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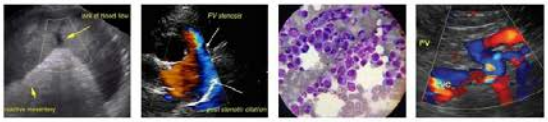

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Shaider Bristol

SPECIES

Canine

BREED

JRT

SEX

Neutered Male

AGE

10 Years

WEIGHT

14.3 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView AH

REFERRING VET

Dr. Pablo Mendoza

INVOICE

38629

DATE

6/10/22

PRESENTING CLINICAL SIGNS

PAWS Request Form: Chief Concern / Provisional Diagnosis: ~Recheck ABd U/S from Sept 2021. Previously noted: • Cystic calculi (2) with minor ventral apical cystitis pattern • Bilateral mild chronic renal changes with non-obstructive right kidney medullary mineralization/renolithiasis • Potential mild subnormal liver with mild gallbladder debris ~ Relevant Medical History and Physical Exam findings: ~Patient was diagnosed with cystic calculi and mild renal mineralization on Sept 2021. Elevated bile acids were noted in bloodwork and P was started on U/D diet. Currently doing well at home. Hematuria resolved and no crystaluria noted on most recent exam. Recommended U/S to recheck calculi ~ Recent Diagnostics: Relevant Labratory Results / Abnormalities: ~ 5/19/22 UA: No hematuria No crystaluria Suspected cocci due to contamination of sample~
Abnormal PE/Chem/CBC/UA Results: Bile Acids were sltly elevated- LABS attached- RADs attached and prev AUS report attached

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to 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, or masses. There are two moderate sized shadowing calculi visualized in the dependent portion of the urinary bladder. One measures at 1.3 cm and one at 0.73 cm. Findings are most consistent with cystic calculi.

The prostate is normal in size (0.85 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 (3.62 cm) with a 0.21 cm non-obstructive nephrolith. 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.15 cm) with pinpoint non-obstructive nephroliths measuring 0.19, 0.26, 0.27 cm. 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.51 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 0.68 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.

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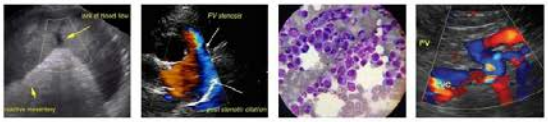

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Spleen

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 normal/borderline small in size, hypoechoic with hyperechoic foci and prominent portal markings.

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, but there are two hyperechoic soft shadowing structures within the lumen measuring 0.92 cm and 0.56 cm, consistent with gallbladder stones. The proximal bile duct is mildly dilated and measures at 0.40 cm. It is not visualized more distally.

Gastrointestinal

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.

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, 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.

Other

A small linear mineralization measuring approximately 0.49 cm in length is visualized at the base of the os penis, most consistent with a urethral calculus or mineralization in the distal urethra.

ULTRASONOGRAPHIC FINDINGS

- Focal shadowing mineralizations within the urinary bladder – most consistent with bladder stones. These are clearly evident on radiographs.

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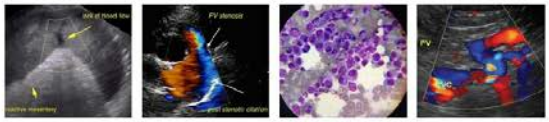

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- Decreased corticomedullary distinction in both kidneys with non-obstructive nephroliths – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. The hyperechoic mineralized foci observed at the corticomedullary junction of the left/right kidney are consistent with small, non-obstructive nephroliths.
- Borderline small, hypoechoic liver with pinpoint hyperechoic foci – While not clearly visualized, there is possible concern for some vascular pathology (microvascular dysplasia, small portosystemic shunt, etc.). Recommend advanced imaging and repeat bile acids.
- Soft shadowing mineralizations evident within the gallbladder – consistent with gall stones (visualized on attached radiographs as well). There is no obvious obstructive disease present.
- Linear mineralization within the penile urethra – most consistent with a distal urethral calculus or mineralization of the wall of the urethra. If desired, retropulsion back into the urinary bladder could be attempted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The previously visualized stones are evident in the urinary bladder and kidneys. Additionally, ther are shadowing stones in the gallbladder and distal urethra. If attempts to dissolve these stones have been made, then they're likely unsuccessful and a cystotomy should be considered if the patient is clinical. Recommend urine culture based on the suspected bacteria seen on urinalysis. It is unlikely that the urinary tract will be cleared permanently in a patient that has indwelling bladder stones. If so, cystotomy should be considered.

The liver appears somewhat abnormal. Consider repeating bile acids and consider a contrast CT scan to look for abnormal shunting vessel. Additionally, a liver biopsy could be performed to look for evidence of microvascular dysplasia, inflammation, etc. At this time, the gall stones do not appear to be causing a significant problem, although there is mild dilation of the bile duct. If cholecystitis is suspected based on lab results, then a course of antibiotics and Ursodiol therapy could be considered.

There is a shadowing mineralization visualized at the base of the os penis. This likely represents a distal urethral calculus or mineralization of the urethral wall. If desired (particularly if a cystotomy is performed) you could pass a urinary catheter and try to retropulse this structure back into the urinary bladder (if it is a urethral calculus).

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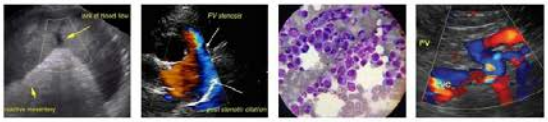

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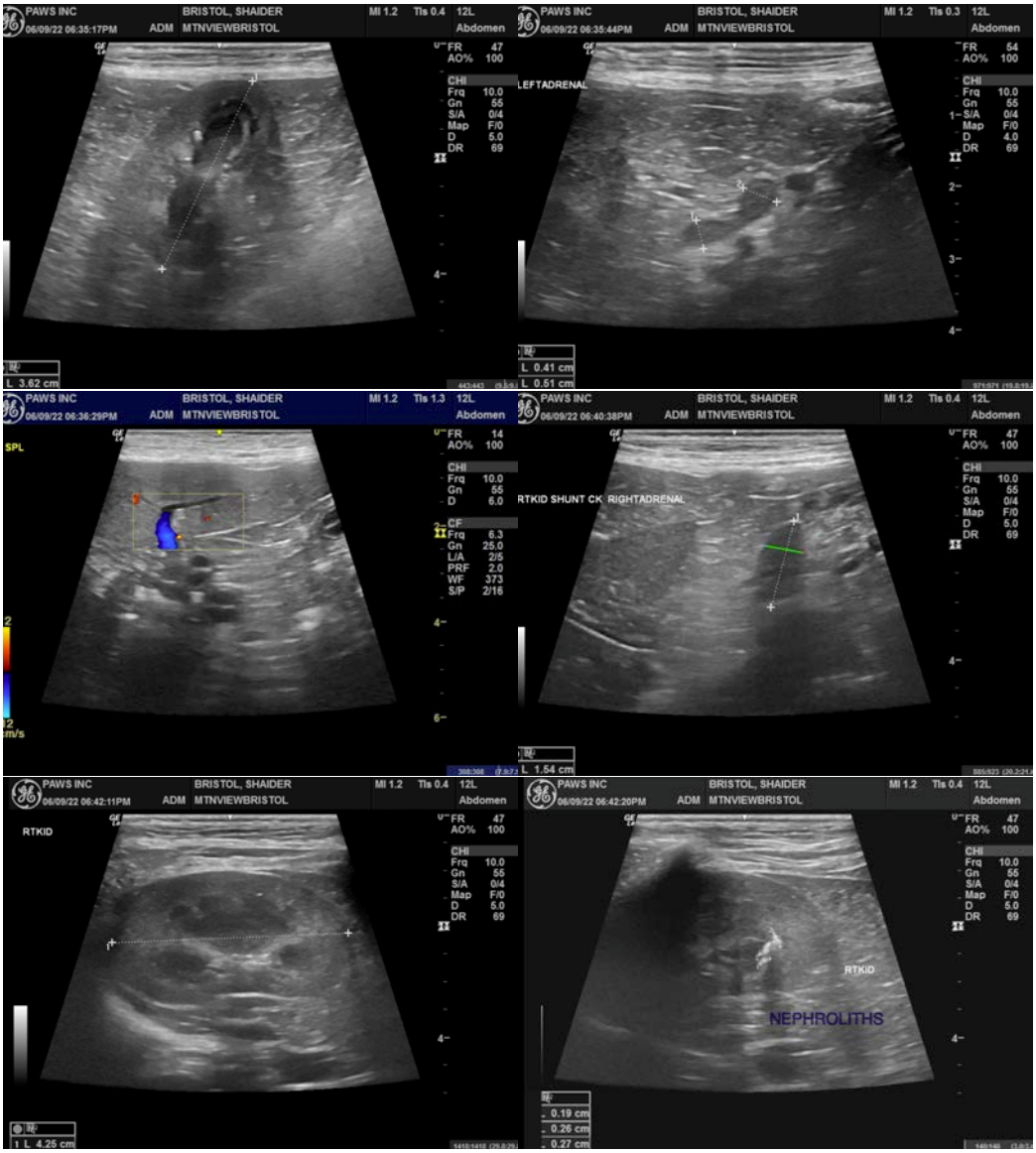

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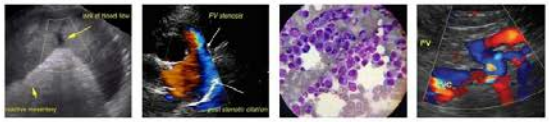

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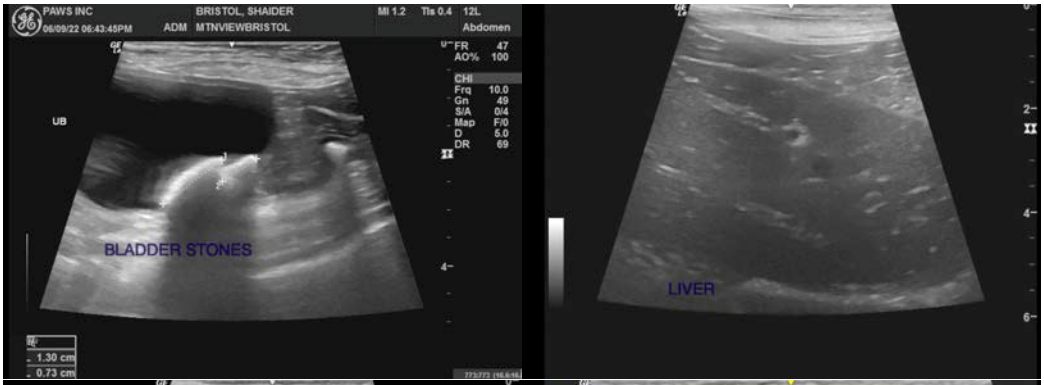

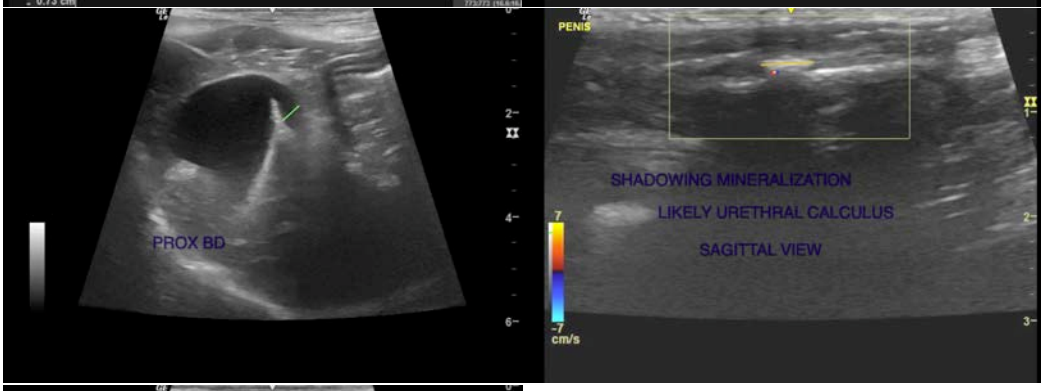

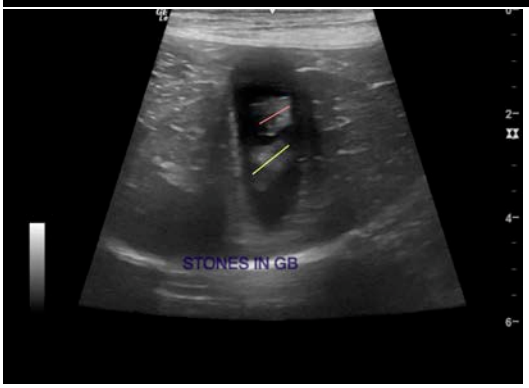

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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