

DATE PRESENTING CLINICAL SIGNS

2/18/22

PATIENT

Monster Usselman

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2017

WEIGHT

11 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Animal Emergency
Hospital

REFERRING VET

Dr. Kalwa

INVOICE

35760

History: Date: 02-17-2022 Notes: Monster is a 5 y/o FS DSH who was referred for worsening azotemia - had a bladder infection and was on antibiotics - then broke with diarrhea and a probiotic was started - started vomiting on the 14-15th, had AXR, and started on cerenia - continued to have diarrhea, no longer vomiting - decreased appetite, did not want to eat yesterday, typically very food motivated - kidney values elevated much higher than previous - Diagnosed with kidney disease for the past 1.5 years, has been well managed the last 6 months - on a prescription kidney diet - no known FB or toxin ingestion - indoor with supervised outdoor Medications: - Cerenia - Revolution - Probiotic

Assesment: Azotemia. Known CKD. Acute worsening after vomiting and diarrhea. BUN = 59, Creat = 6.0. 2/17/22 at RDVM

UA: USG 1.022, inactive sediment

Current Medications: Oral Buprenorphine 0.3mg/ml 0.34, Gabapentin Capsules 100mg 1, Ondansetron 2mg/mL Injection (Per mL) 0.75, Oral Buprenorphine 0.3mg/ml 0.34, Gabapentin Capsules 100mg 1, Gabapentin Tablets 50mg 1, Pantoprazole (Protonix) 40mg/vial Injection (Per mL) 1.2, Ondansetron 2mg/mL Injection (Per mL) 0.75, Gabapentin Tablets 25mg 1, and Oral Buprenorphine 0.3mg/ml.

Lab Results: Attached.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: IV sedative.

Stat Report: Not requested.

LIMITED ULTRASONOGRAPHIC EXAMINATION

Urinary System

The urinary bladder is significantly 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 is small, measuring 2.78 cm in length. It is somewhat irregular in shape and has decreased corticomedullary distinction with hypoechoic cortices and pyelectasia at 0.25 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 is normal in size, measuring 4.23 cm in length. It is somewhat irregular in shape and has decreased corticomedullary distinction with hypoechoic cortices and pyelectasia at 0.49 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.

ULTRASONOGRAPHIC FINDINGS

- Small left kidney and bilateral pyelectasia with decreased corticomedullary distinction and hyperechoic cortices in both kidneys - Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the left/right kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

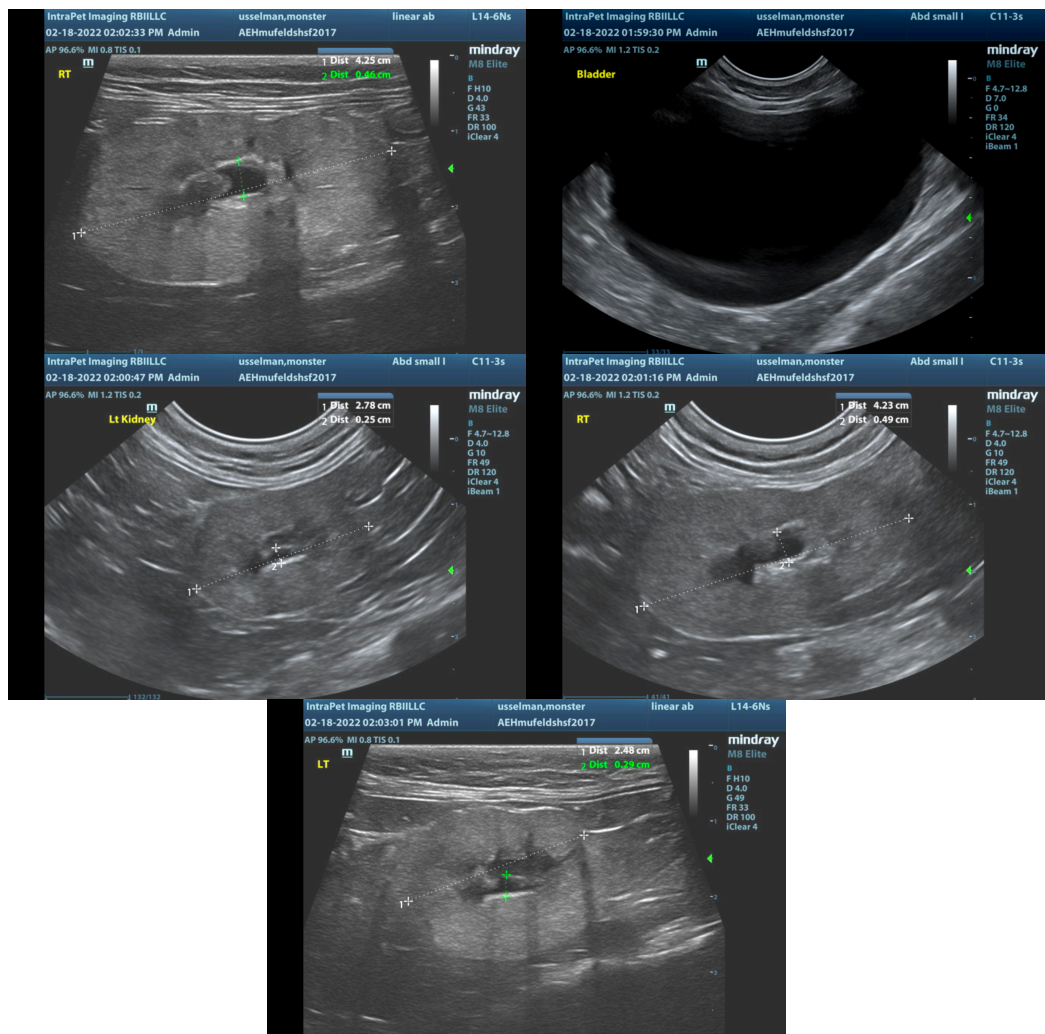
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are observed in the urinary tract such as a mass, obstruction or stones. The left kidney is small, which is either consistent with congenital agenesis or scarring after an inflammatory event. The right kidney appears somewhat hypertrophied and large to normal in size. There are parenchymal changes consistent with chronic renal disease, and bilateral pyelectasia, which could be an indicator of previous pyelonephritis or current pyelonephritis.

Based on the history provided, I would suspect there is chronic renal disease present, possibly with a component of congenital renal dysplasia and an acute on chronic crisis exacerbating this, based on the recent episodes of gastrointestinal signs. If not already done, consider:

- Blood pressure evaluation
- Urinalysis and culture
- Urine protein/creatinine ratio

If the patient is stable enough to continue long-term treatment, you can see improvement over more protracted periods of time in these cases.



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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