

PATIENT

Bailye Levy

SPECIES

Canine

BREED

Shih Tzu

SEX

Spayed Female

AGE

11 Years

WEIGHT

15.4 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Kelly Vazquez

HOSPITAL NAME

Northvale Vet Clinic

REFERRING VET

Dr. Stefanie Simon

INVOICE

35688

DATE

2/16/22

PRESENTING CLINICAL SIGNS

Patient presents for history of hematochezia, anorexia, and vomiting for 5 days, now resolved. Today having slightly soft stool but no blood. Diarrhea on 1/7/22 responded to flagyl, probiotics, and Propectalin but clinical signs returned on 2/11/22 and did not respond to meds until today.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.61 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 is large in size (4.77 cm) and irregular in shape. Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is a very large anechoic cystic structure that appears to be arising from the caudal portion of the right kidney measuring 4.8 cm x 3.5 cm. This lesion is thin walled, and there is apparent inflammation and effusion surrounding the cystic structure. This inflammation comes into contact with areas of bowel. It is not clear if the cystic lesion connects to the renal pelvis. There is no evidence of nephroliths, and renal vasculature appears normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.42 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 in size measuring 0.63 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.

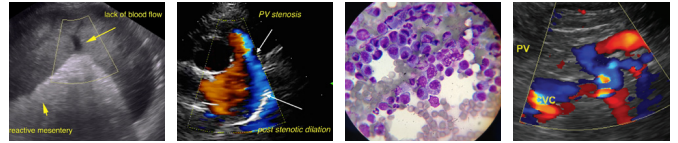
Spleen

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.



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Gastrointestinal

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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.

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The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measured 0.52 cm. Jejunum wall measured 0.27 cm.

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Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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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.

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Free Abdomen

There is no diffuse free fluid, but there is free fluid in the peritoneal cavity around the cystic renal structure. The omentum is very hyperechoic in this region.

PRIMARY FINDINGS

- Large right-sided renal cyst with surrounding fluid and inflammation. An abscess cannot be ruled out, but seems unlikely based on the anechoic nature of the fluid observed. There is focal peritonitis around the structure.
- Mild small intestinal thickening – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

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SECONDARY FINDINGS

- Mildly reduced corticomedullary distinction in both kidneys – The bilateral renal findings are consistent with age-related change.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large fluid-filled anechoic structure arising from the area of the caudal right kidney. This structure is large and there is surrounding fluid and inflammation. It is difficult to determine if this structure has a direct communication with the renal pelvis or not, as the lesion disrupts the normal renal architecture and displaces normal surrounding structures.

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Typically, these lesions are very benign, but there is focal peritonitis around this lesion, which is unexpected. This could be due to trauma, less likely infection, etc., and typically these are an incidental finding. However, given the surrounding peritonitis and the possibility that this contributing to inflammation in the abdomen/bowel, it could be more relevant. These can be drained for fluid analysis and cytology and to help with patient comfort, but if there is a connection with the renal pelvis, they typically fill up rapidly and can leak somewhat. Options moving forward would include:

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- Abdominal contrast CT scan to help delineate where the renal connection is and if there is any concern about removal or drainage of this lesion.

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- You could consider drainage of this lesion with a very small gauge needle. If this done, I typically recommend you pass through a small amount of cortex prior to going into the cyst to help act as a cork and prevent fluid backflow. I do not see an obvious window where this would be possible in the images submitted.

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- The most conservative option is continued monitoring with ultrasound, urinalysis and culture if no intervention is desired.

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Additionally, the small intestine appears subjectively thickened. This could be an indicator of small intestinal disease. Again, it is difficult to determine if the vomiting and upset stomach could be secondary to the focal peritonitis, or if it is a primary gastrointestinal issue. You could consider a qualitative PLI, TLI, cobalamin and folate to Texas A&M to get more information about the pancreas and small intestine. You could consider a novel protein/hydrolyzed protein prescription diet, probiotic therapy, and other general treatment for gastroenteritis/colitis. If symptoms persist, recommend obtaining GI biopsies. If surgery is pursued for the renal cyst, you could consider obtaining GI biopsies at the same time.

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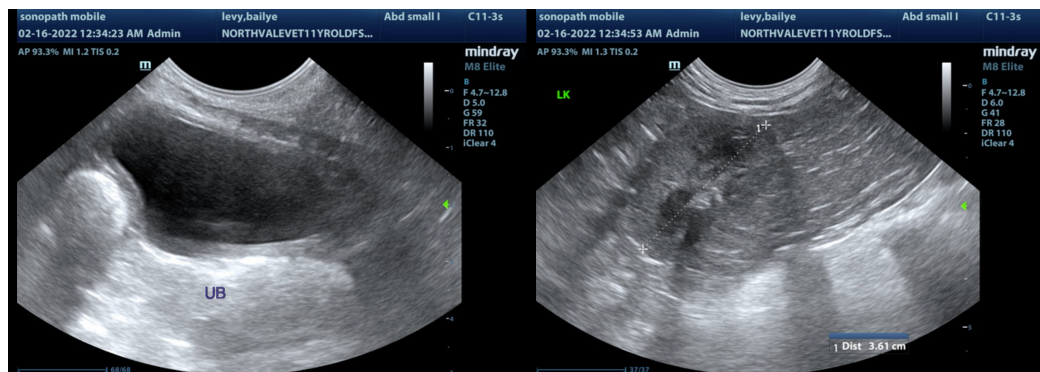
Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

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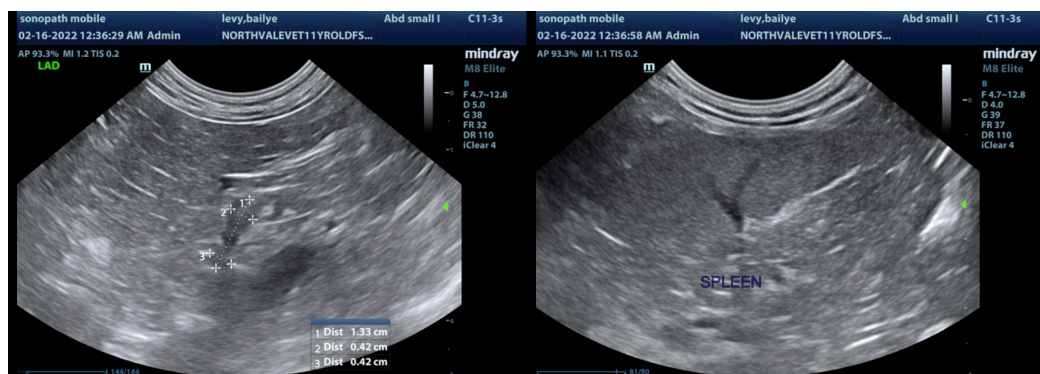
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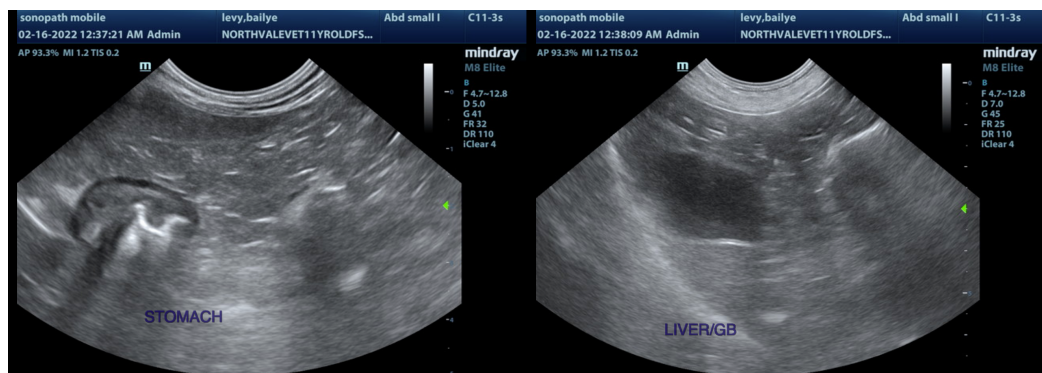
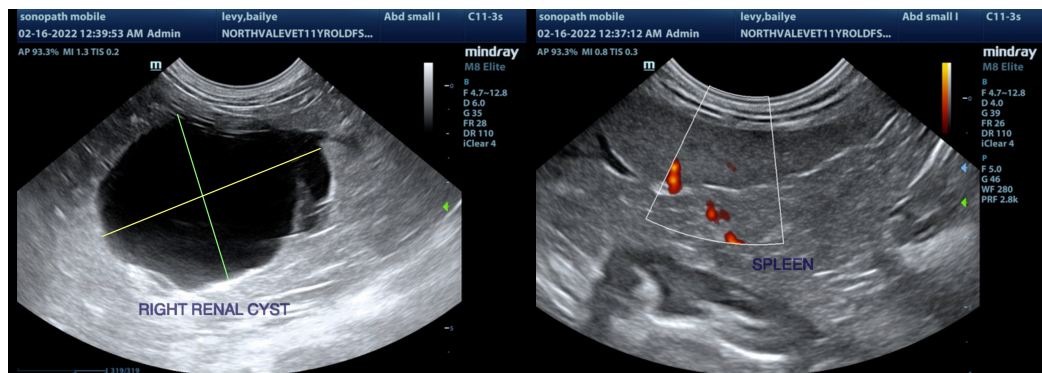
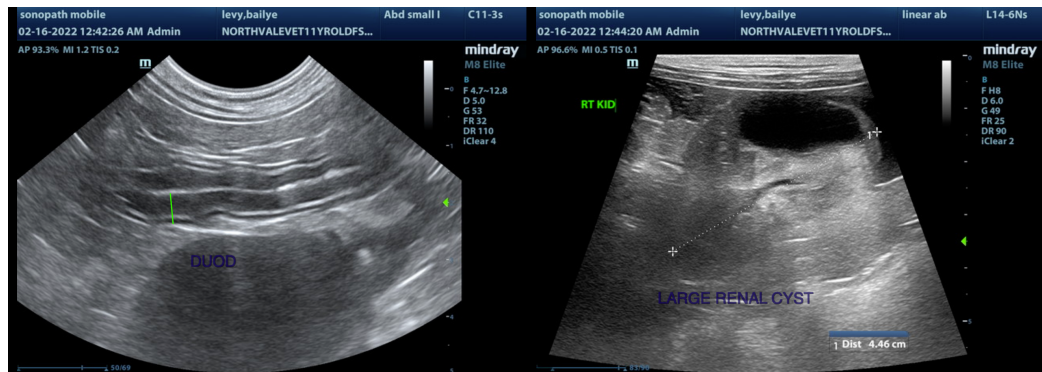
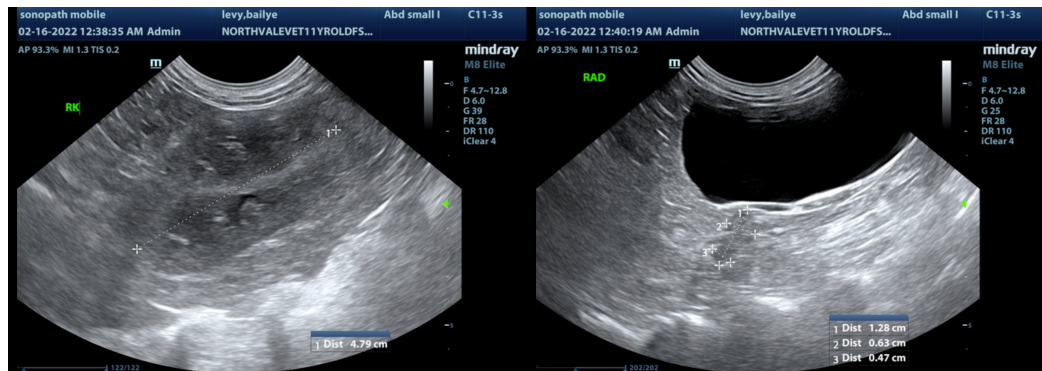
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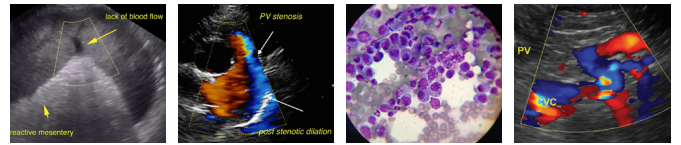
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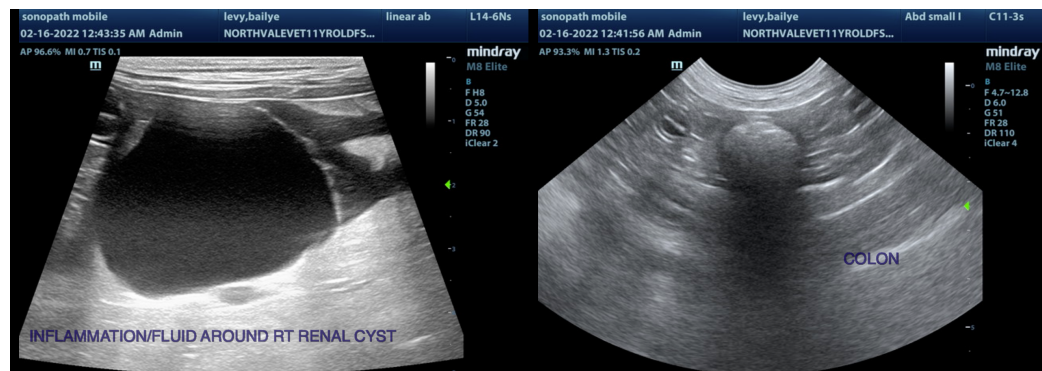
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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