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Clinical Sonography & Telecytology
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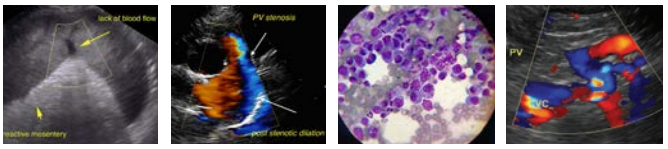

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1-800-838-4268 info@sonopath.com

PATIENT

Princess Panda Norris

SPECIES

Canine

BREED

Cavachon

SEX

Spayed Female

AGE

11 Years

WEIGHT

12.3 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Cassells-Conway

HOSPITAL NAME

Central Broward AH

REFERRING VET

Dr. Janeen Lezcano

INVOICE

24787

DATE

8/18/21

PRESENTING CLINICAL SIGNS

P presented w acute hx of PU/PD. Waking owner up in meddle of night to drink and urinate. P also crying for water when gets up in AM. No change in food or other. No v/d/c/s, no weight loss. Eating great. P is current on Lepto vaccines but does like to drink from puddles.
Abnormal PE/Chem/CBC/UA Results: CBC: plt ct: 497H, Chem: ALP: 145H, t bili: 0.4, 4+ hemolysis, triglyc: 946H (had food approx 9hrs prior to blood draw), T4: 2.1, UA: SG: 1.007, very quiet sediment, C/S: no growth LDDS test: pre: 5.6, 4hr post: 0.6, 8hr post: 1.1 Prev blood work, 8/20: CBC: plt ct: 413H, Chem: ALT: 127H, 3+ hemolysis, T4: 3.0, UA: SG: 1.048, 2+ prot

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears slightly irregular on the mucosal surface diffusely. The 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 left kidney has a normal shape and size (3.79 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. Numerous small cortical cysts are present. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.23 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. Small cortical cysts noted and a larger cyst measuring 0.97 cm. 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 0.28 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 0.26 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 large in size with normal echogenicity and 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. There are numerous, ill-defined, hyperechoic nodules throughout the liver, varying in size from 0.2-.0.78 cm.

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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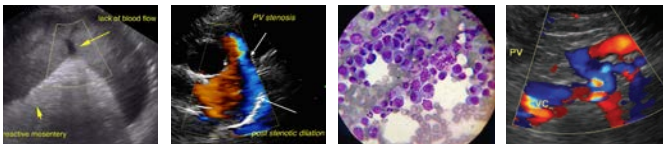

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Gastrointestinal

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. 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

- Slightly irregular urinary bladder mucosa – most consistent with cystitis or can be artifactual due to lack of adequate luminal distention. Recommend urinalysis and culture.
- Decreased corticomedullary distinction of both kidneys with cortical cysts – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Large, 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Based on today's ultrasound, two possible causes for increased thirst and urination could be cystitis, as urinary tract infections can cause increased thirst and urination. Recommend urine culture. Additionally, there are changes in the kidneys consistent with chronic progressive disease. The urinalysis reported in the history is more dilute than you would typically see with chronic renal failure alone, but this can be a big factor. Additionally, the liver is large with ill-defined nodules. Liver disease causes increased thirst and urination, so you could consider a liver function test, testing for Leptospirosis, and even a fine needle aspirate of the liver. Additional differentials exist for causes of PU/PD, but based on today's scan, these are the area I would initially focus on.

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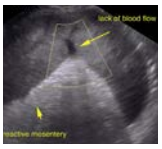
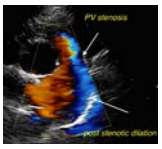
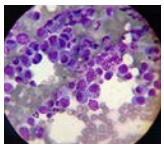
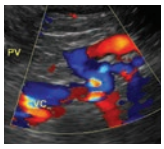

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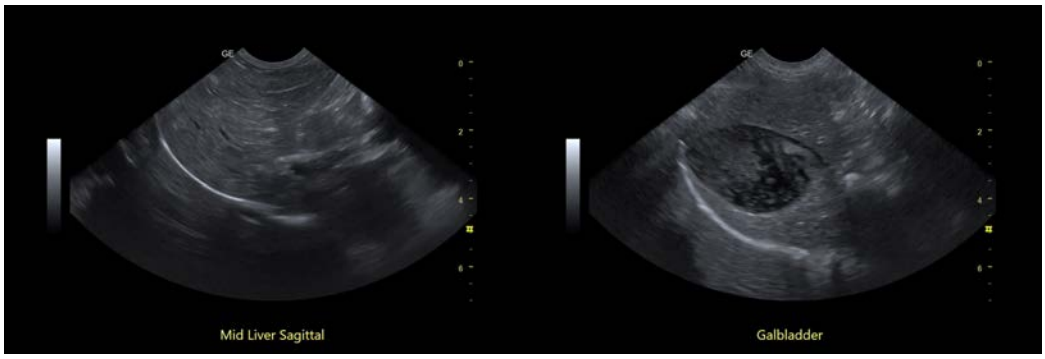

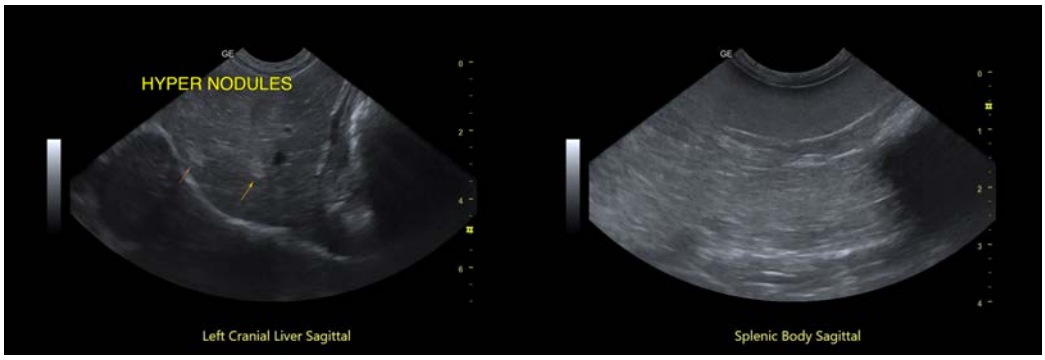

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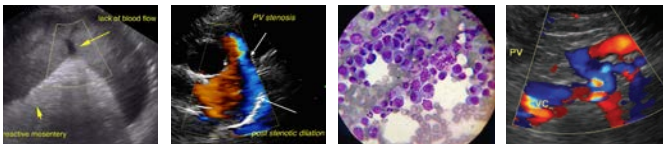

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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