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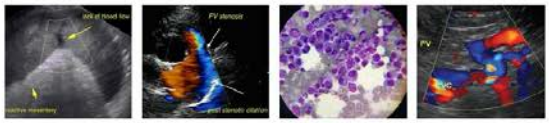

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Jayce Przygoda

SPECIES

Canine

BREED

Lab Retriever

SEX

Intact Male

AGE

1 Year

WEIGHT

95 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Monte Vista AH

REFERRING VET

INVOICE

33613

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12/21/21

PRESENTING CLINICAL SIGNS

Lab Results (12/14/2021): CBC- All WNL. Chemisty panel- Na:K Ratio High (38), K- Low-Normal (4.0), Na High-Normal (150), All Else WNL. Total T4- Normal (2.8). UA- Freecatch, USG 1.021, pH 6.5, All Else WNL. A: K low-normal- R/O PU, Other. Urine USG- grey zone- R/O Early Renal insufficiency, hydration status, Other. PU/PD reported by O- R/O Normal for Jayce, No salty treats (bully sticks, etc.), Lepto., Addison's Disease, Pyelonephritis, Congenital Renal Dysplasia, Liver Shunt/Disease, CDI/NDI/Psychogenic Polydipsia all unlikely given level of urine concentration. Given electrolyte values- suspicious that PU is driving PD- R/O Lower urinary tract/urinary issue. P: Urine c/s/mic was negative in the past. Recommend serial first am USG measurements x 5 to assess concentrating ability. Recommend basal cortisol and MAT Lepto. Titers. Recommend abdominal imaging (radiographs and ultrasound). Consider bile acids and repeat urine c/s/mic. PU/PD. O reports that Jayce has been drinking ~4 big bowls of water on average each day and has been urinating a bit more than normal for the past ~2 weeks. O did switch dog food to adult formula, is feeding Instinct Dry dog food, grain-inclusive. No other known toxin ingestion or known trauma. Otherwise O notes that he appears to be doing well, he is E/D Normally, No V/C/S. Has had mildly loose stools with mucous, no blood or straining noted by O.
Abnormal PE/Chem/CBC/UA Results: sedated dex/torb

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi. A normal but prominent right ureteral papillae is visualized. The left is visualized but an opening is not seen. Additionally there is a contracting prominent tubular structure visualized distal to the urethra which is suspicious for a left sided ectopic ureter.

The prostate is large in size (1.79 cm in height in the sagittal view) but has a regular shape with smooth external margins. The parenchyma is heterogenous but no discrete focal lesions are present. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (6.5 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (7.12 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal/borderline flat in size measuring 0.51 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal/borderline flat in size measuring 0.64 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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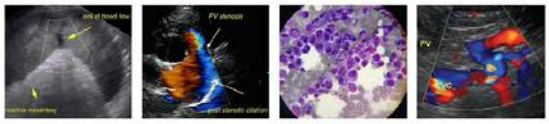

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Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. 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. The duodenum measured as normal (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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 pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a mild mesenteric lymphadenopathy visusalized with a mesenteric lymph node measuring 1.0 cm in transverse section. The sublumbar lymph nodes measure as normal at 0.85 and 0.47 cm. The omentum is of normal echogenicity.

Other

A brief view of the heart was submitted. No significant pericardial effusion was seen.

The left and right testicles are visualized and appear within normal limits.

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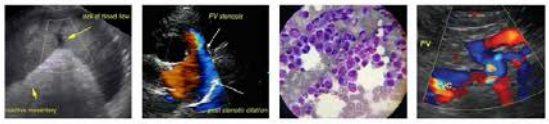

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PRIMARY FINDINGS

- Possible left sided ectopic ureter with closed left ureteral papillae- recommend confirmation with a contrast CT scan
- Large, heterogeneous prostate – Prostatic changes are most consistent with benign prostatic hyperplasia. Other differentials include bacterial prostatitis and prostatic neoplasia. However, given the lack of lower urinary tract symptoms, these differentials are considered less likely in this patient.
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely. This is often a very normal finding in young dogs.

SECONDARY FINDINGS

- Subjectively "flat" adrenal glands – Although these adrenals are normal size, they are somewhat flat for such a large dog. Consider confirming normal cortisol levels.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no obvious lesion visualized to explain the recent in thirst. The diagnostic recommendations listed in the history are very good. First I would typically have the owner quantitate water intake as over approximately 4.5 liters per day in this dog, and I would evaluate urine concentration first thing in the morning over several days to ensure this is a real problem.

Based on the ultrasound images there is concern for a possible subtle ectopic ureter on the left side. This ideally should be confirmed with a contrast CT scan as it is not really typical for PU/PD to be a common symptom of an ectopic ureter (it can be with infection etc..).

In a dog this age with no obvious illness, other primary diferenteials would be a urinary tract infection/prostatitis, psychogenic polydipsia, Leptospirosis, or Addison's disease. I cannot definitively rule out the possibility of a liver shunt, but this seems very unlikely based on the images visualized. That being said, a liver function test and even a contrast CT scan of the abdomen could be considered if these problems are thought more likely

(1) Hyperadrenocorticism (may be a mixed primary PU and PD)
(2) Hypoadrenocorticism (either Addison's or hypocortisolism)
(3) Hypercalcemia
(4) Diabetes Mellitus
(5) Liver Disease (hepatic encephalopathy may be a mixed primary PU and PD)
(6) Pyelonephritis
(7) Leptospirosis (can present without azotemia)
(8) Chronic Renal Disease/Renal Failure (can present pre-azotemic, especially in dogs, but expect the BUN & creatinine not to be at the low end of the reference range)

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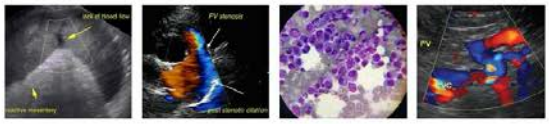

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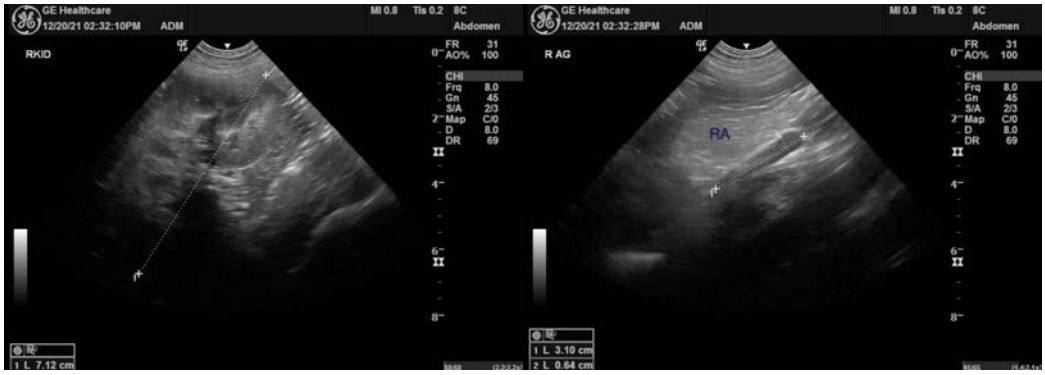
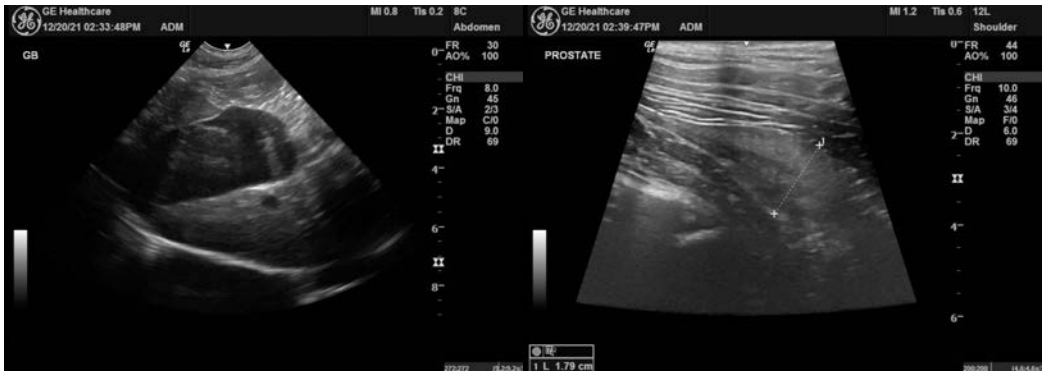
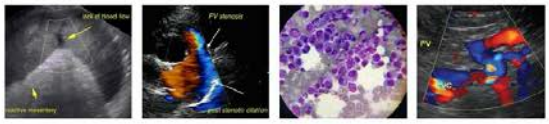
(9) Hyperthyroidism
(10) Hypokalemia
(11) Pyometra (including stump pyometra in spayed dogs)
(12) Renal Tubular Diseases (glycosuria or Fanconi & Fanconi-like syndromes or RTA)
(13) Chronic Partial Urinary Obstruction or Post-Obstructive Diuresis
(14) Iatrogenic Disease due to medications (diuretics, phenobarbital, KBr; diets either high in salt [such as S/D] or very low in protein (such as U/D))
(15) Pheochromocytoma
(16) Polycythemia
(17) Hypertension Acromegaly (expect these patients to have diabetes)
(18) Paraneoplastic Syndromes (particularly splenic hemangiosarcoma?)
(19) Pericardial Effusion
(20) Atypical Cushing's and SARDS Psychogenic Polydipsia (as in a true behavior disorder with a compulsive element)
(21) Primary Non-Medical Polydipsia (aka "I drink a lot because I like it or I engage in activities that promote it, but that doesn't mean I'm sick")
(22) Psychogenic Polydipsia (as in a true behavior disorder with a compulsive element)
(23) Acromegaly (expect these patients to have diabetes)
(24) Primary Nephrogenic Diabetes Insipidus (Congenital Nephrogenic Diabetes Insipidus, other diseases that cause primary PU other than Congenital Diabetes Insipidus would be considered Acquired Nephrogenic Diabetes Insipidus)
(25) Central Diabetes Insipidus

**Keep in mind that diabetes insipidus is a VERY rare disorder and that water deprivation tests are rarely/if ever recommended-if possible consider referral to an internal medicine specialist if reaching that point.







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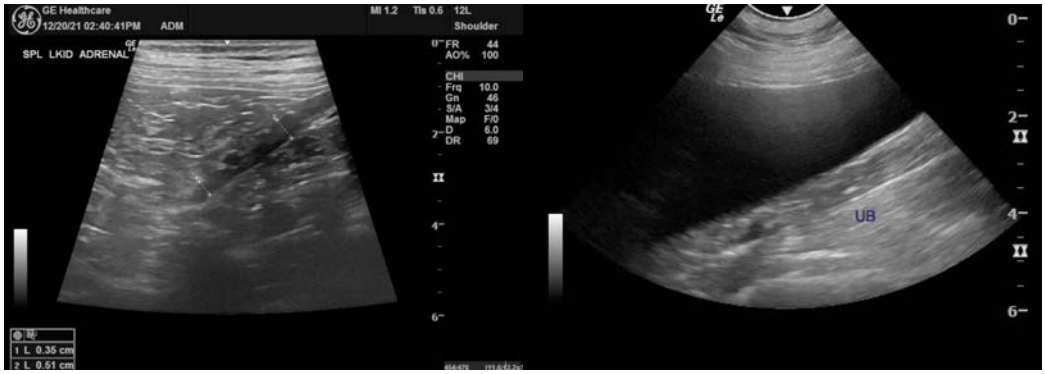

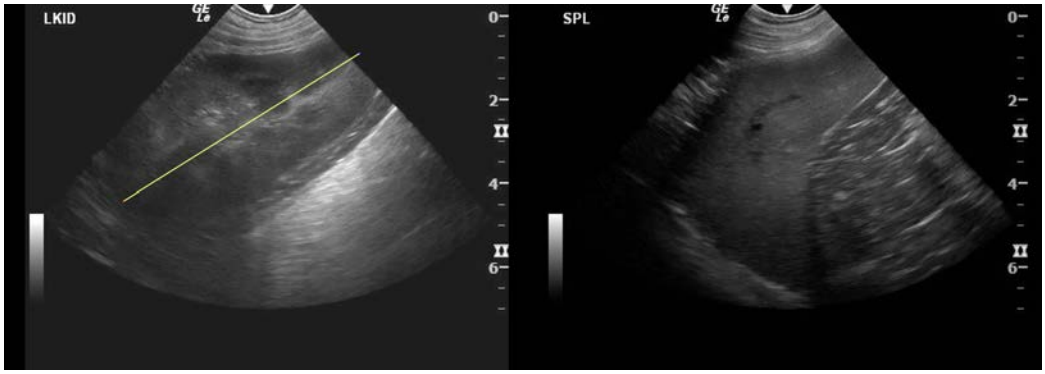

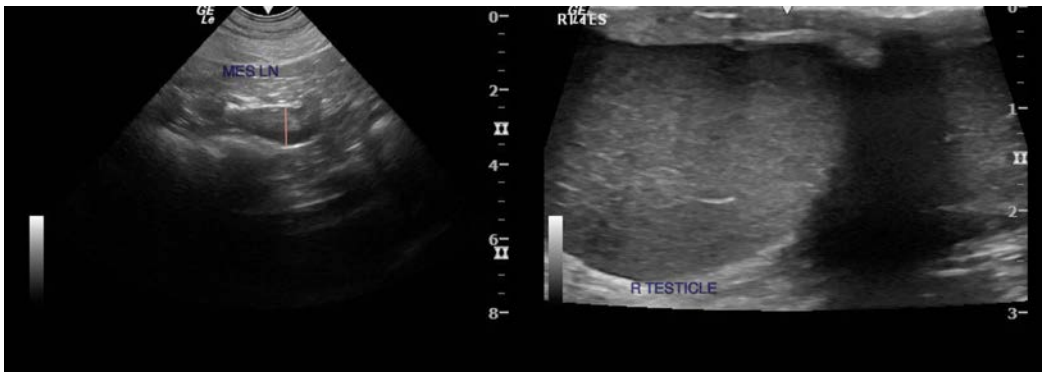

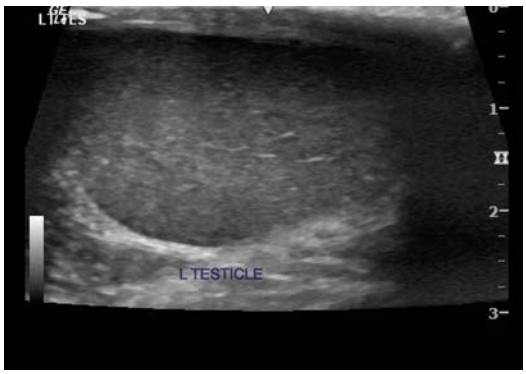

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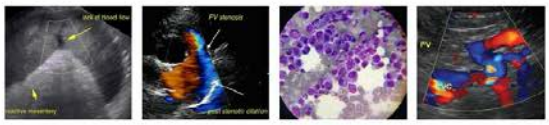

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com