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Clinical Sonography & Telecytology
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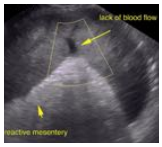
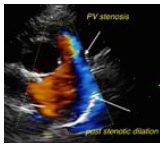
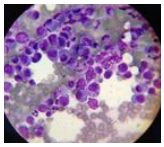
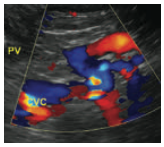





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Mason Kipnis

SPECIES

Canine

BREED

Boston Terrier

SEX

Neutered Male

AGE

12

WEIGHT

26.4

INTERPRETED BY

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

IMAGING PERFORMED BY

Arch Gordon

HOSPITAL NAME

Coral Ridge Animal Hospital

REFERRING VET

Arch Gordon

INVOICE

10087

DATE

3/1/2023

PRESENTING CLINICAL SIGNS

Weight loss and increased urination Also noted new heart murmur on exam HSM 3/6

Abnormal PE/Chem/CBC/UA Results: UA USG 1.013- protein 30 mg dl non hyaline casts present no bacteriuria noted, no uroliths SDMA, BUN and Creat normal ALT elevated -131- 18-121 u/l ALP 850 - 5-160 U/L GGT 14 - 0-13 U/L CK 422 10-200U/l CBC -normal

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 (0.51 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 normal in size (6.57 cm) but irregular in shape. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex: medulla ratio. There is pyelectasia at 0.53 cm and there are numerous very large renal cysts measuring from 1.0 cm - 4.0 cm in size, disrupting the normal renal architecture and occupying approximately 50 percent of the renal parenchyma.

The right kidney has a normal shape and size (5.76 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction with numerous smaller cortical cysts largest of which measures 1.50 cm. There is no evidence of focal 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 0.37 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.

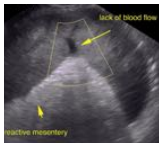
The right adrenal gland is normal in size measuring 0.55 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

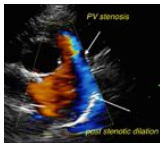
Spleen

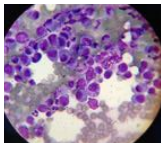
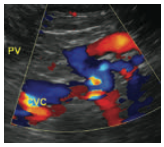
The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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.





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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and 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 (0.61 cm), and the jejunum measured as normal (0.37.) 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 prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

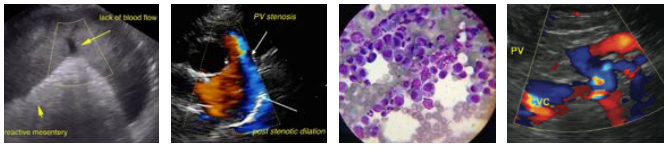
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Decreased corticomedullary distinction both kidneys with a severely cystic left kidney with pyelectasia and a mildly cystic right kidney. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. I'm concerned that the renal pyelectasia may be due to a partial obstruction from the renal cysts.
- Prominent mottled pancreas. The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis, or chronic pancreatitis.
- Heterogenous 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

The kidneys are significantly abnormal, and the left kidney is severely cystic with significantly reduced renal parenchyma. Additionally, there is some pyelectasia present it is uncertain if some of these cysts



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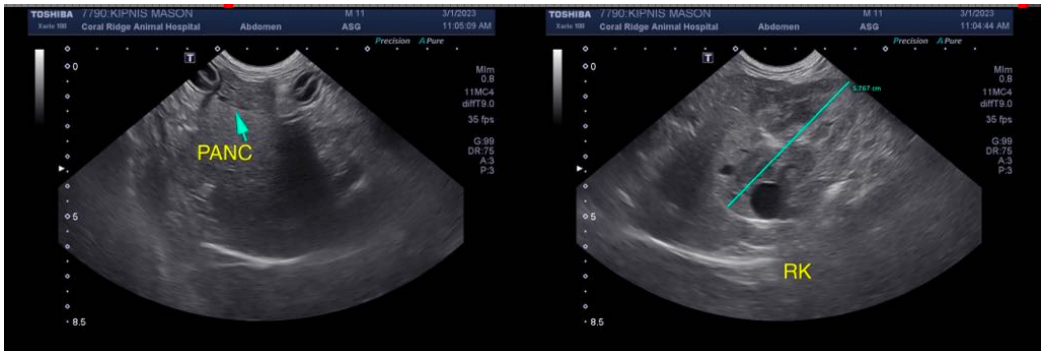
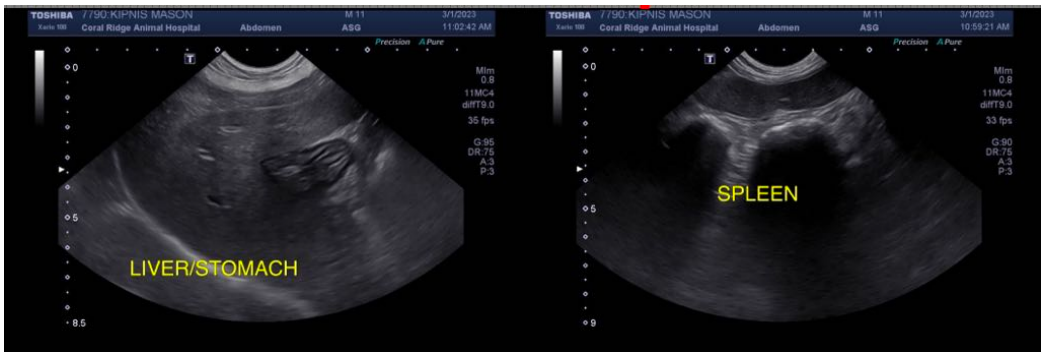
could be causing a partial obstruction. It is also uncertain how much of the current symptoms are attributable to the kidneys. I suspect the PUPD is based on the isosthenuria. Often, we can consider renal cysts insignificant and just monitor, in this situation it's harder to say. You could consider an IVP or contrast CT scan to better evaluate the cysts and to evaluate urine flow from the kidney, to see if they're having a significant impact. Drainage of these cysts is typically unrewarding as often they recur quickly and there is risk of leaking urine into the abdomen. Additionally, nephrectomy could be considered but this would be a risk as I suspect the right kidney is not functioning normally. Recommend a blood pressure and urinalysis and C/S.

Additionally, the liver is large and heterogenous with the elevation of ALP present this could be contributing to the PUPD. As it is significantly heterogenous almost with ill-defined nodules in some regions. You could consider a liver function test and a fine needle aspirate of the liver, to try to determine if this is a vacuolar hepatopathy or something different. If Cushing's is strongly suspected you could consider adrenal function testing, but I think this would be difficult to interpret as the renal changes/ (concurrent illness) could make adrenal function testing difficult to interpret and the adrenal glands are not overtly enlarged.

In an ideal situation I would likely consider a contrast CT scan to try to get a rough estimate of GFR and the location and the extent of renal cysts, to try to determine if any intervention is necessary. Otherwise, I would likely treat for chronic renal disease and symptomatic therapy.





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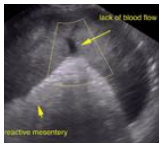
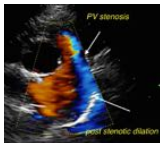
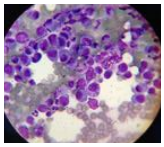
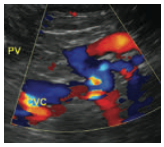

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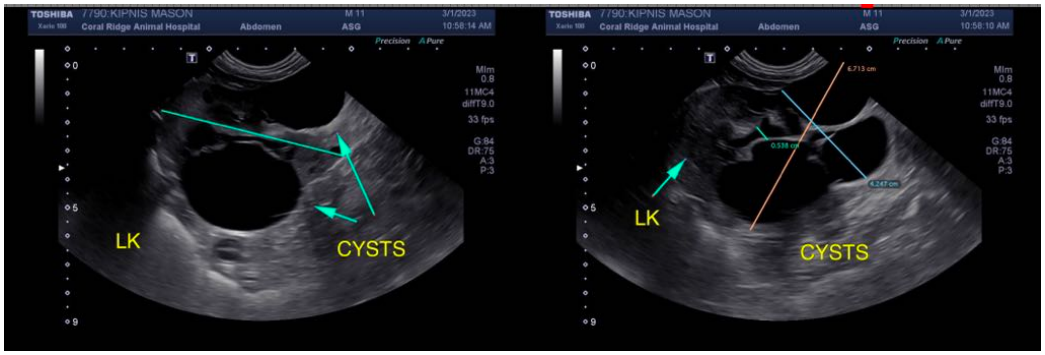

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com