

**DATE PRESENTING CLINICAL SIGNS**

3/30/22

BP 130 mmHg. Elevated renal values, Phosphorus, calcium, TP, and globulins, elevated cholesterol, SP GRAVITY 1.017; PH 5.0; PROTEIN 2+

PATIENT

Trinity Young

WBC UAM 6-10 HPF 0 - 5, RBC UAM 50-75 HPF, BACTERIA NONE SEEN, EPI CELL 2+ (3-5)/HPF, RAFTS OF EPITHELIAL CELLS PRESENT

SPECIES

Canine

OCC HYALINE (0-1)/LPF, elevated ALP (433)-but lowest it has been in yrs. (was very elevated when first started seeing pet and was on phenobarbital and got as high as 3,418 in 2019), recent UTI (E. coli) and flare-up of pancreatitis (spec cpl continues to be persistently elevated 415). History of proteinuria prior was w/o azotemia, UPC in July was 2.7 (has been as elevated as 4 in past) but recent UTI precluded UPC evaluation. Hx of seizures, on KBr, Hx of hypertension, Hx of elevated triglycerides, Hx pancreatitis, Hx arthritis, have not performed ionized Ca yet.

BREED

Sheltie

Current Medications: KBR 500 mg PO q 24 hours since 2019, RC GI Low fat diet since 2020, Enalapril 7.5 mg PO BID since 2019, Amlodipine 2.5 mg PO q 24 hours since 2020, Dasuquin. Recent completion of Baytril 10 mg/kg q 24 hours X 14 days (no significant change in SDMA, BUN;

SEX

Spayed Female

creatinine decreased from 2.0 to 1.7; P increased from 5.5 to 6.3; Ca decreased from 12.6 to 12) Cerenia, gabapentin, Provable were also given at that time

Date of Previous IntraPet Ultrasound: 7/25/2018. See attached.

Sedation: Patient sedated with Torbugesic.

Stat Report: Not requested.

AGE

5/1/11

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**WEIGHT**

45.6 Pounds

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.

INTERPRETED BY

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

The left kidney is normal in size (4.75 cm) with small non-obstructive nephroliths. It is irregular in shape. Overall echogenicity is slightly hyperechoic with poor 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 hydronephrosis. Renal vasculature is normal.

IMAGING PERFORMED BY

Andi Parkinson RDMS

The right kidney is normal in size (4.93 cm) with pinpoint non-obstructive nephroliths. It is irregular in shape. Overall echogenicity is slightly hyperechoic with poor 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 hydronephrosis. Renal vasculature is normal.

HOSPITAL NAME

Frederick Road VH

Adrenal Glands

The left adrenal gland is normal in size measuring 0.72 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.

REFERRING VET

Dr. Beyer

The right adrenal gland is normal in size measuring 0.80 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.

INVOICE

36592

Spleen

The spleen is subjectively normal in size and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. Rare discrete focal hyperechoic, perivascular parenchymal abnormalities are present. The appearance of these lesions is most consistent with benign splenic myelolipomas. The blood flow through the hilus and splenic parenchyma appears normal.

Liver

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

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a mild amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering 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 prominent and hypoechoic as compared to the surrounding isoechoic 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 cystic lesion in the caudal abdomen most consistent with a cystic lymph node measuring 2.2 cm x 3.1 cm and 0.15 cm x 0.11 cm. The omentum is generally of normal echogenicity.

PRIMARY FINDINGS

- Decreased corticomedullary distinction in both kidneys with small nephroliths – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

SECONDARY FINDINGS

- Moderate gallbladder debris – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

- Moderate shadowing ingesta within the gastric lumen – Findings are most consistent with food. Correlate with feeding history. If the patient was fasted, consider such differentials as delayed gastric emptying or partial pyloric outflow tract obstruction (none observed).
- Cystic structures in the caudal abdomen – These are most consistent with cystic lymph nodes. Recommend continued monitoring.

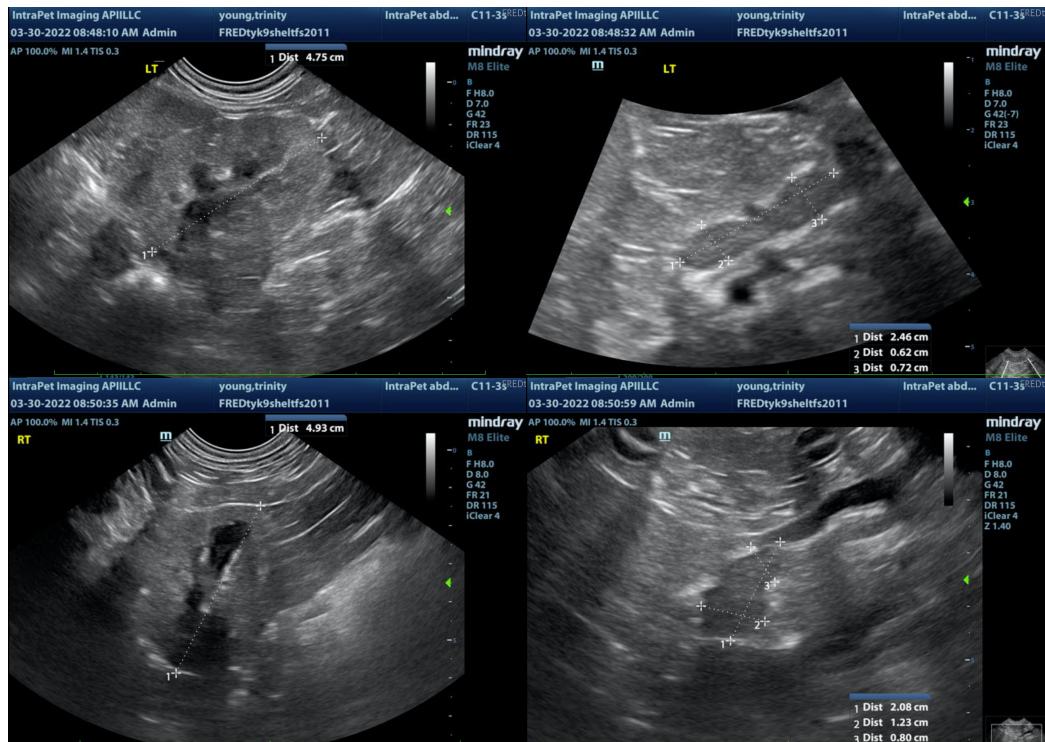
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

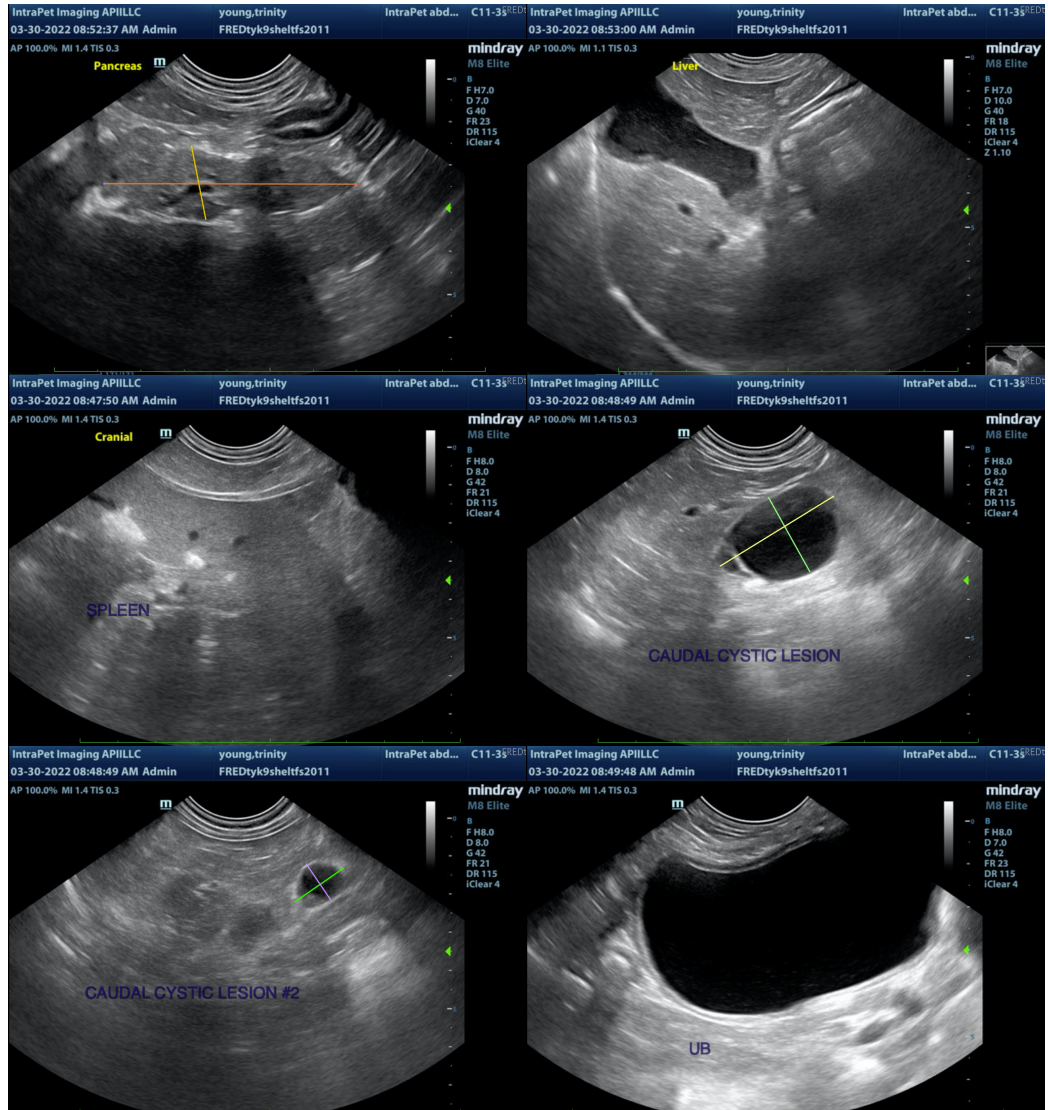
The changes observed in the kidneys are most consistent with chronic progressive disease, and these findings correlate with the history provided of azotemia, proteinuria, hypertension, and urinary tract infections. Recommend continued monitoring for these issues.

There are no focal lesions associated with the liver. The parenchyma is somewhat heterogeneous, and the adrenal glands are normal/borderline enlarged in size. If signs consistent with Cushing's disease are present, you could consider adrenal function testing.

The pancreas is prominent and hypoechoic to the surrounding hyperechoic mesentery. These findings are most consistent with either mild chronic pancreatitis or a previous episode of pancreatitis.

There are at least two small cystic lesions observed in the caudal abdomen. I suspect these are cystic lymph nodes, and hopefully are benign/incidental. Continued monitoring is warranted.





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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