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Clinical Sonography & Telecytology
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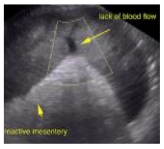
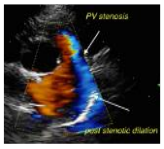
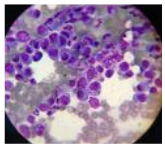
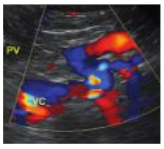




SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Zoe Futh

SPECIES
Canine

BREED
Mix Small Breed
JRT-like

SEX
FS

AGE
10 years

WEIGHT
17 lbs.

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

IMAGING PERFORMED BY
Dr. Sorbo

HOSPITAL NAME
Mill Brook Animal Clinic - VBF

REFERRING VET
Dr. Sorbo

INVOICE
16013

DATE
1/31/23

PRESENTING CLINICAL SIGNS

New patient to me. Short version problem list: -Wt loss -Proteinuria and azotemia -Hypertension. Ongoing weight loss of 3lbs in the past three years. Presented to a colleague in January due to tick found on P. Labs showed proteinuria and elevated C6. P was placed on doxycyline. P was also placed on enalapril for the proteinuria. P was also placed on a phosphate binder. Presented to me a week ago, which revealed ongoing weight loss of an additional 0.1-0.2lbs over the past 1-2 weeks. Appetite reduced, but P has never had a great gusto for food. We added amlodipine a week after enalapril, no change in BP.

Abnormal PE/Chem/CBC/UA Results: Jan 10th: Alb 2.3 [2.7-4.4] Glob 3.9 [1.6-3.6] BUN 95 [6-31] Crea 4.2 [0.5-1.6] SDMA 42.1 [<14] Phos 15.6 [2.5-6.0] USG 1.014 urine WBC and RBC 3-4 [0-2] C6 408 [<30] Fecal neg. BP taken with me: 262mmHg avg, repeated and confirmed. BP during sedation for scan = 180mmHg. Liver values wnl. Unable to do lepto PCR as P is on doxy atm.

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. Primarily anechoic urine was present in the lumen. Mild nondependent particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The area of the aortic trifurcation was free of pathology.

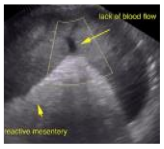
Normal size and margination were present in the kidneys. Mild to moderate loss of corticomedullary border demarcation was present with pinpoint medullary mineral and discrete hyperechoic cortical foci, which may indicate pinpoint discrete areas of cortical microinfarction, fibrosis, or concurrent mineralization. No pyelectasia was noted. The left kidney measured 5.5 cm in length. The right kidney measured 6.3 cm in length.

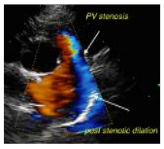
Adrenal Glands

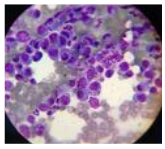
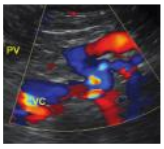
Mild parenchyma heterogeneity and mild capsule asymmetry were present in the bilateral adrenal glands without suspicion of overt neoplasia. The left adrenal gland was normal in size measuring 0.5 cm width in the cranial pole and 0.51 cm width in the caudal pole. The right adrenal gland was mildly prominent in size, based on caudal pole width measurement in light of body weight, with no evidence of neoplastic criteria. The right adrenal gland measured 0.59 cm width in the cranial pole and 0.57 cm width in the caudal pole.

Spleen

The spleen was normal in size and contour with mild generalized parenchyma heterogeneity. A solitary, nondisruptive mildly nonhomogeneous medial splenic nodule was present measuring 0.7 cm in diameter.





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Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Subjective mild increased hepatic vascular volume, likely secondary to sedation, was noted. The gallbladder was non-distended in size containing primarily anechoic content with moderate nonorganized, echogenic gallbladder debris. The gallbladder was otherwise normal. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild retained anechoic fluid was present. No evidence of mechanical pyloric outflow obstruction or obstructive pyloric mural pathology was noted.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical / metabolic ileus, obstruction, or foreign material.

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

Pancreas

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder sediment - cellular debris / protein, crystalline debris, mucus, possible
- Nonspecific moderate chronic renal changes exhibiting pinpoint cortical medullary mineral, potential for corticomedullary microinfarction or fibrosis
- Nonspecific yet subjective benign splenic nodule
- Moderate gallbladder debris - not consistent with mucocele criteria
- Gastritis pattern with mild gastric hypomotility, sonographically unremarkable small bowel

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urine C/S on a sterile urine sample is recommended if evidence of inflammatory sediment. Recheck UPC level (if not recently done) is suggested. No overt evidence of adrenal neoplastic criteria as a contributing factor to the patient's hypertension. No overt evidence of intraabdominal neoplastic criteria was noted.

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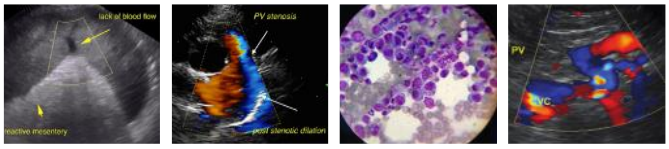

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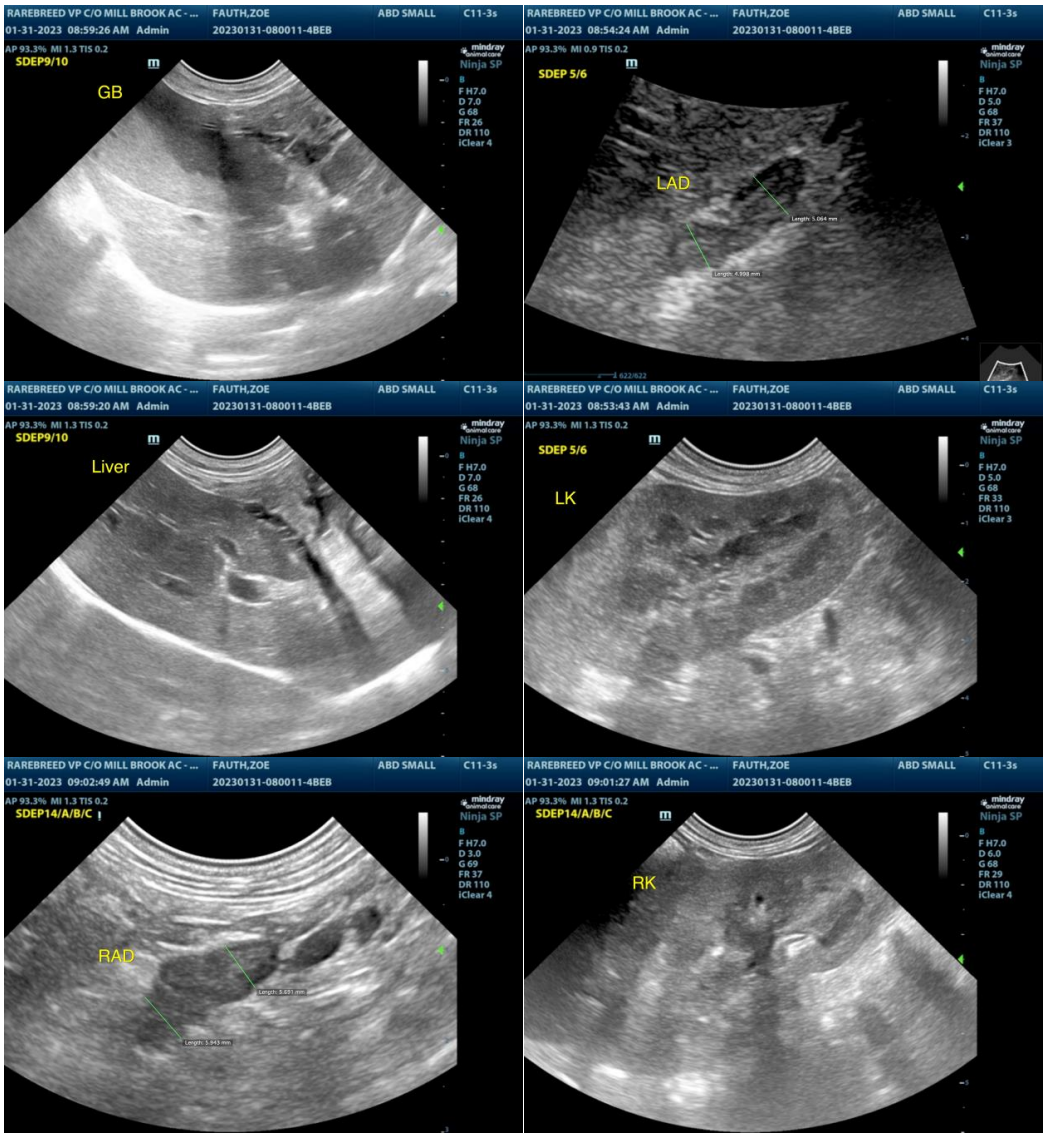
A GI panel to include PLI/TLI/Cobalamin/Folate, as well as three-view chest radiographs to rule out occult disease as a contributing factor to the patient's weight loss are warranted. Empirical therapy for gastritis if clinical signs consistent with gastritis i.e., vomiting, etc., is recommended.

For an additional charge, internal medicine consult can be utilized through Sonopath.com. You can select the internal medicine drop down at http://spa.sonopath.com/.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services



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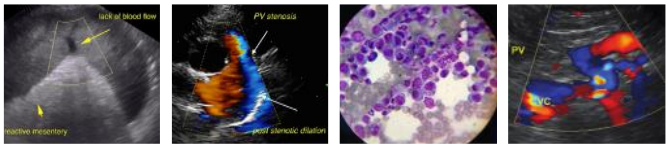

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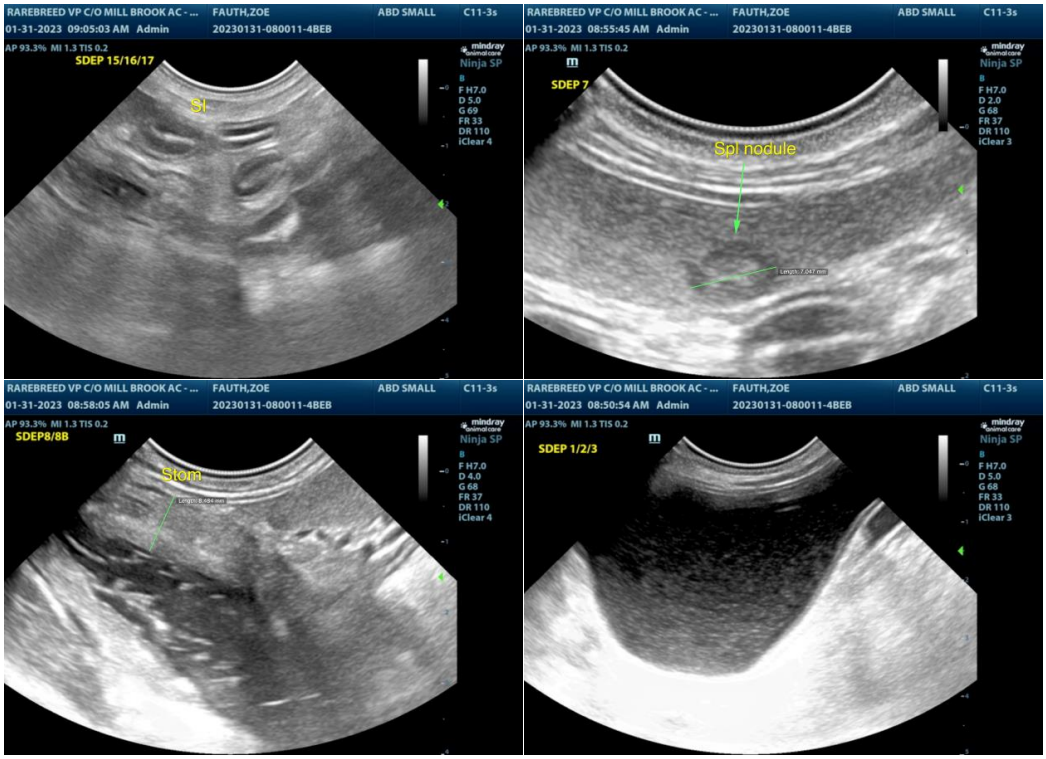

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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