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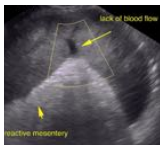
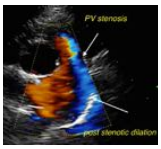
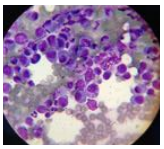
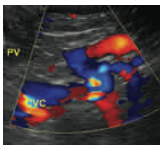

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1-800-838-4268 info@sonopath.com

PATIENT
Magic Verma

SPECIES
Canine

BREED
Maltese Poodle Mix

SEX
Neutered male

AGE
10 years

WEIGHT
20 lbs

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Jessica Miller, RDMS

HOSPITAL NAME
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PRESENTING CLINICAL SIGNS

Hx of nephroliths and cystoliths. More recently severely azotemic. Current meds: IV fluids, cefazolin, Baytril, Metronidazole, famotidine, cerenia
Abnormal PE/Chem/CBC/UA Results: 4/30/22: HCT 37, Creat 13.5, BUN >130, Phos 16.1, 5/2/22: HCT 25, Creat 5.2, BUN 79, Phos normal UB: moderate rods 9-40/HPF SG: 1.016

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed sand accumulation up to 2.2 cm and was non-obstructive at the time of the sonogram. The pelvic urethra was imaged 3.0 cm beyond the cystourethral junction and appeared normal.

The residual prostate measured 0.8 cm.

The right **kidney** measured 4.22 cm with pelvic and corticomedullary calculi. The contour was swollen and irregular. Retroperitoneal and abdominal free fluid was noted. The left kidney was uniform and measured 4.03 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 2.07 x 0.56 cm at the caudal pole and 0.98 cm at the cranial pole. The left adrenal gland measured 2.23 x 0.59 cm at the caudal pole and 0.56 cm at the cranial pole.

Spleen

The **spleen** in this patient was mildly enlarged with uniform parenchyma and was folded upon itself caudally. This is a positional variant and is not pathological. There was no evidence of significant disease.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. The hepatic veins were dilated. This is consistent with passive congestion, which is likely contributing to the ascites. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident. Pleural effusion was noted through the diaphragm. Free fluid was noted between the liver lobes.

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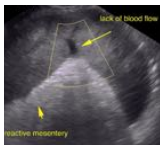
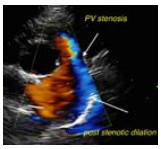
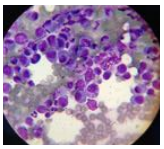
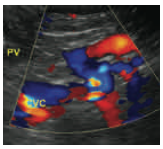

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Gastrointestinal

The **gastric** wall was severely thickened with loss of mural detail. Wall thickness in the gastric fundus measured 1.6 cm. The pylorus appeared patent. Reactive mesentery was noted around the stomach and pancreas.

Pancreas

The right limb of the **pancreas** is heterogenous and irregular.

Heart

Rapid view of the heart revealed no evidence of pathology. However, arrhythmogenic activity was present.

ULTRASONOGRAPHIC FINDINGS

Passive congestion pattern with subjectively normal echocardiogram. No evidence of masses.

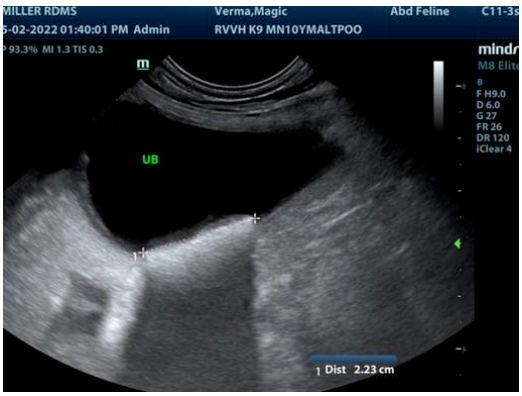
Non-cardiogenic pleural fluid.

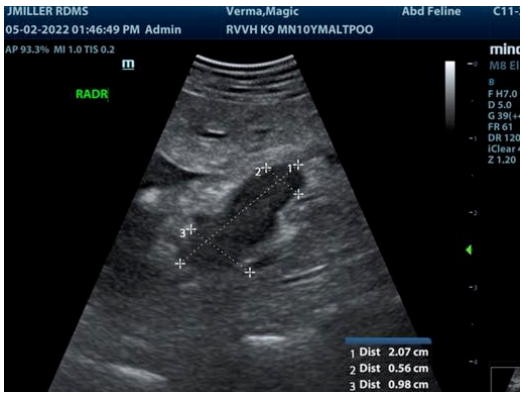
Gastric thickening with loss of detail meeting neoplastic criteria.

Renal calculi with irregular renal cortices and non-obstructive bladder calculi/sand.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are multiple issues occurring in this patient. The pleural effusion is strongly concerning for a thoracic neoplastic process, possibly metastatic from the gastric wall. Pleurocentesis and cytospin is warranted. Although the chest radiographs ire unremarkable, chest CT is warranted to assess for extracardiac pulmonary disease. Metastatic disease may be an issue. The pleural fluid did not appear present on baseline radiographs. Therefore, repeat radiographs are warranted to assess for pleural effusion and obstructive disease in the caudal mediastinum that may be emerging. The prognosis is guarded. Gastroscopy could be considered. Regarding the azotemia prerenal and renal insults may be playing a role. Passage of calculi may be playing a role; however, there was no obstructive disease noted at the time of the sonogram.





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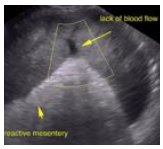
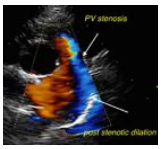
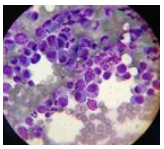
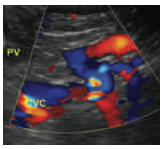

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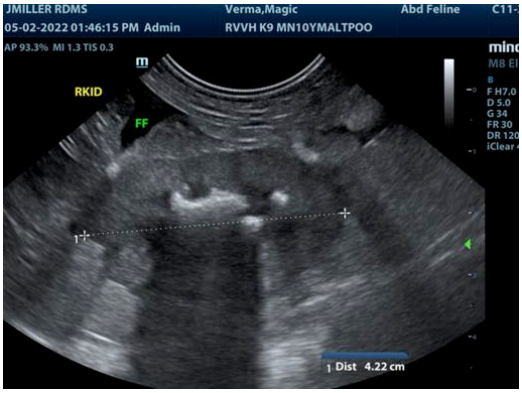

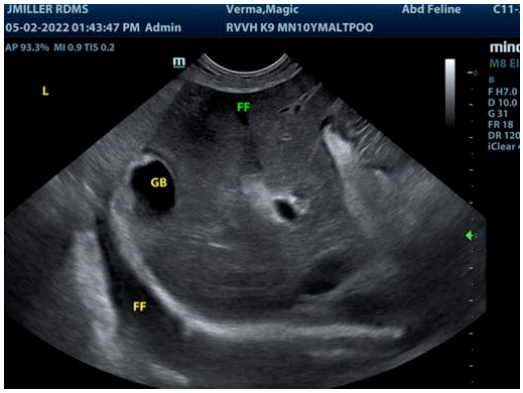

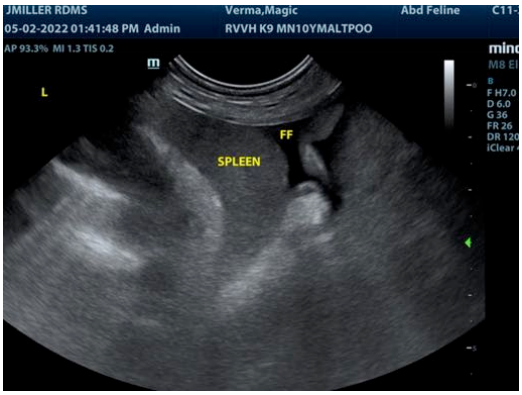

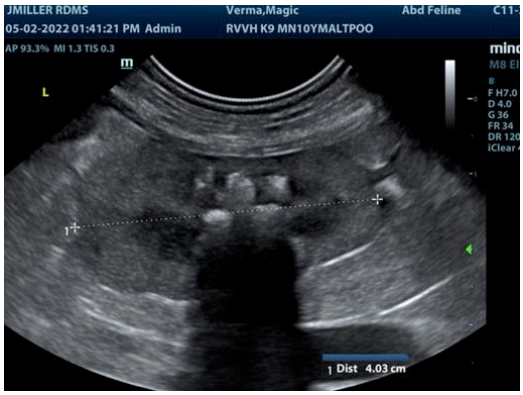

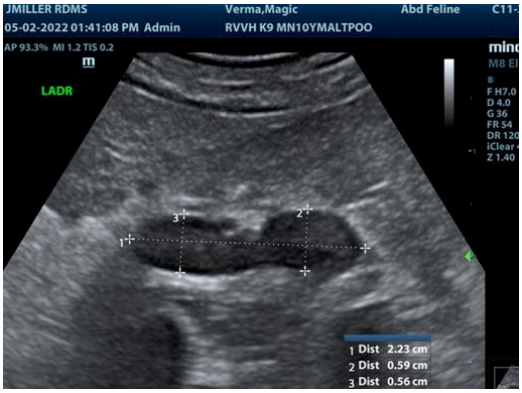

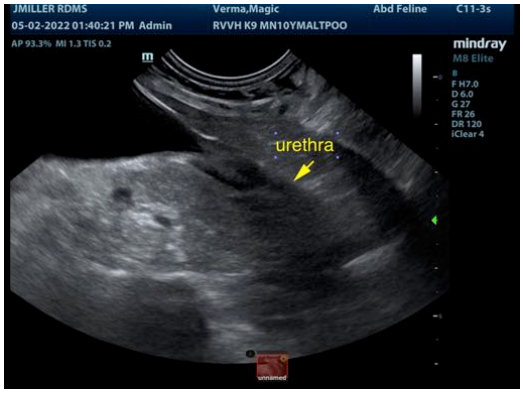

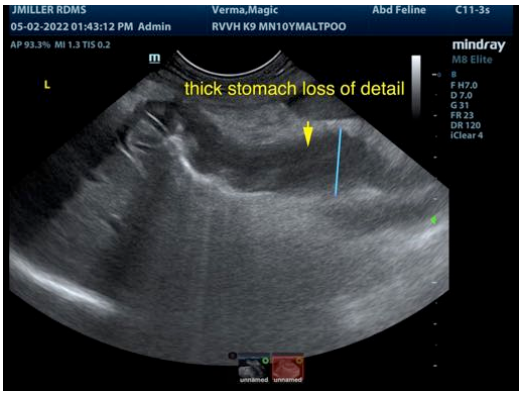

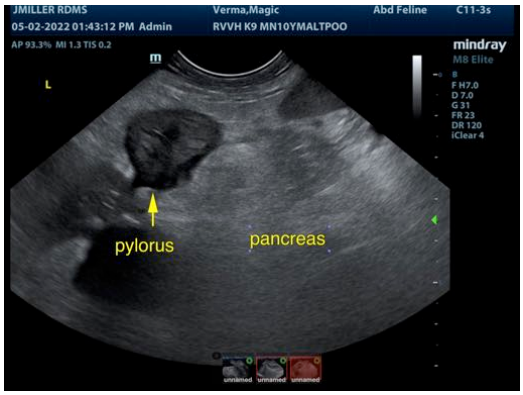

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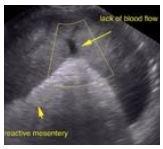
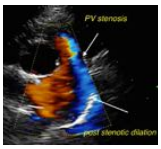
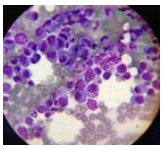
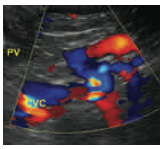

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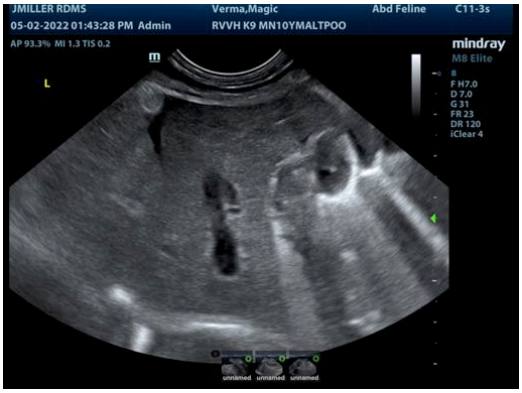

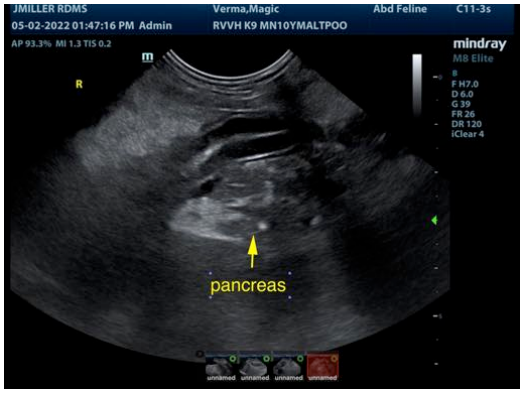

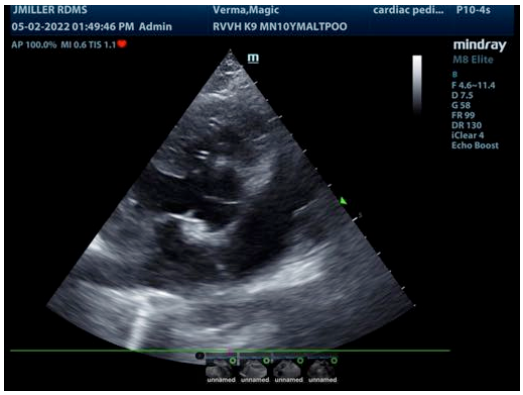

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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