



**PATIENT**

Charlie Trulby

**SPECIES**

Canine

**BREED**

Brittany Spaniel

**SEX**

Neutered Male

**AGE**

12 Years

**WEIGHT**

49 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Kelly Vazquez

**HOSPITAL NAME**

New Bridge VP

**REFERRING VET**

Dr. Abina Glennon

**INVOICE**

47086

**DATE**

5/3/23

**PRESENTING CLINICAL SIGNS**

Patient presents for renal disease. Current meds: Enalapril, IVFs, and Unasyn.

Abnormal PE/Chem/CBC/UA Results: BUN 101, SDMA 24, Creat, 5.9.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately distended with anechoic urine. The Bladder wall largely appears normal in thickness with a smooth mucosal surface. There is a focal irregularity visualized in the dorsal trigone region in the area of the ureteral papillae, where there is an irregular mash effect measuring 2.41 cm x 0.75 cm. No evidence of a ureteral obstruction is visualized.

The prostate is normal in size (1.14 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (5.81 cm) with a small cortical cyst at 0.61 cm. Overall echogenicity is slightly hyperechoic with poor 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.

The right kidney is somewhat irregular in shape and measures 5.25 cm with mild pyelectasia at 0.25 cm. Overall echogenicity is slightly hyperechoic with poor 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.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.61 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

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



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**Gastrointestinal**

The stomach contains shadowing 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 moderate 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 area of 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, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

**PRIMARY FINDINGS**

- Focal mass effect visualized in the dorsal aspect of the trigone of the urinary bladder – Possible differentials include transitional cell carcinoma, a polyp, other.
- Decreased corticomedullary distinction in both kidneys with mild right-sided pyelectasia – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the kidney(s) could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- 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**

- Shadowing ingesta visualized within the gastric lumen – Findings are most consistent with a non-fasted patient.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Both kidneys have decreased corticomedullary distinction, but no focal lesions such as discrete mass effects or calculi. Additionally, there is no significant dilation of the ureters at this time. The azotemia reported is likely due to primary renal disease. Unfortunately, there is also a mass effect visualized in the trigone region of the urinary bladder. This could represent a benign or neoplastic lesion.



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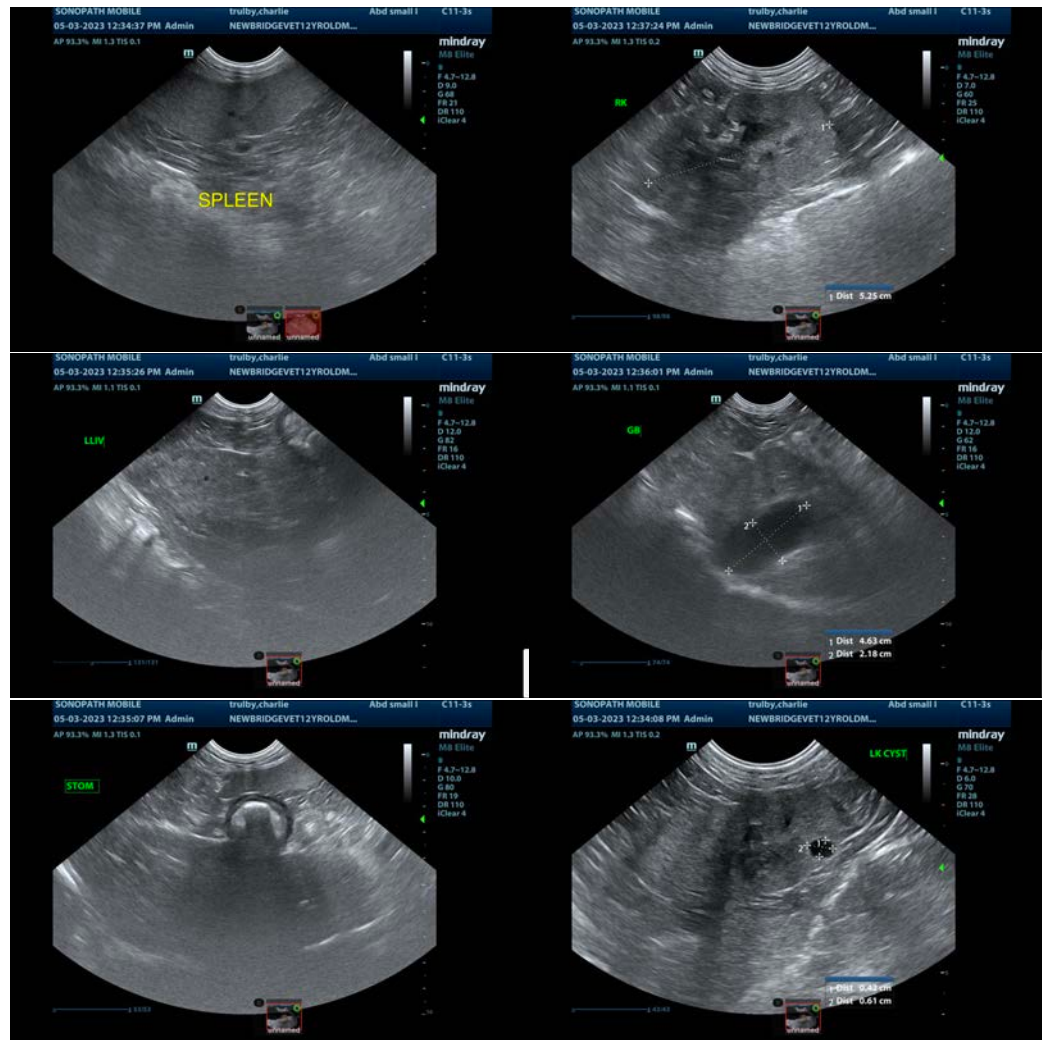
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Recommend urinalysis and culture. If a urinary tract infection is present, this could be an inflammatory polyp. Unfortunately, this is in the region of the ureters, although no evidence of ureteral obstruction is visible at this time. Options moving forward would include a traumatic catheterization if no urinary tract infection is present, or possibly a cystoscopic biopsy. Unfortunately, I do not suspect the azotemia is associated with this lesion, as there is no evidence of an obstruction at this time.

Consider diuresis for the azotemia reported as well as screening for Leptospirosis, urine cultures for pyelonephritis, and a blood pressure evaluation. Evaluate the history for any exposure to toxins or medications that could be potentially nephrotoxic. Additionally, consider a urine protein to creatinine ratio, looking for excessive protein loss.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.





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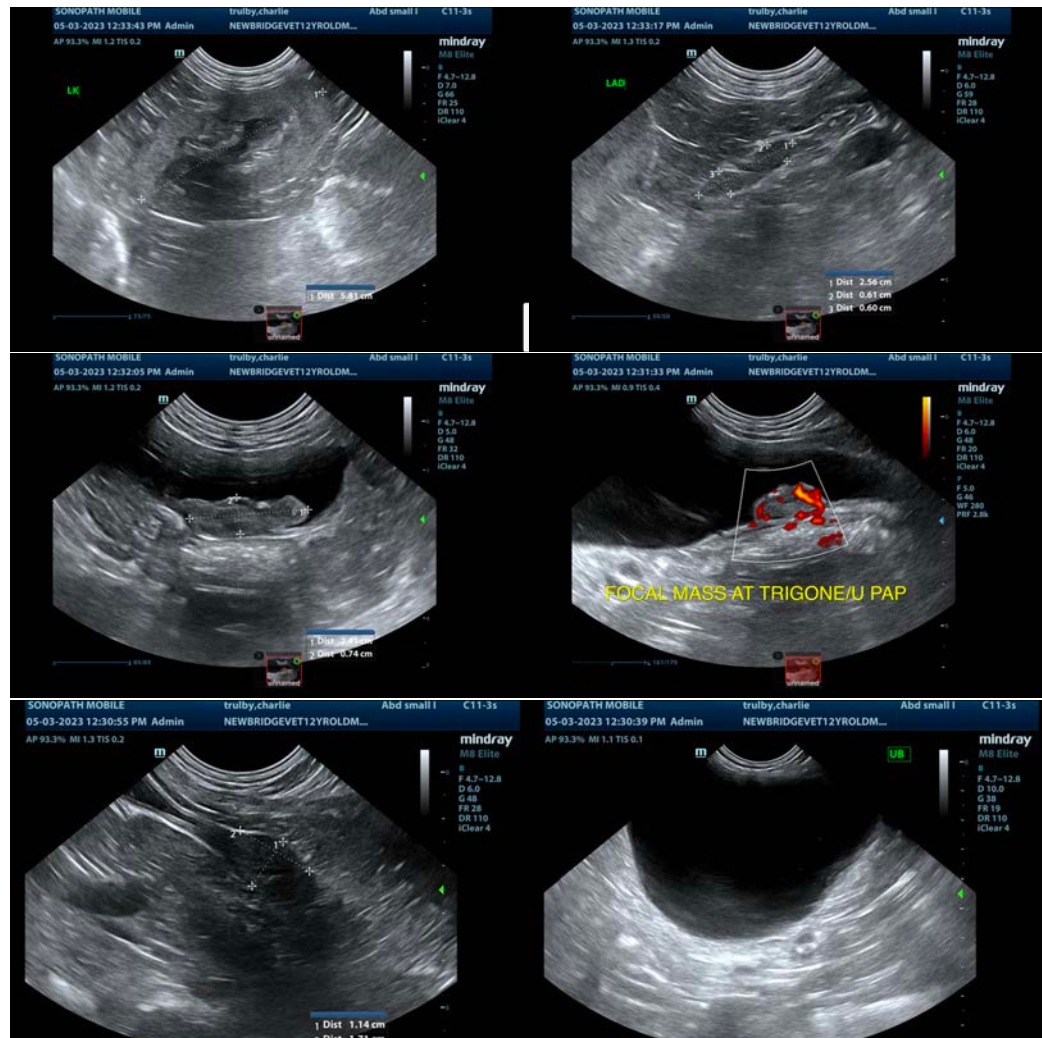
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com