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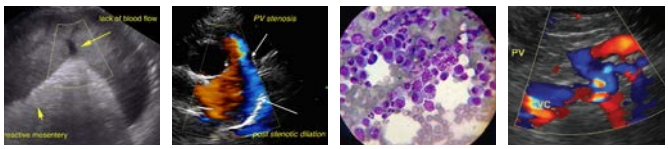

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PATIENT
Rusty Comes

SPECIES
Canine

BREED
Terrier X

SEX
Neutered Male

AGE
13 Years

WEIGHT
12 Pounds

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

IMAGING PERFORMED BY
Dr. Gudrun Gunther

HOSPITAL NAME
New Frontier AMC

REFERRING VET
Dr. Gudrun Gunther

INVOICE
39682

DATE
7/20/22

PRESENTING CLINICAL SIGNS

Was losing weight/hyporexia since owners moved to a new house but since owner has changed schedule and addressed patient stress/anxiety patient is back to his normal self, has regained his weight
History of hypothyroidism - well controlled by Thyroxine
Abnormal PE/Chem/CBC/UA Results: CKD - IRIS stage 2/4 otherwise CBC and rest of CHEM WNL

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 (0.95 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 (4.22 cm) with normal small cortical cysts. One is visualized measuring 0.37 cm. Mild pyelectasia is noted at 0.21 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.1 cm) with mild pyelectasia at 0.18 cm and numerous small cortical cysts, the most prominent of which measures 0.64 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 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 right adrenal gland is normal in size measuring 0.57 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 normal/borderline large 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 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.

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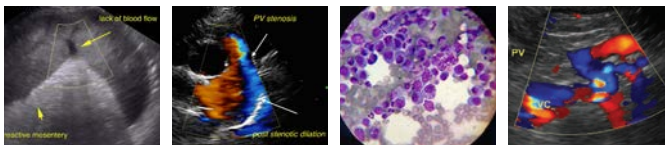

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Gastrointestinal

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. In some images, the pyloric wall appears somewhat prominent and mildly thickened, but wall layering appears intact.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measured 0.51 cm. Jejunum wall measured 0.35 cm. 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.

PRIMARY FINDINGS

- Decreased corticomedullary distinction in both kidneys with small cortical and mild pyelectasia – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the left/right kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- Mildly 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.

- Moderate gallbladder debris – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

- Mildly thickened small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

SECONDARY FINDINGS

- Subjective mild pyloric wall thickening – most consistent with gastritis, although infiltrative disease cannot be excluded as a possibility. Recommend continued monitoring.

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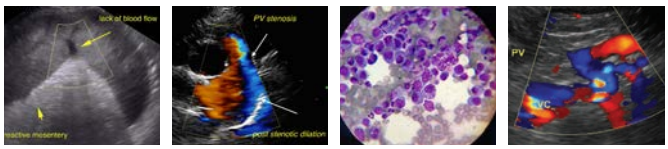

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No prominent focal lesions are visualized such as mass lesions, etc. on today's scan.

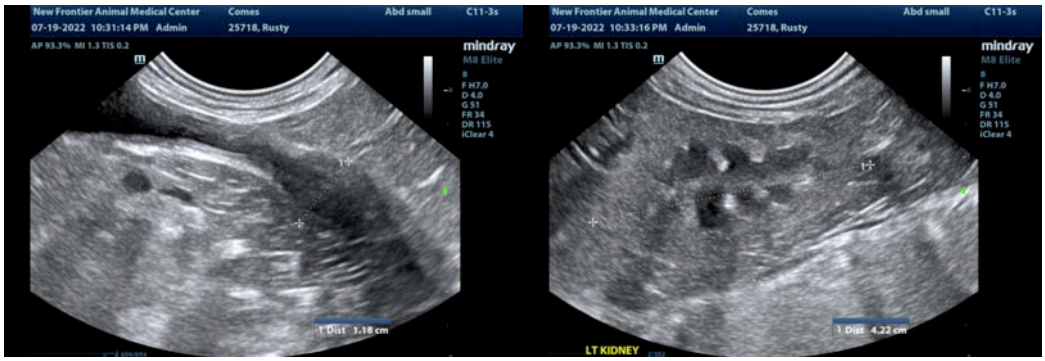
Both kidneys have decreased corticomedullary distinction with numerous small cortical cysts and mild pyelectasia. If not already done, recommend blood pressure evaluation, urinalysis and culture.

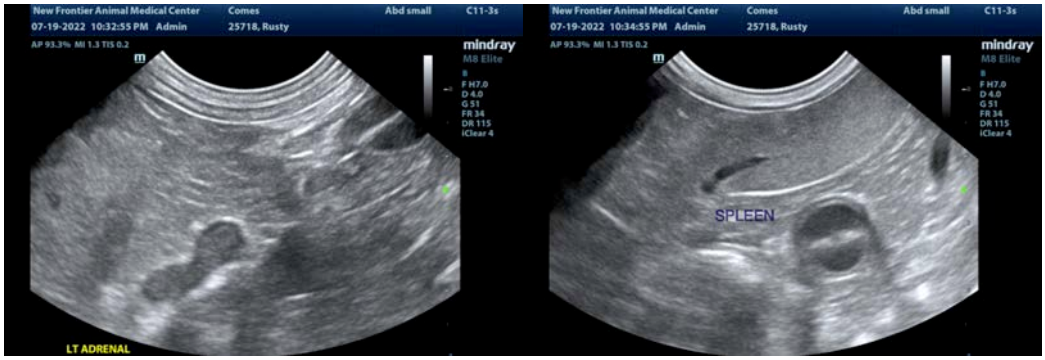
The liver is mildly heterogeneous. The significance of this with normal liver enzymes is unclear. I suspect this is within normal limits for this particular pet, but continued monitoring is warranted.

There is a moderate amount of gallbladder debris including some shadowing debris. The gallbladder wall appears relatively normal, and with a lack of liver enzyme elevations, the significance of this is unclear. Options moving forward would include chronic Ursodiol therapy and continued monitoring, or continued monitoring (ultrasound and bloodwork) without Ursodiol therapy.

The small intestine appears subjectively thickened, as does the pyloric antrum. There is intact wall layering and no specific focal lesions. Findings would be most consistent with diffuse inflammation/infiltrative disease (less likely underlying neoplasia).

- Consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to look for further evidence of small intestinal disease.
- Recommend a novel protein/hydrolyzed protein prescription diet.
- Consider chronic probiotic therapy.
- If GI signs persist despite a dietary change, consider obtaining GI biopsies.





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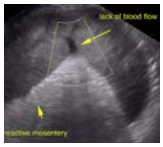
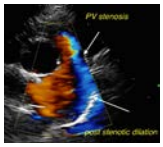
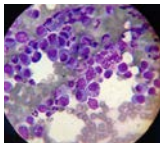
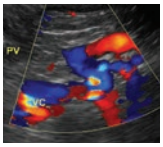

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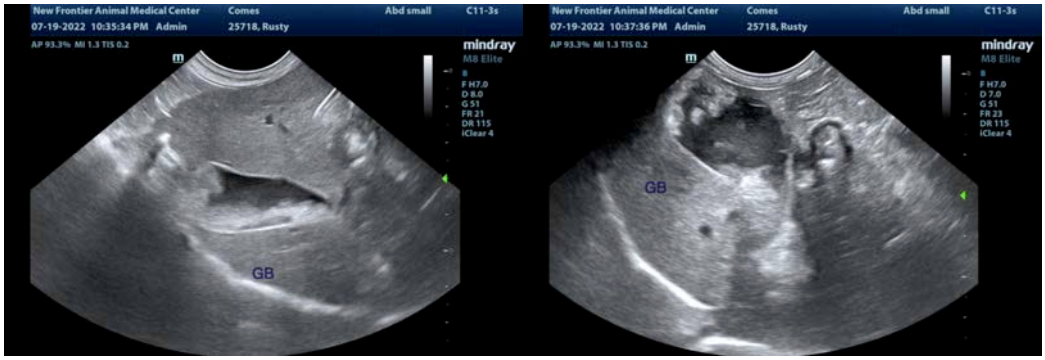

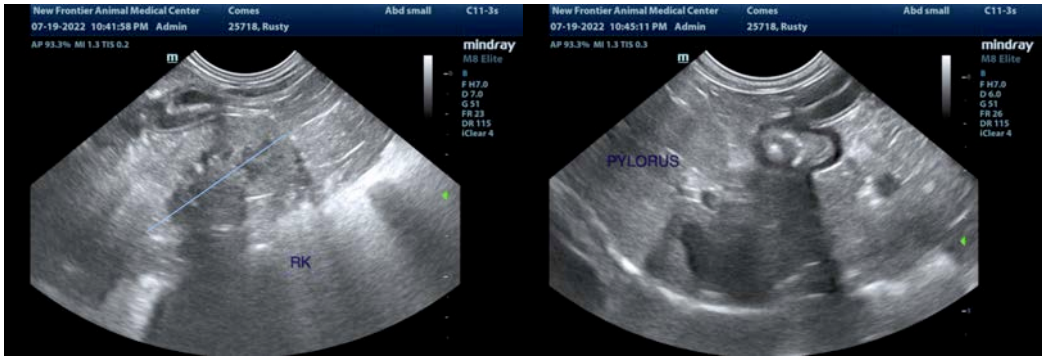

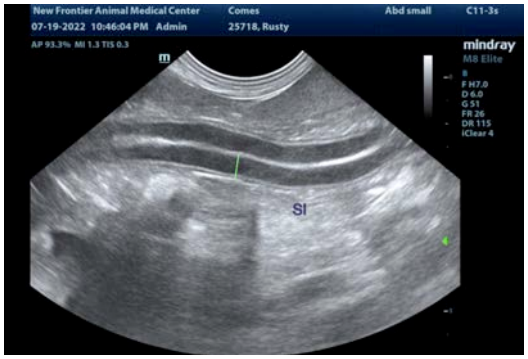

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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