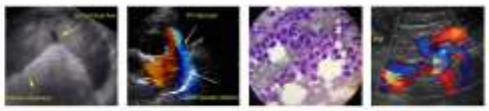
PAUS
Pet Animal Ultrasound Service



SonoPath
Clinical Sonography & Telecytology
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1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Snoopy Maslyn

SPECIES

Canine

BREED

Beagle

SEX

FS

AGE

11 years

WEIGHT

35.9 lbs.

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Wood RIver AH

REFERRING VET

Casey Schuelke, DVM

INVOICE

13203

DATE

1/28/22

PRESENTING CLINICAL SIGNS

History chronic kidney disease (glomerulonephritis - had been well managed), hypertension, gastric ulcers, UTI/possible kidney infection. Clinical presentation: inappetance for 1.5 weeks, diarrhea, increased thirst, lethargic, started coughing after being on high rate of IV fluids. BP: 150 mmhg on Enalapril (stopped until kidney values normalize). No murmur. Having bi-cavity ultrasound studies.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal renal size with asymmetrical margination were present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Variably sized cortical cysts were present in both kidneys. An example of a left kidney cortical cyst measured 1.5 cm in diameter. The left kidney measured 7.1 cm in length. The right kidney measured 6.5 cm in length.

Adrenal Glands

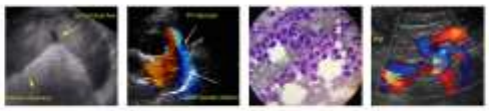
The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.58 cm width in the cranial pole and 0.58 cm width in the caudal pole. The right adrenal gland measured 0.56 cm width in the cranial pole and 0.68 cm width in the caudal pole. No evidence of adrenal hyperplasia or tumors was noted. Focal areas of suspect dystrophic mineral were present in both adrenal glands.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. A solitary, well-demarcated, uniform echogenic intraparenchymal nodule was present, measuring 1.2 cm in diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder exhibited potential for mild distention containing moderate dependent to nondependent yet nonorganized, nonmineralized debris. Suspect



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areas of entrapped mucus between the luminal debris and ventral wall were present. Mild dilation of the cystic biliary duct containing mucus was present. The common bile ducts were normal.

Gastrointestinal

The stomach presented mild to moderate wall thickening secondary to mild to moderate echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The ventral gastric body wall including the gastric mucosa measured up to 1.0 cm width. Mild gastric distension with minor retained anechoic fluid and luminal gas was present.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Mild duodenojejunal mucosal speckling was present. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The duodenum wall width measured 0.40 cm. The jejunum wall width measured 0.30 cm.

Normal visible colon wall layers were present with non-formed feces in lumen.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Intermittent mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). No effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Benign liver nodule - consistent with lipogranuloma or nodular hyperplasia
- Moderate gallbladder debris - potential for very early gallbladder mucocele
- Chronic nephropathy with variably sized cortical cysts
- Normal bilateral adrenal size with suspect Incidental pinpoint dystrophic mineral
- Gastroenterocolitis pattern with associated benign to reactive Intermittent mesenteric lymph nodes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further renal staging to include urine C/S and recheck UPC (If not recently done), on sterile urine sample is recommended.

No overt evidence of hepatic congestion suggestive of increased right heart pressure. Potential for more chronic gastroenterocolonopathy may be considered if persistent or recurrent gastrointestinal signs are noted.

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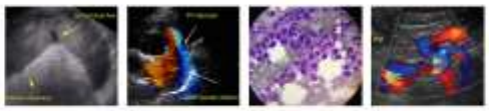

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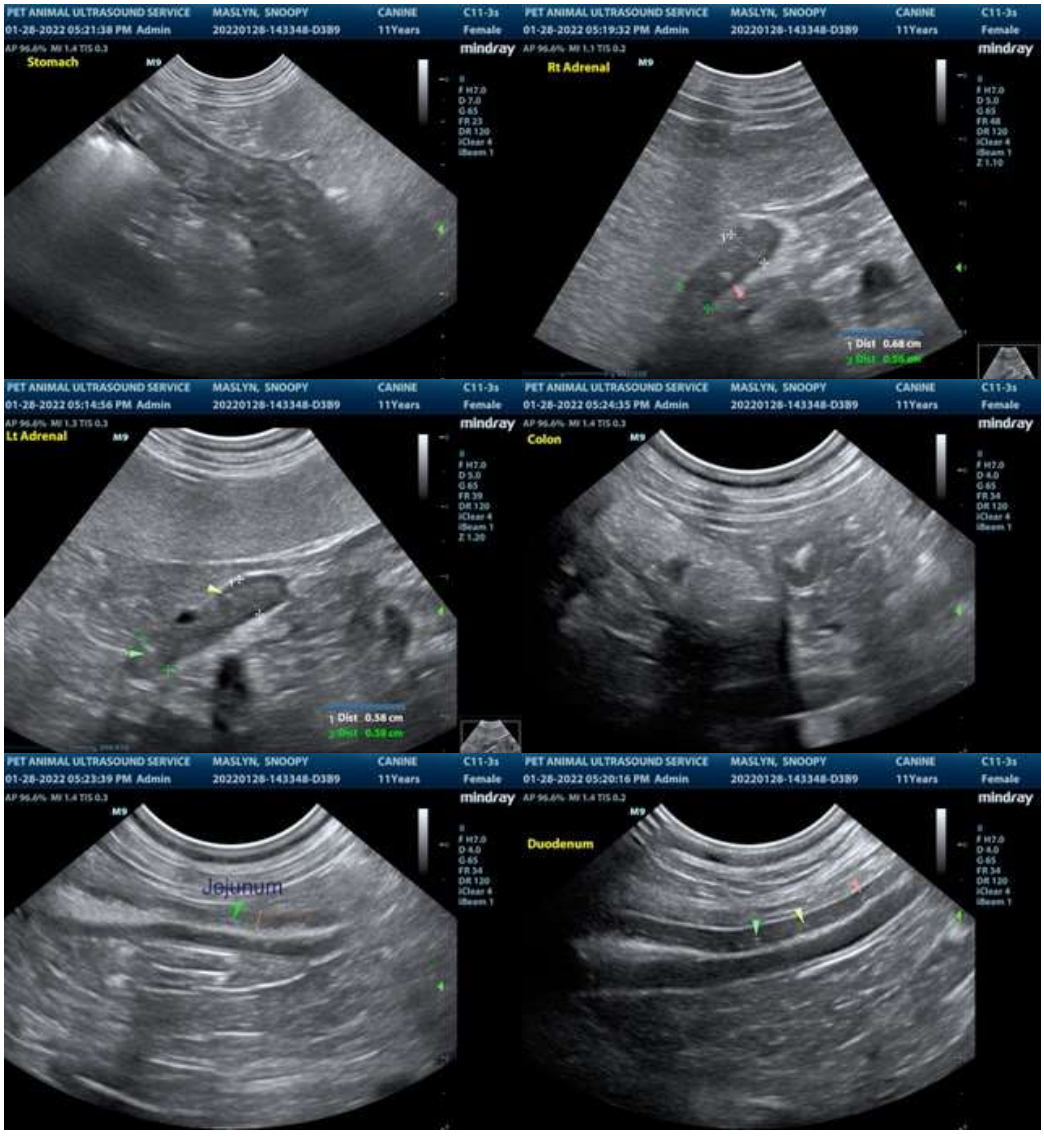
Empirically, a limited antigen or hydrolyzed diet trial with potential long term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Proviable or Visbiome), antibiotic trial and as needed gastrointestinal support with assessment of clinical response may prove beneficial. Intestinal biopsies may be indicated if GI signs continue despite empirical therapy.



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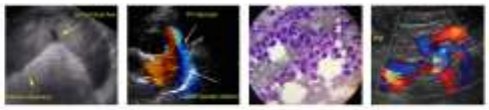

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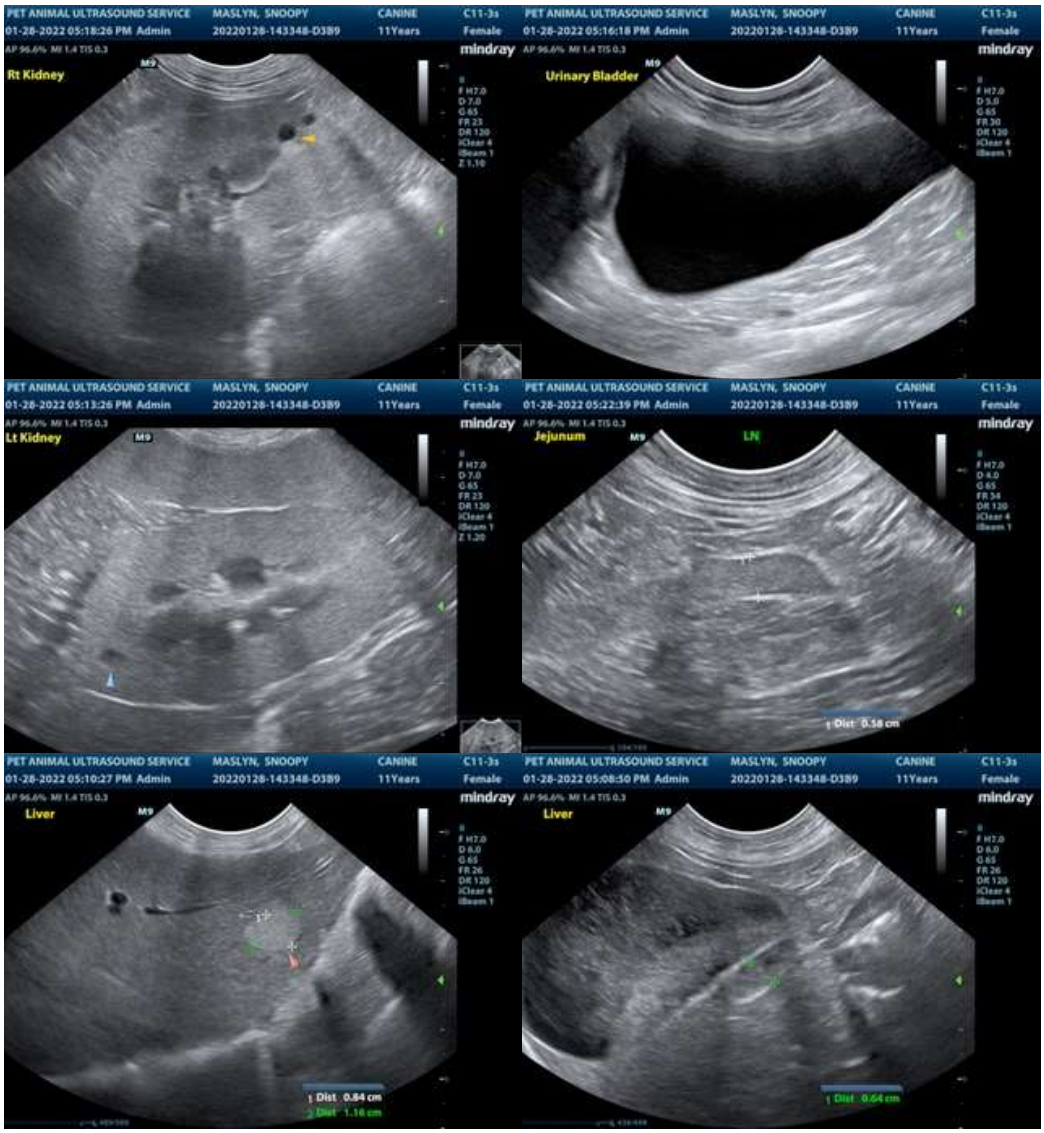

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com