1-2 mg/kg BID) can be employed long term to enhance urethral tone.



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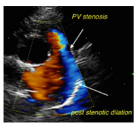

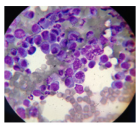

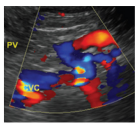

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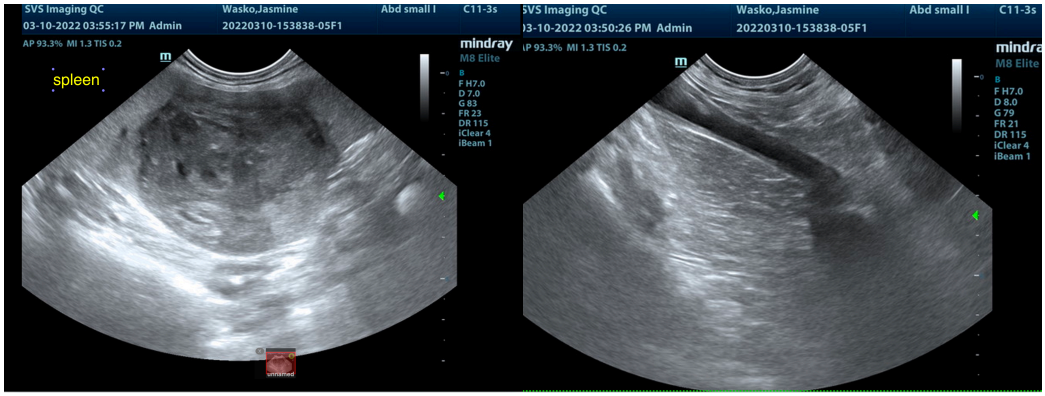

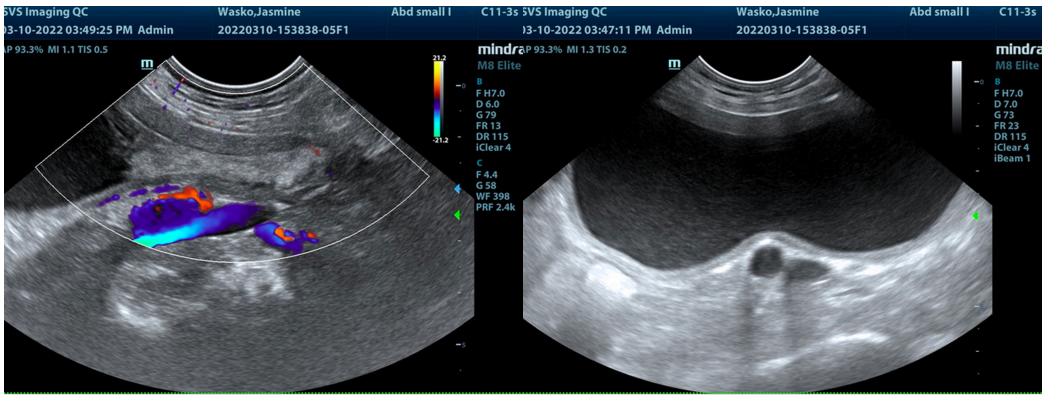

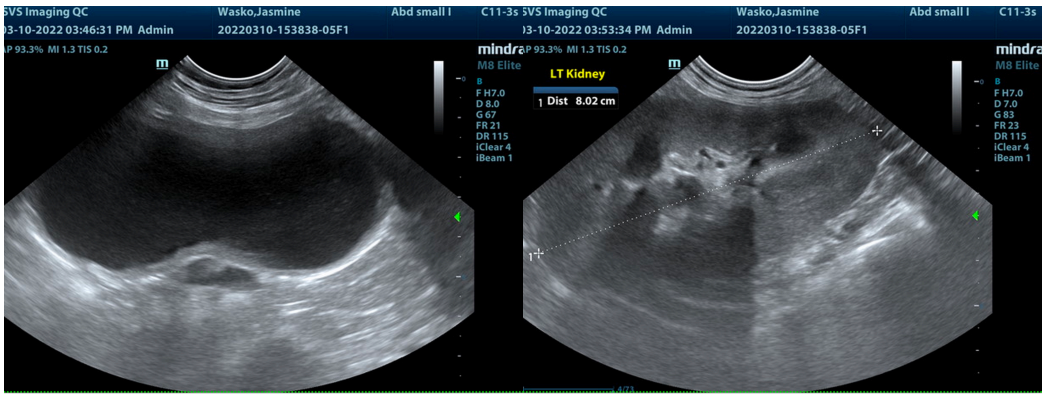

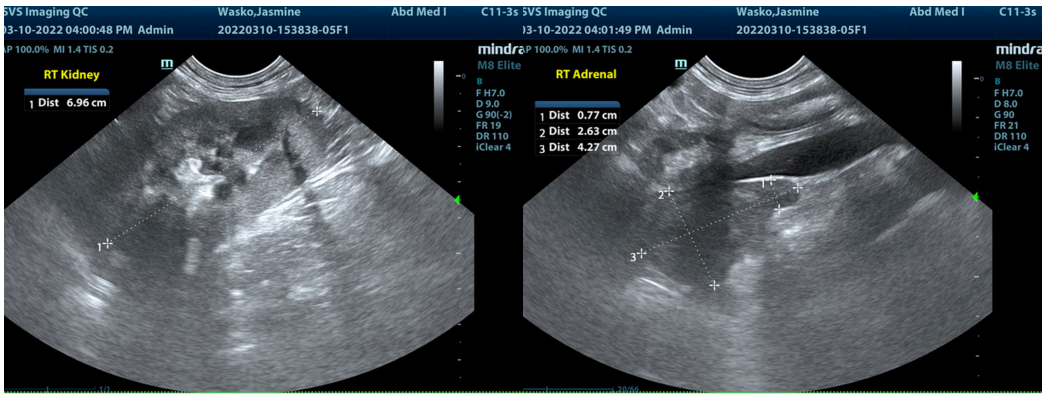

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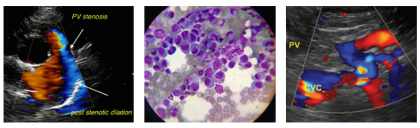

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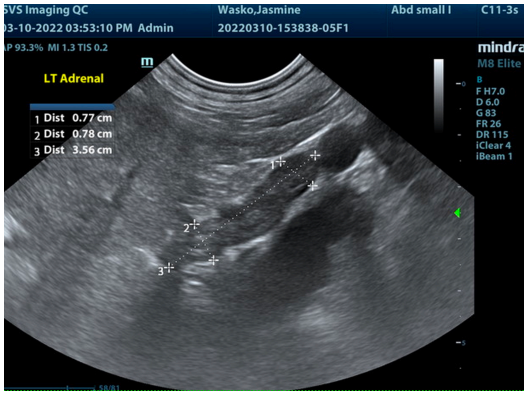

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com