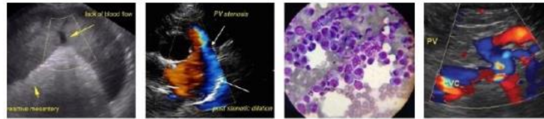


PATIENT

George Chlan

SPECIES

Canine

BREED

Bassett Hound

SEX

MN

AGE

4 years

WEIGHT

20.4 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Beatties PH Stoney Creek

REFERRING VET

Dr. Mellish

INVOICE

13874

DATE

2/11/22

PRESENTING CLINICAL SIGNS

Seen Feb 7 for lethargy, PU/PD weight loss, decreased appetite. diagnostics done and started on oral medications Presented Feb 10 for recheck for anorexia and now not drinking. No C/D/V/S, good energy level. Very thin. IV fluids, Sulcrate, metronidazole, clavasepting, gabapentin, cerenia INJ started Feb 10
Abnormal PE/Chem/CBC/UA Results: Feb 7 CBC - elevated RBCs, HCT, decreased WBC, neut, PLT, PCT Chem - elevated urea 10.3 crea 169, Ca, Lipa, Na Feb 10 CBC - highly elevated RBC, HCT, HGB, decreased WBC 3.9, eos, lym, PLT, PCT Chem - elevated Na 161, Crea 252, Urea 15.6 Rads: FINDINGS: The visible portion of the caudal thorax is normal, without evidence of esophageal dilation. The liver is normal in size and margination. The spleen is normal in contour and size. There is gas and fluid in the stomach. The small intestine is normal and relatively uniform in diameter, with normal opacity. There is gas and formed fecal material in the colon. The urinary bladder is not clearly visible, and is likely empty. The kidneys are largely obscured by overlying intestine, but no overt renal abnormalities are observed. Peritoneal serosal detail is adequate. There is a rounded fat opaque nodule on the ventral abdomen, likely representing a small umbilical hernia. No additional musculoskeletal abnormalities are seen. CONCLUSIONS: The abdomen is unremarkable. No cause for abdominal pain, anorexia, and azotemia is identified. RECOMMENDATIONS: Abdominal ultrasound examination should be considered for further investigation. Urinalysis is recommended, if not already performed.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Mild, nondependent,t particulate to focally hyperechoic sediment was present, likely indicative of mild cellular or crystalline debris. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

No overt pathology in the area of the residual prostate.

The area of the aortic trifurcation was free of pathology.

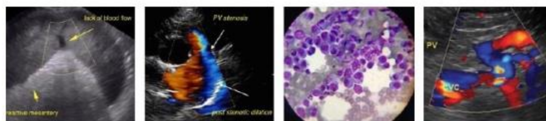
Both kidneys were normal in size and margination with maintained 1:3 cortex / medulla ratio with minor loss of corticomedullary demarcation. Normal medullary volume was present. No evidence of pyelectasia or retroperitoneal inflammation/effusion. The left kidney measured 6.6 cm in length. The right kidney measured 6.8 cm in length.

Adrenal Glands

Both adrenal glands were indistinctly visualized owing to patient body condition and size. The left adrenal gland measured 0.48 cm at the caudal pole in width. The right measured 0.49 cm at the caudal pole in width.

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.



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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. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mild wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild retained anechoic fluid was present in the stomach without evidence of retained ingesta, fluid or foreign material or mechanical pyloric outflow obstruction. The ventral gastric body wall, including the mucosa, measured 0.67 cm with width.

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 ileus, obstruction, or foreign material. The duodenum wall measured 0.46 cm. The jejunum wall measured 0.33 cm.

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

Several to intermittent prominent hypoechoic to mildly swollen mesenteric to mesenteric root lymph nodes were present in the mid abdomen. Some of the lymph nodes exhibited width/length ratio <0.5, although several exhibited mildly abnormal width/length ratio >0.5. An example measured 3.0 cm x 1.6 cm.

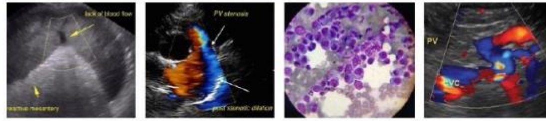
No effusion was present. The omentum was of uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mild urinary bladder sediment
- Overtly normal bilateral kidneys- no evidence of pyelectasia or retroperitoneal inflammation
- Gastritis pattern with mild gastric hypomotility, overtly normal small bowel
- Intermittent, nonspecific hypoechoic to mildly swollen mesenteric to mesenteric root lymph nodes- nonspecific, lymphadenitis, potentially owing to inflammatory bowel episode, while potential for emerging neoplastic lymphadenopathy cannot be excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Subjectively, the bilateral kidneys did not appear to be consistent with end stage renal failure. Consider potential for acute kidney injury or insult, such as leptospirosis/infectious, toxin exposure or other. Full urinary work up, including urinalysis, culture and sensitivity and baseline UPC, as well as leptospirosis titers/PCR recommended. Further assessment, given the patients decreased body condition, may



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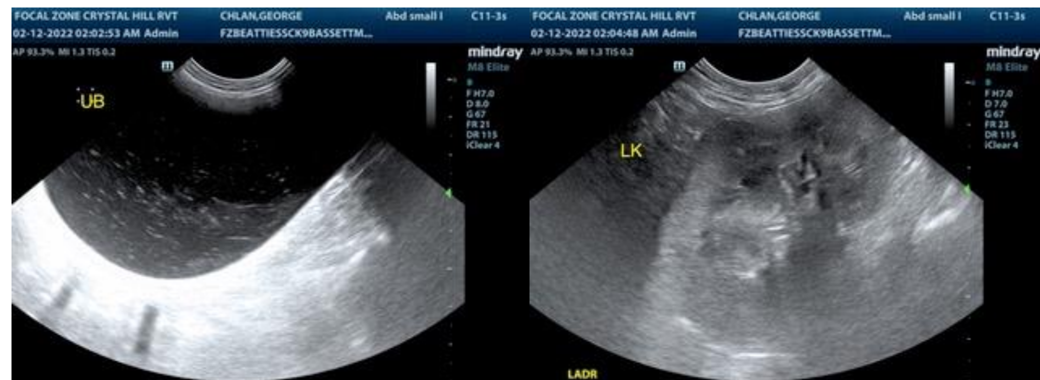
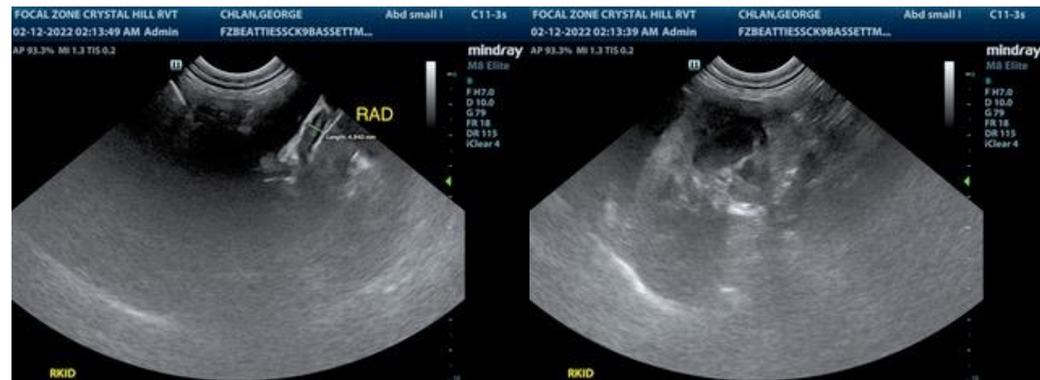
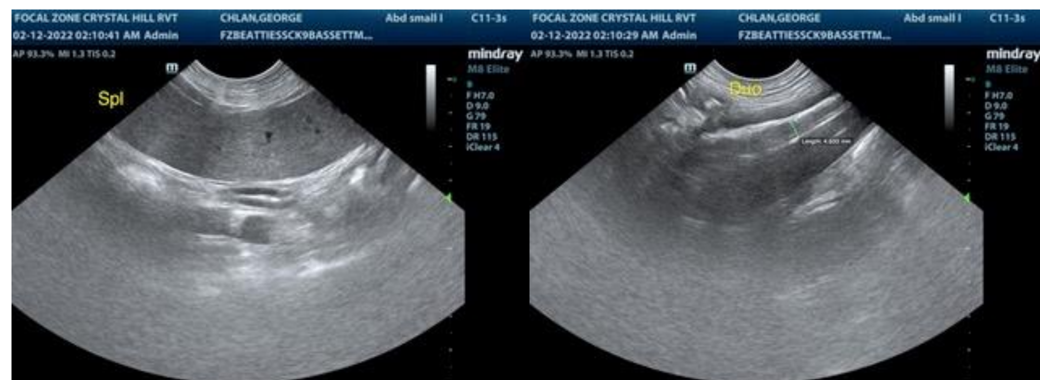
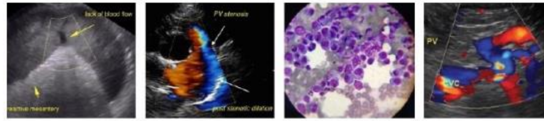
include a GI panel, to include PLI, TLI, cobalamin and folate, to assess for occult pancreatitis or structurally insignificant gastrointestinal disease as well as adrenal screening to rule out occult Addisons disease given the azotemia and overall normal kidney appearance.

Empirically, hospitalization with IV fluid protocol, as needed gastrointestinal support, monitoring of renal response, urine output and body weight would be appropriate.









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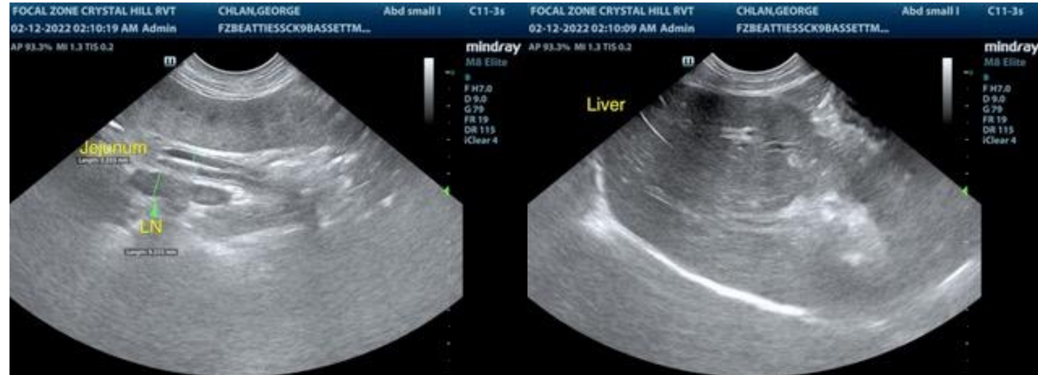
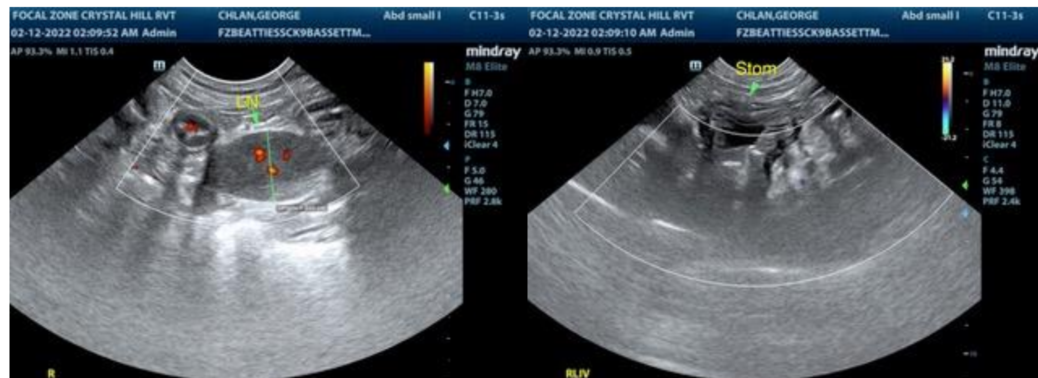
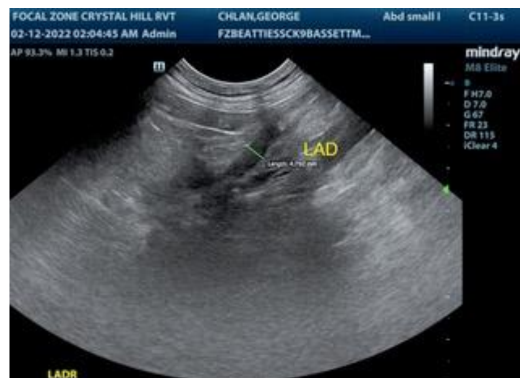


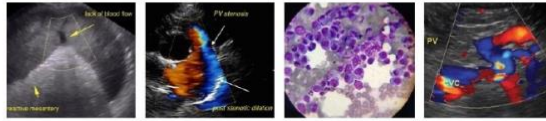




The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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



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