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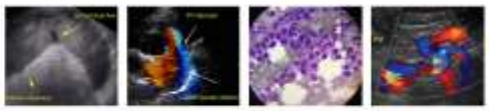

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PATIENT

Skye Colace

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

4 years

WEIGHT

41 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

New England AMC

REFERRING VET

Katherine Doyon, DVM

INVOICE

12374

DATE

10/18/21

PRESENTING CLINICAL SIGNS

Vomiting, r/o GI FB (obstructive vs non-obstructive) vs gastroenteritis vs extra-GI (pancreatitis vs hepatitis/ hepatopathy vs renal disease) vs less likely neoplasia. Lethargy, Stranguria, Azotemia, Hypokalemia, Hyperphosphatemia. Not eating and lethargic for past 2 days. Vomiting this morning, yellow bile. Seems to be straining to urinate this morning. No travel history. No previous history of dietary indiscretion. No prior medical issues. No diarrhea. On exam: BCS 4/9; moderately dehydrated. Non-painful on palpation. Medications: IVC, LRS, Cerenia. Radiographs: No evidence foreign body. No radiographic changes to explain clinical signs.
Abnormal PE/Chem/CBC/UA Results: CBC- WNL Lepto in house Snap test- negative 4DX- negative Chem- Bun 81, Creat 3.1, Phos 7.0, K 3.1, Cl 108. 10/17/21 Repeat BUN 46 Creat 1.8

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. No evidence of urinary bladder distension was noted. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Intermittent, mesenteric and medial iliac 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). An example of a medial iliac lymph node measured 0.41 cm width. An example of a mesenteric lymph node measured 0.38 cm width.

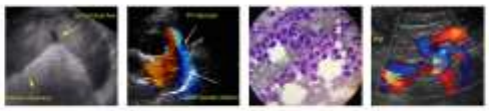
Normal size and overall margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary border demarcation expected for the age of the patient. Mild pyelectasia was present in both kidneys. The left kidney measured 7.0 cm in length. The right kidney measured 7.1 cm in length. No evidence of retroperitoneal Inflammation or effusion associated with either kidney was noted.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.52 cm width at the caudal pole and 0.49 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.51 cm width at the caudal pole and 0.51 cm width at the cranial pole.

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



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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 uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with minor gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material. The gastric body wall width measured 0.48 cm.

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

Normal visible colon wall layers were present with subjective semi-formed to potentially soft 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

Primary Findings

- Bilateral nephropathy
- Sonographically unremarkable urinary bladder and visible proximal urethra
- Gastroenteritis pattern

Secondary Findings

- Mild gallbladder debris (non-mucocele)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Subjectively, the appearance of the bilateral kidneys exhibited chronic to possible acute on chronic criteria, yet the kidneys did not appear to be end-stage. The pyelectasia present in both kidneys is suspected to be owing to IV fluid therapy, yet the potential for pelvic scarring, pyelectasia owing to

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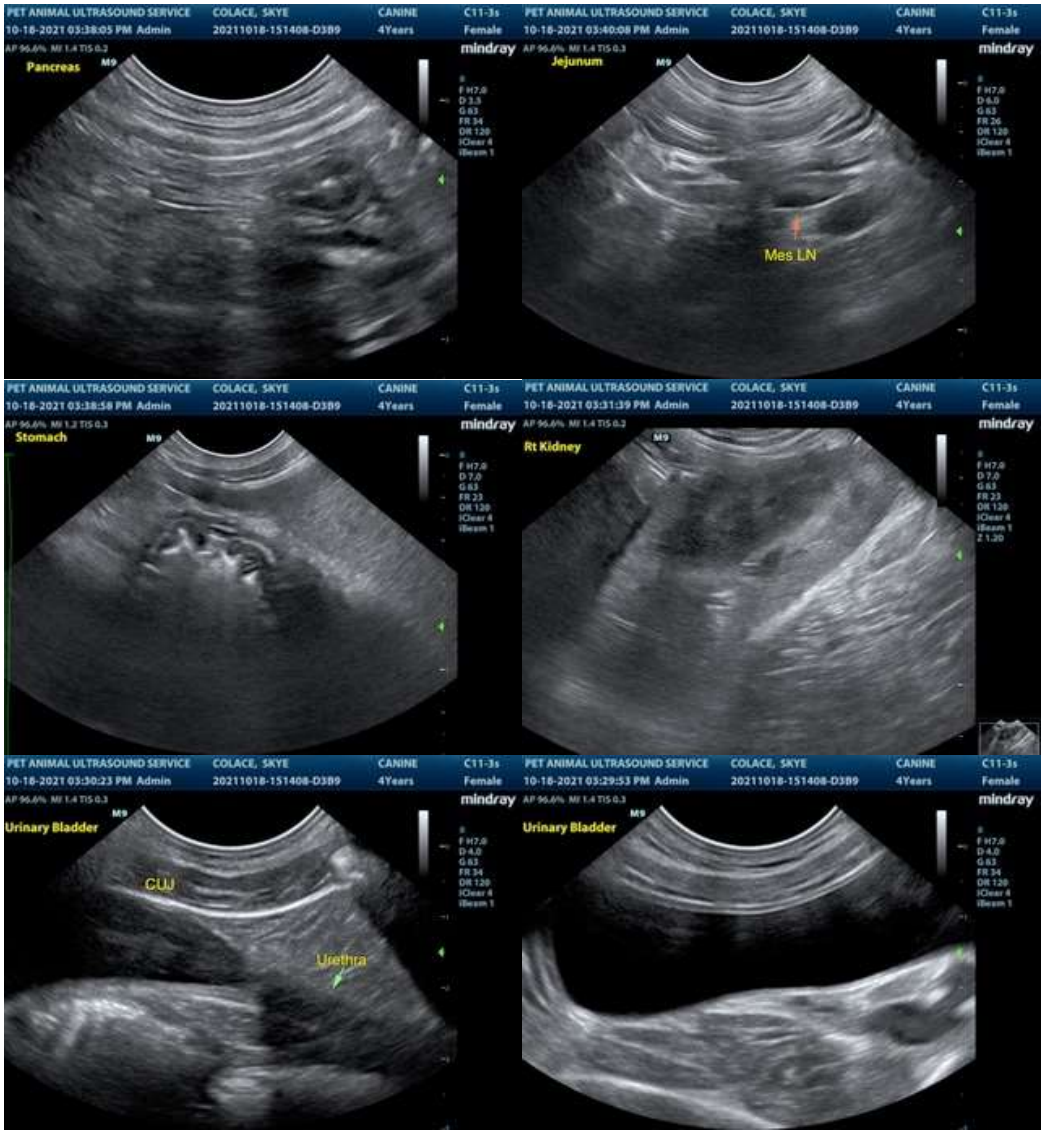
early chronic changes, or less likely potential for pyelonephritis are possible. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Assessment of systemic blood pressure is suggested. No overt evidence of pathology associated with the lower urinary tract was noted as an obvious cause of stranguria.

Although though less likely given the overall normal bilateral adrenal glands, screening cortisol may be considered to rule out occult Addison's Disease.

Continued renal and GI support is suggested with an assessment of clinical response.



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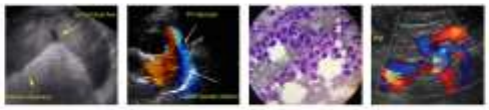

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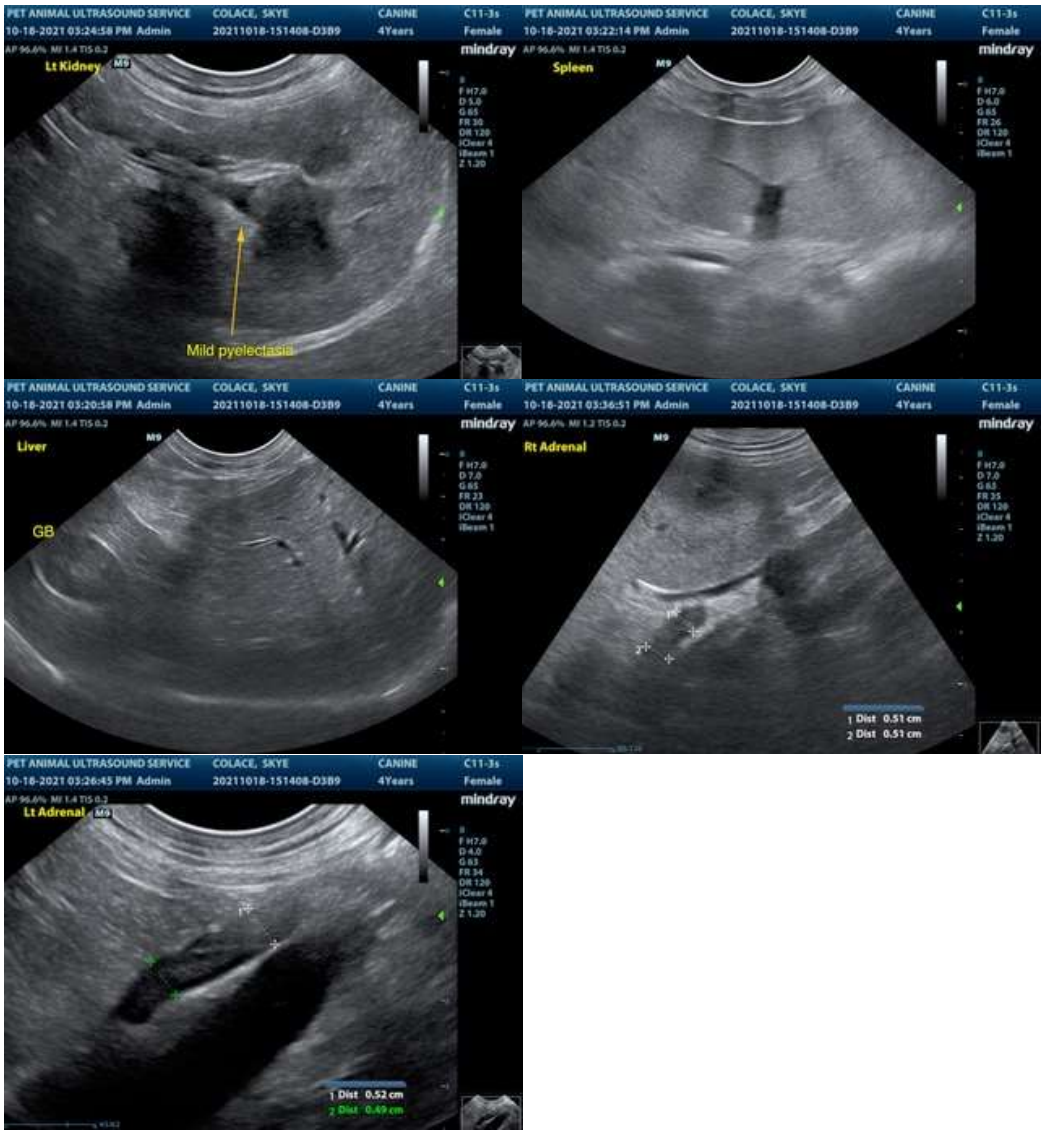

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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