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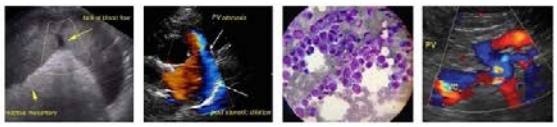

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Ollie Shuttle

SPECIES

Canine

BREED

Poodle X

SEX

Neutered Male

AGE

15 Years

WEIGHT

3.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Graham AH

REFERRING VET

Dr. Lukacs

INVOICE

38966

DATE

6/22/22

PRESENTING CLINICAL SIGNS

Main concerns: 1. Recheck echo: Heart murmur diagnosed 1 yr ago, echocardiogram at that time dx chronic valvular disease and mild pulmonary hypertension 2. Possible syncope like episode once 2 weeks ago 3. Right kidney cyst diagnosed 1 year ago; at that time bloodwork WNL; new azotemia 4. Inappetence and abdominal pain last week, has resolved; elevated pancreatic enzymes and CPL Examined 6/16/22: did not eat for last 2 days, seems better since then, loud borborygmi but no vomiting or diarrhea; for a few days owner noticed dog in a bowing position, seemed painful in abdomen. No coughing noted. Possible mild exercise intolerance. Owner noted a possible seizure like or syncope episode last week, lasted 30 seconds, suddenly off balance, wobbly, whining, did not completely lose consciousness. Pet quiet afterwards for few hours but back to normal. On Now kibble Diagnosed with a heart murmur 1 year ago (grade 3/6), echo results at that time: "There is evidence of moderate to severe tricuspid regurgitation with mild right ventricular and right atrial enlargement. anterior leaf let of the mitral valve is thick and irregular, but no regurgitation as noted. the tricuspid valve was thick in the wall portion but seems to be incomplete in the wall portion of it. The aortic and pulmonary valve appear normal and . There is no evidence of masses in the myocardium, the left aortic velocity and right pulmonary outflow velocities were within normal limits. there is normal systolic myocardial function. There is no evidence of pericardial effusion. LA to Ao ratio is normal value. (1.4). Echo DX Chronic valvular disease Cardiac function is still within normal limits. Suspected Pulmonary hypertension as part of the right side involvement." No medications given at that time. One year ago also diagnosed with suspected right kidney cyst, was thought to be an incidental finding at that time. Bloodwork unremarkable one year ago. At time of exam, patient seemed comfortable, no abdominal distension or pain noted, BAR, vitals WNL. Grade 3/6 heart murmur, PMI right side, femoral pulses strong/synchronous/even, mild jugular pulses noted. Palpable right kidney enlargement. Abnormal PE/Chem/CBC/UA Results: 6/16/22: CBC/biochemistry SDMA 22 (0 - 14 ug/dL) Creatinine 147 (44 - 133 umol/L) Urea (BUN) 22.9 (3.2 - 11.0 mmol/L) Amylase 1684 (337 - 1469 IU/L) Lipase 821 (0 - 250 IU/L) Spec cPL 700 (0 - 200 ug/L) HR114 RR 26 BP MAP 100

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is minimally distended, preventing full evaluation. No evidence of calculi observed. The prostate was not clearly seen.

The left kidney has a normal shape and size (3.35 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is large in size, measuring 5.89 cm (with the cyst). Without the cyst included, the kidney measures 3.73 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is a large cortical cyst visualized associated with the right kidney measuring 5.73 cm x 5.3 cm. This is coming off the periphery of the kidney, and there appears to still be ample renal parenchyma present. The cystic structure impairs visualization of many of the local anatomic structures. I do not see evidence of a ureteral obstruction. 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 0.50 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.

Visualization of the right adrenal gland was obscured by the large right renal cyst.

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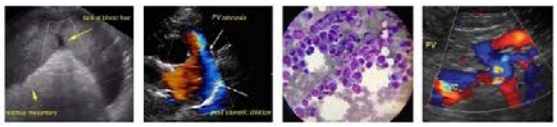

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Spleen

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 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 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.

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

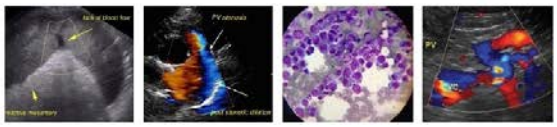
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys with a very large right renal cyst – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. There is a large cyst associated with the right kidney. There is no surrounding inflammation or echogenic debris inside of the cyst to suggest an abscess, etc. There appears to be ample renal tissue adjacent to the cystic region, and the renal pelvis is visible and does not appear obstructed.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan is relatively normal for a 15 year old aside from the cystic change associated with the right kidney. It is difficult to assess how much impact the kidney is having on renal function, but I am not



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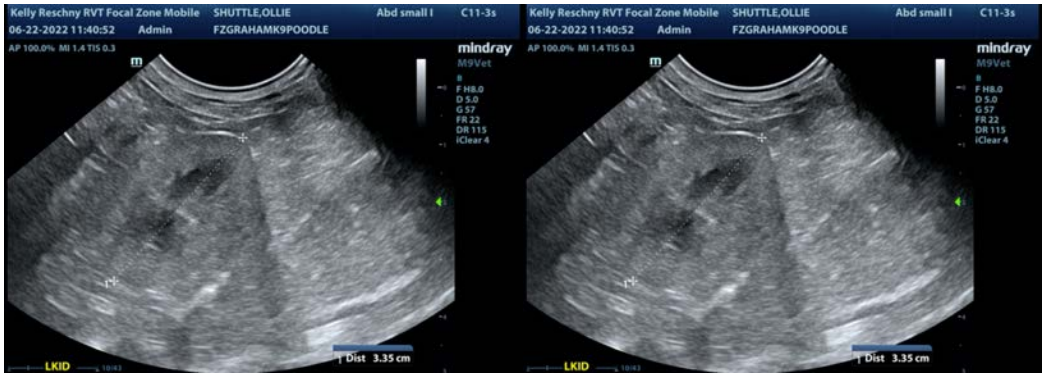
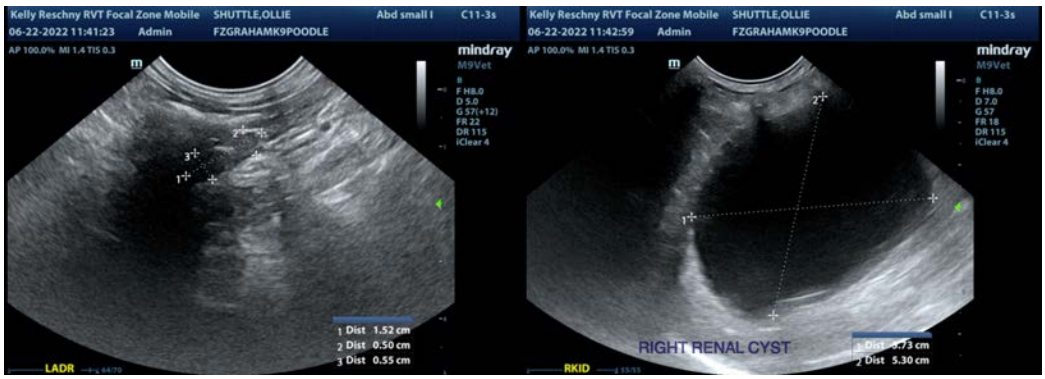
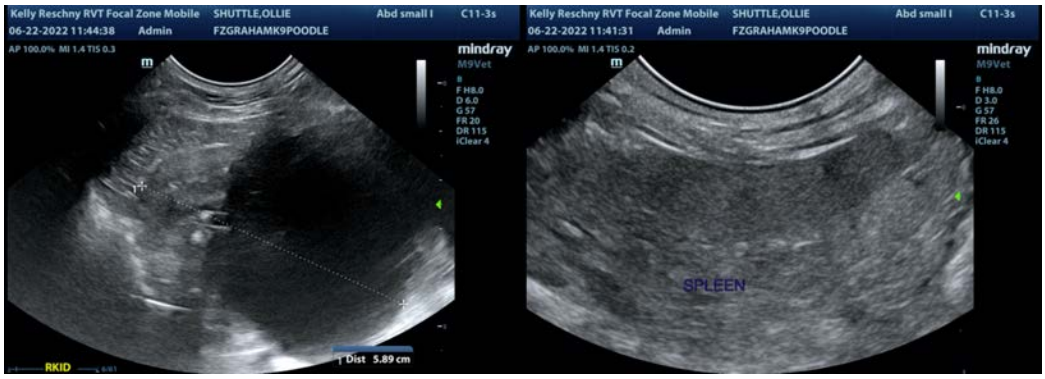
convinced it is a significant amount, as there does not appear to be an obstruction, and bilateral renal disease must be present for there to be azotemia. In people, hypertension is a very common sequela to renal cysts, so recommend blood pressure evaluation +/- urine protein to creatinine ratio and a urine culture.

If the patient seems uncomfortable associated with this cyst, you could consider percutaneous drainage. This has variable results, and often the cysts will refill relatively quickly. If drainage is attempted, it is recommended that you pass the needle through a small amount of renal parenchyma prior to entering the cyst, so as to provide a seal and prevent backflow of fluid out of the kidney/cyst. Additionally, a fine needle aspirate should not be performed if there is any uncontrolled hypertension.







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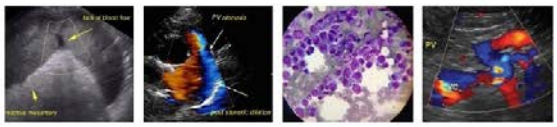

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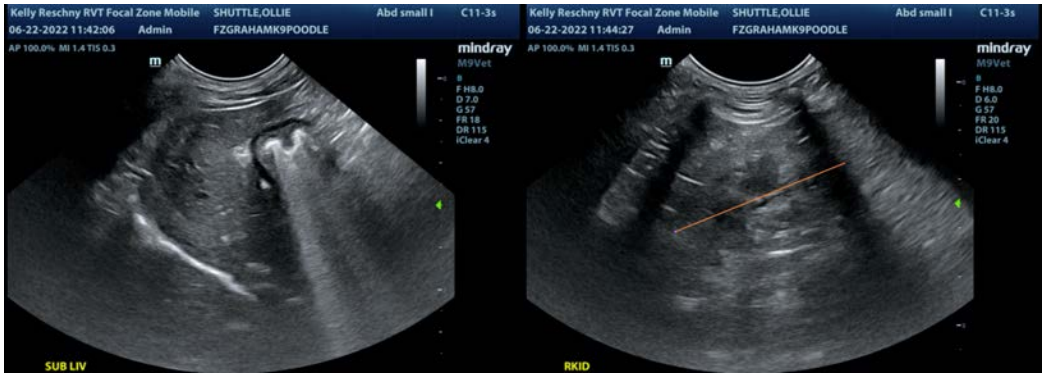

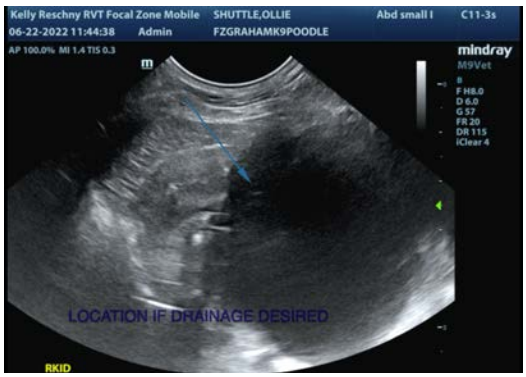

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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