

**DATE**

3/18/22

PATIENT

Sammy Johannssen

SPECIES

Canine

BREED

Norwegian Elkhound

SEX

Neutered Male

AGE

8/9/10

WEIGHT

65.4 Pounds

INTERPRETED BYEric Lindquist, DMV
DABVP, Cert. IVUSS**IMAGING PERFORMED BY**

Rachel Brilhart RDMS

HOSPITAL NAMEJacksonville Vet
Hospital**REFERRING VET**

Dr. Kablis

INVOICE

36316

PRESENTING CLINICAL SIGNS

Presented for symptoms of DJD. Bloodwork done for possible NSAIDS.

Current Medications: Amoxicillin 200mg 3 tabs BID.

Lab Results: TP 7.8, Glob 4.4, AST 69, ALT 240, ALKP 176, BUN 38, Crea 2.6, Ca 11.6, CBC normal, T4 <0.5, 4dx neg. UA- USG 1.012, Prot 100, RBC 7/hpf, Lepto PCR blood and urine neg.

Radiographs:

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**The **urinary bladder** presented structurally unremarkable wall with a 1.4 cm sand accumulation. The pelvic urethra was unremarkable.The **kidneys** presented moderate degenerative changes with cortical remodeling and increased echogenicity. Some loss of corticomedullary definition noted. Microcystic changes noted throughout the cortices. An anechoic cyst was noted in the dorsal cortex of the left kidney at 0.94 cm. The left kidney measured 6.36 cm. The right kidney measured 6.42 cm. Blood flow was subnormal on power doppler assessment of the renal cortices. Corticomedullary mineralization also noted.**Adrenal Glands**Both **adrenal glands** were mildly enlarged and heterogeneous with remodeling, especially in the left adrenal gland. Likely hyperplasia. However, if any evidence of Cushing's disease is present, then PDH would be a potential. The right adrenal gland measured 3.19 cm x 0.86 cm at the caudal pole and 0.86 cm at the cranial pole. The left adrenal gland measured 2.77 cm x 1.1 cm at the caudal pole and 0.83 cm at the cranial pole.**Spleen**The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were 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. A right cranial hyperechoic nodule noted in the liver measuring 2.5 cm. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The **gallbladder** was mildly over distended with suspended and dependent debris, yet not to the level of emerging mucocele, yet sludge appears to be mildly excessive. No adjunctive inflammation was noted.**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

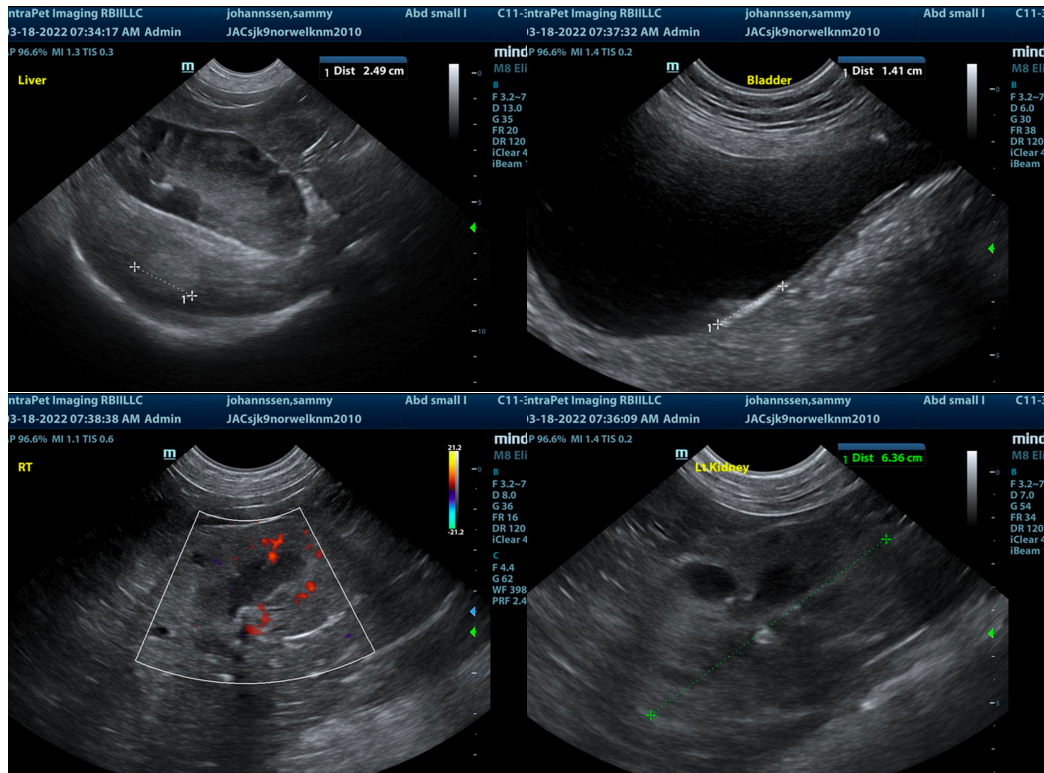
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxyphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

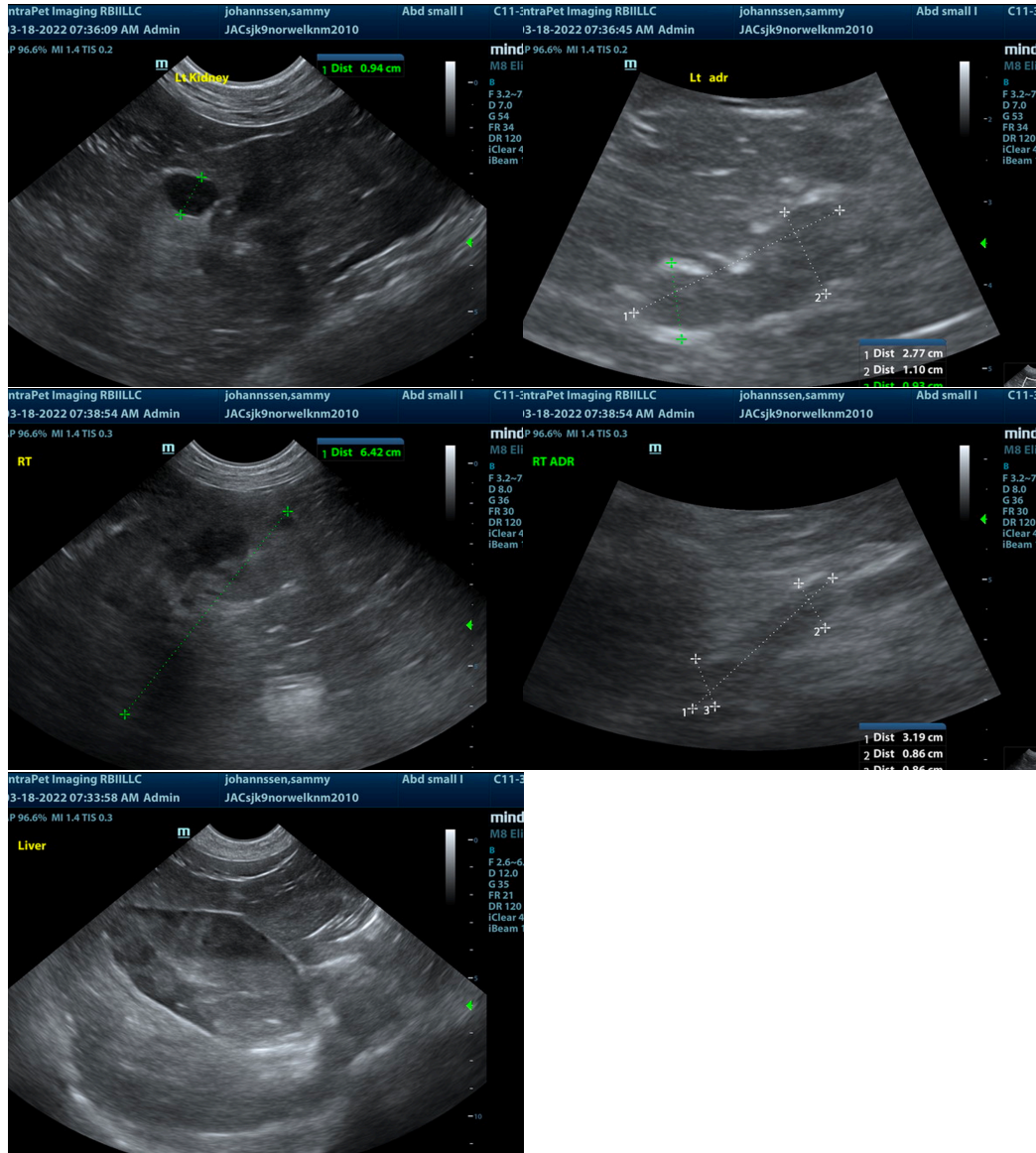
ULTRASONOGRAPHIC FINDINGS

- Moderate degenerative renal changes
- Bilateral adrenal hypertrophy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient may be passing sand periodically from the kidneys to the bladder. The kidneys appear moderately compromised. 72-hour IV fluid protocol, urine culture and sensitivity indicated. Blood pressure measurements warranted. Long-term management of the gallbladder presentation with Ursodiol therapy indicated and reassessment of the azotemia after 72-hours of therapy. Both prerenal and renal disease may be playing a role in this patient +/- passage of sand periodically, inducing an acute insult.





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.

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