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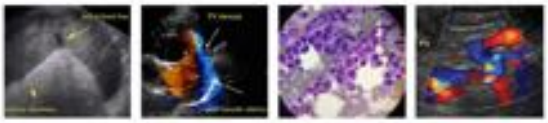


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8348

PATIENT

Lulu Lizotte

SPECIES

Canine

BREED

Lab Ret

SEX

Spayed Female

AGE

2/27/2017

WEIGHT

26.14kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Dr. Carrie Vet Calls

REFERRING VET

Dr. Carrie McCraw

INVOICE

10199

DATE

4/19/2023

PRESENTING CLINICAL SIGNS

Bilateral CCL tears, surgical repair of L-hind. Intermittent vomiting/diarrhea, resolved with food switch to Royal Canin HP. Prior bee stings- develops hives, mild ataxia, vomiting- responsive to Benadryl/Dex SP. Recessed vulva. Main complaint is the stumbling/wobbly episode.

Abnormal PE/Chem/CBC/UA Results: 2/20/23- Chem: BUN 22, Cr 1.2, SDMA 12. UA: USG 1.036, WBC 6-10, RBC 0-2, moderate rods. *This was an asymptomatic UTI, routine BW/UA monitoring at annual wellness exam.RX: Amoxicillin 500 mg/125 mg clavulanic acid: 1 tablet PO q 12 hours x 5 days.3/15/23- Off Galliprant x 2 weeks, limping again, will RX: Gabapentin 300 mg PO q 12 hours as needed for pain (not to give w/ Trazodone)- only gave for a few days, hold R-HL up to urinate, otherwise no limping. UA: USG-1.024, WBC 0-2, RBC 0-2, no bacteria seen. *This sample was taken 5 days after finishing Clavamox. 4/15/23- ER visit- had been outside at 8 pm, woke up at 3 pm, moved off couch was staring, swaying, stumbled, almost face planted wouldn't move, laid down, gave Trazodone, slept, didn't get up for breakfast at 8 am, still swaying but not as intense, seemed foggy, ate a little, eyes runny. DX: CBC- WBC 5.79 (6-17). Chem: BUN 25.2, Cr 1.1, NA 153 (141-152). UA: RBC/WBC many, long rods seen. Urine drug test: wnl. TX: Baytril 136 mg: 2 PO q 24 x 10 days. Was back to normal within 24 hours.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is large. The urinary bladder wall is slightly irregular and of normal thickness (0.24 cm). 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 measuring 6.94 cm with mild pyelectasia at 0.17 cm. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

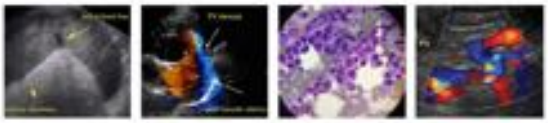
The right kidney is small measuring 2.54 cm with irregular margins and very abnormal/absent normal architecture. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.68 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 0.55 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



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

Gastrointestinal

The stomach contains large fluid and ingesta. 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

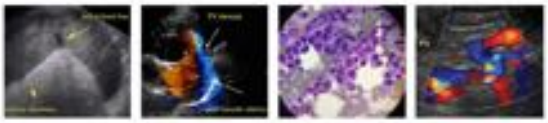
The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are visible/slightly prominent mesenteric lymph nodes. The left sub-lumbar lymph node measures 0.97 cm, the right measures 0.8 cm in width, and the mesenteric lymph nodes measure 0.48 cm and 0.52 cm. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Distended urinary bladder with prominent mildly irregular wall. Findings could be consistent with chronic inflammation or cystitis.
- Trace renal pyelectasia of the left kidney. This is likely secondary to PUPD.
- Large, shadowing ingesta and fluid within the gastric lumen. Findings are most consistent with a non-fasted patient.



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- Small sclerotic right kidney. This is likely secondary to previous injury/insult (infectious, toxic, congenital, etc.)
- Prominent mesenteric lymph nodes. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No distinct lesion is visualized to explain the recurrent urinary tract infections described. This problem can be very frustrating and in a young dog over time these infections can become very resistant and become much more serious. Ideally, I would recommend a cystoscopy combined with a contrast CT scan looking for any anatomic abnormalities, which could be corrected including the ureters, vaginal vault, etc. and to plan for long-term management can be devised. If this is not possible then consider cystoscopy and if the vulva is juvenile and hooded, consider a vulvoplasty. For general management consider:

- Cranberry supplement if E. coli infections are common.
- Chronic probiotic therapy. This medication needs to be spaced from antibiotics by at least an hour.
- Hygienic wipes for after urination
- Frequent walks
- Frequent cultures and treatment based on active cystitis and C/S results.

A cause for the stumbling and mentation changes is not observed. Consider the possibility of medication reaction, toxin ingestion, a vascular accident (stroke), vestibular episode, hypotension, atypical seizure activity, etc. If this happens again, I recommend videoing the episode and consider consultation with the veterinary neurologist provided patient's blood sugar is normal, etc.

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)

kathleen.sennello@sonopath.com