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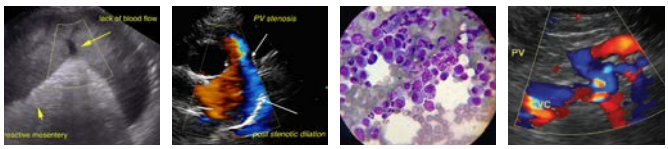


PATIENT

Tyson Quaglietta

SPECIES

Canine

BREED

Hound X

SEX

Neutered Male

AGE

11 Years

WEIGHT

56.7 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Cresskill AH

REFERRING VET

Dr. Joe Khodari

INVOICE

38755

DATE

6/15/22

PRESENTING CLINICAL SIGNS

Vomiting and sometimes regurgitates. Better on Sucralfate and omeprazole, but can't wean off or symptoms return. Muscle wasting, prominent spine, and progressive weight loss. Current meds: Sucralfate, omeprazole, +/- cerenia.
Abnormal PE/Chem/CBC/UA Results: SDMA 18, creat. 1.5, BUN 39. U/A: WNL, no proteinuria, USG: 1.023.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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.

The prostate is normal in size (1.16 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 is large and irregular in shape, measuring approximately 7.69 cm x 4.72 cm. It has very abnormal architecture and numerous cystic regions. It is hypoechoic and has no corticomedullary distinction, with some cystic areas that could represent renal cysts or asymmetrical pyelectasia. Findings are most consistent with a left renal mass. Recommend fine needle aspirate.

The right kidney has a normal shape and size (5.71 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.89 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 0.84 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.

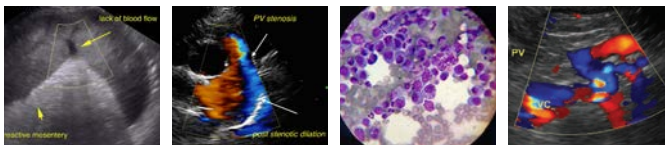
Spleen

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 primarily anechoic. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach is dilated with a large amount of 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 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.

ULTRASONOGRAPHIC FINDINGS

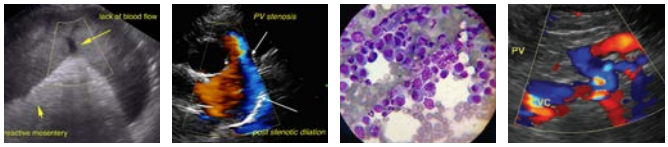
- Large, irregular left kidney with abnormal architecture – findings are suggestive of a left renal mass, although a very dysplastic kidney could be considered. Recommend a fine needle aspirate.
- Large shadowing material within the gastric lumen – Moderate amount of shadowing material in gastric lumen - Correlate with feedings history and abdominal radiographs. If adequately fasted then consider such differentials as delayed gastric emptying or a partial outflow tract obstruction (none visualized).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left kidney is very abnormal and large with irregular architecture and some cystic regions. This could be consistent with a primary renal mass, or less likely a severely dysplastic kidney. Consider a fine needle aspirate.

It is somewhat difficult to link the abnormal kidney with the history of vomiting and regurgitation. Typical workup for regurgitation would include 3-view thoracic radiographs to look for evidence of megaesophagus with a barium swallow additionally to look for evidence of an obvious mass lesion, stricture, etc. If there is concern for an intraluminal lesion, then either esophagoscopy or fluoro barium esophogram could be considered, as this would also assess motility.

Additionally, I typically screen these patients for megaesophagus, hypothyroidism, and Addison's disease. Esophagoscopy is also helpful for evaluating for esophagitis, a mass at the gastroesophageal sphincter, etc. There can be a paraneoplastic link between myasthenia gravis and other neoplasms, so the renal mass could be loosely associated with the symptoms described. If a fine needle aspirate confirms a mass lesion, then ideally consider a contrast CT scan for surgical planning and to better



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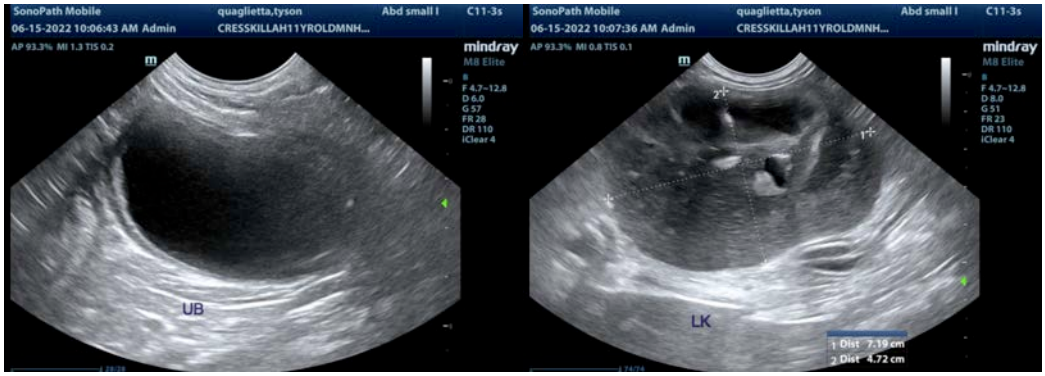
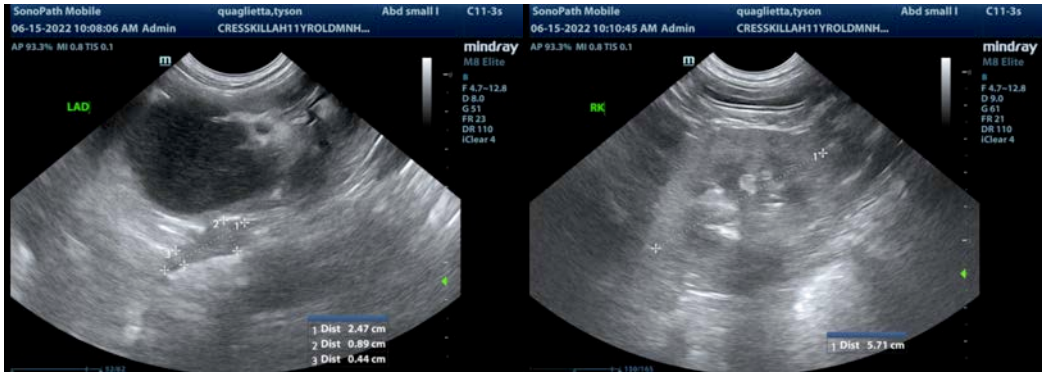
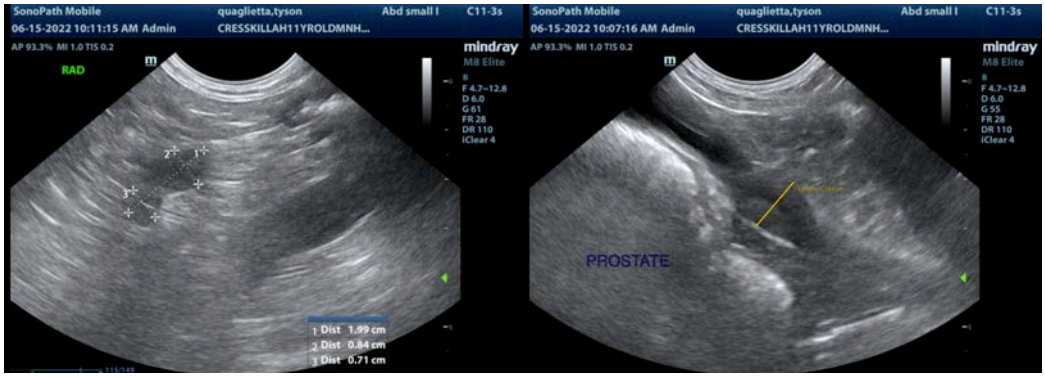
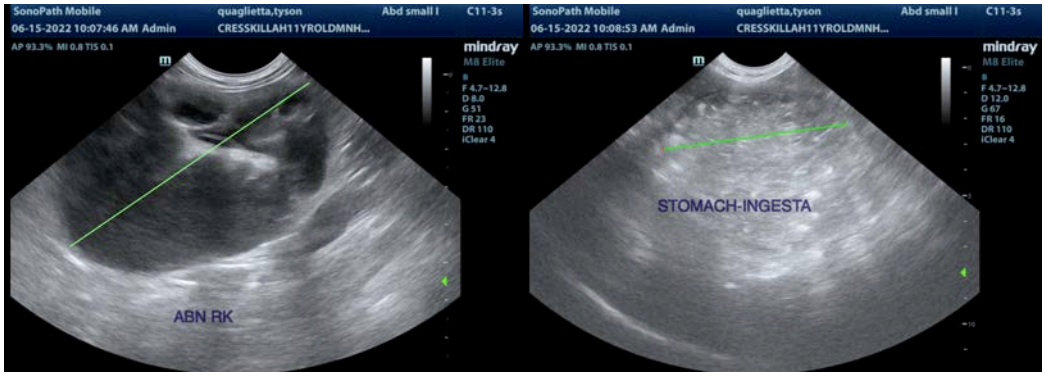
evaluate for any evidence of metastasis.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.









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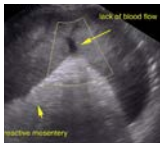
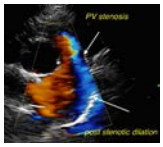
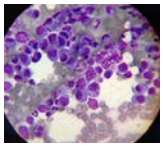
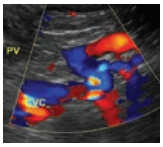

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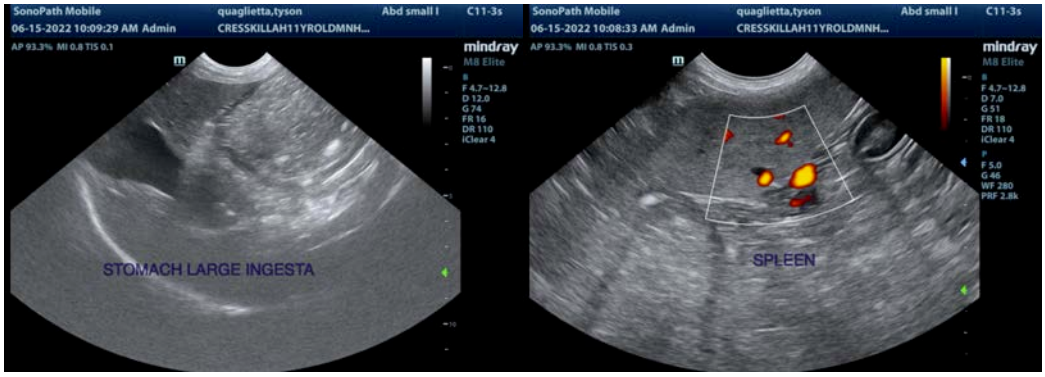

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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