


**PATIENT**

Oliver Tiscareno

**SPECIES**

Canine

**BREED**

Labrador Retriever

**SEX**

Neutered Male

**AGE**

8 Years

**WEIGHT**

43.2 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Patti Mayfield, DVM

**HOSPITAL NAME**

East Bend AH

**REFERRING VET**

Jamie Thurk, DVM

**INVOICE**

21342

**DATE**

2/28/23

**PRESENTING CLINICAL SIGNS**

History: Patient had previous history of elevated Creat (2.0) measured once in 2021 at previous veterinary clinic. No follow up or evaluation of USG was performed at the time. Patient presented for hyporexia/anorexia, vomiting, lethargy. Renal disease was documented and he has been receiving the following treatments: -- IVF -- Cerenia -- Clavamox (patient is unwilling to take this medication or possible adverse response, therefore discontinued -- Cephalosporin initiated -- Omeprazole -- Phosphate binder -- Cosequin Patient has not had exposure to any known toxins and no travel history. No sedation necessary for AUS -- Patient is likely to be started on both amlodipine and benazapril -- Currently receiving kidney diet

Abnormal PE/Chem/CBC/UA Results: PE: -- Unremarkable -- BP: 200 mmHg CBC: -- Mild non-regenerative anemia: -- HGB: 12.6 g/dL (13-20) -- RBC: 4.93 M/uL (5.3-8.7) Remainder unremarkable/normal CHEM: -- BUN: 67 mg/dL (7-27) -- Creat: 5.8 mg/dL (0.5-1.8) --PHOS: 10.2 mg/dL (2.5-6.8) -- ALT: 191 U/L (10-125) --CHOL: 417 mg/dL (110-320) -- AMYL: 1987 U/L (500-1500) UA (free catch): -- USG: 1.015, yellow, pH: 6.0 -- 3+ proteinuria -- No casts, no crystal, no bacteria, no glucose, no ketones Urine C/S: Pending 4DX/HW: -- Neg for all Fecal O&P/Giardia: -- Neg for all Cardiac ProBNP: 10,000 pmol/L (<900) \*\* No heart murmur or arrhythmia in this patient \*\*

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**
**Urinary System**

The urinary bladder was mildly distended with normal tone. Anechoic urine was present with no sediment or calculi. No evidence of urinary bladder inflammatory criteria or tumors were noted. The urethra was normal to a depth of 5.0 cm.

The area of the residual prostate appeared normal and free of pathology.

The area of the aortic trifurcation was free of pathology.

Both kidneys were normal in size with mild capsule asymmetry. Potential for cortical microinfarctions was present. Mild loss of corticomedullary border demarcation was noted yet maintained 1:3 cortex to medulla ratio. Bilateral mild pyelectasia was noted. The left kidney measured 6.5 cm in length. The right kidney measured 6.0 cm in length. Subtle left retroperitoneal free fluid was noted around the caudal pole of the left kidney.

**Adrenal Glands**

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 3.0 cm length x 0.61 cm width at the caudal pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 1.7 cm length x 0.52 cm width at the caudal 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 thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

**Liver**



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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. Normal hepatic vascular volume was noted with no evidence of congestive criteria.

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The gallbladder was non-distended in size with anechoic content and mild nonorganized echogenic gallbladder debris. The cystic and common bile ducts were normal.

**Gastrointestinal**

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The visualized gastric walls were normal. The lumen of the stomach contained mild ingesta, exhibiting mild progressive distal acoustic shadowing and mild luminal gas.

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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**

**AGE**

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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 was evident.

**Free Abdomen**

**WEIGHT**

43.2 kg

No overt lymphadenopathy or peritoneal effusion was present.

**ULTRASONOGRAPHIC FINDINGS**

**INTERPRETED BY**

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- Nonspecific chronic nephropathy with mild bilateral pyelectasia
- Scant left retroperitoneal free fluid
- Sonographically unremarkable gastrointestinal tract with mild gastric ingesta
- Normal urinary bladder
- Low-grade benign hepatopathy
- Minor gallbladder debris – incidental

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Sonographically, the appearance of the kidneys, in conjunction with the previously noted elevated creatinine levels, is most consistent with chronic nephropathy. Potential for chronic glomerulonephritis given the degree of proteinuria vs other nephropathy. The bilateral pyelectasia is suspected to be secondary to chronic renal changes or potential pelvic scarring with pyelonephritis considered less likely. Correlation with pending culture and sensitivity, as well as recommended UPC level. Pending additional urinary work up, and assuming consistent proteinuria, protein losing nephropathy therapy with monitoring of systemic BP and serial UPC would be reasonable. Infectious disease serology could be considered if clinically indicated.

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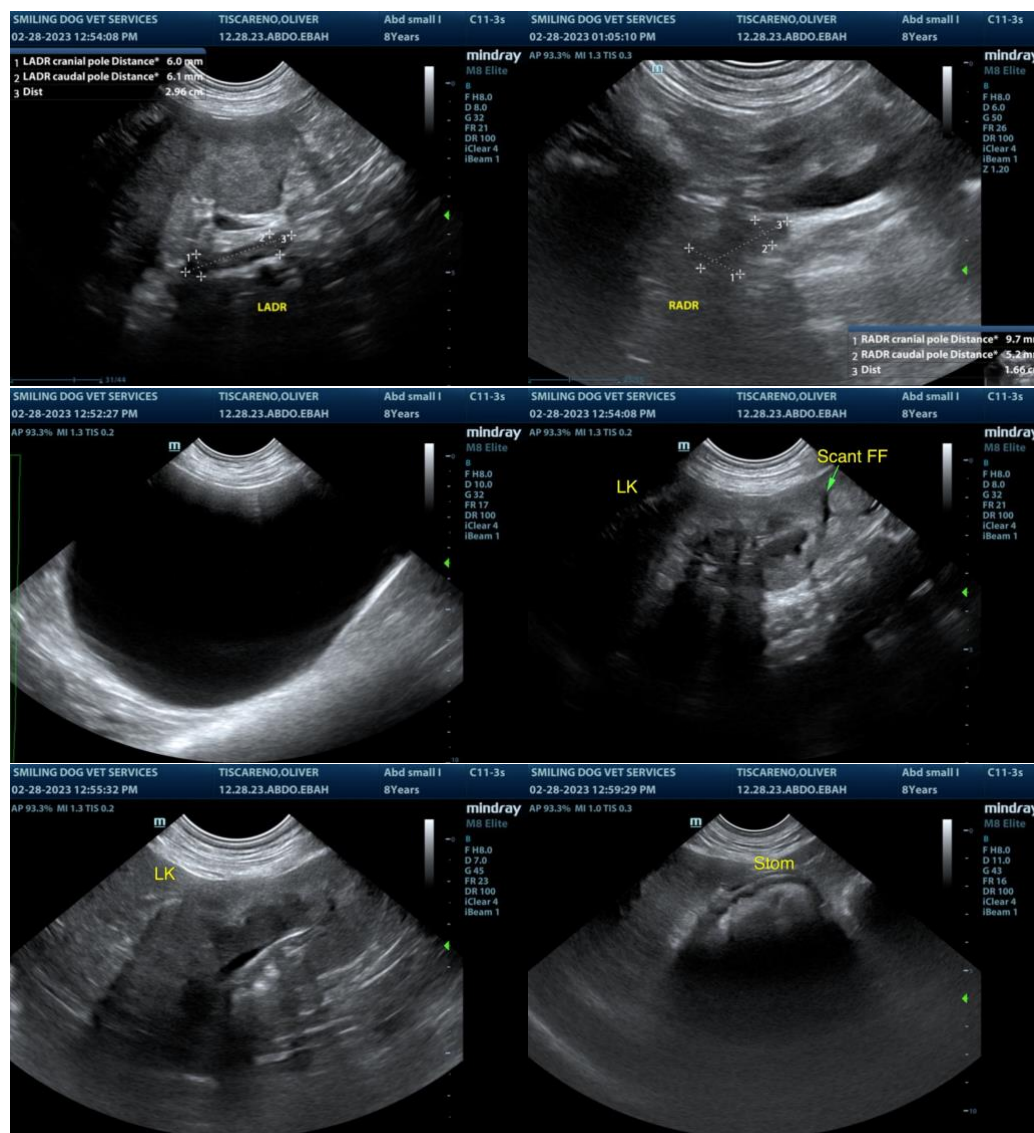
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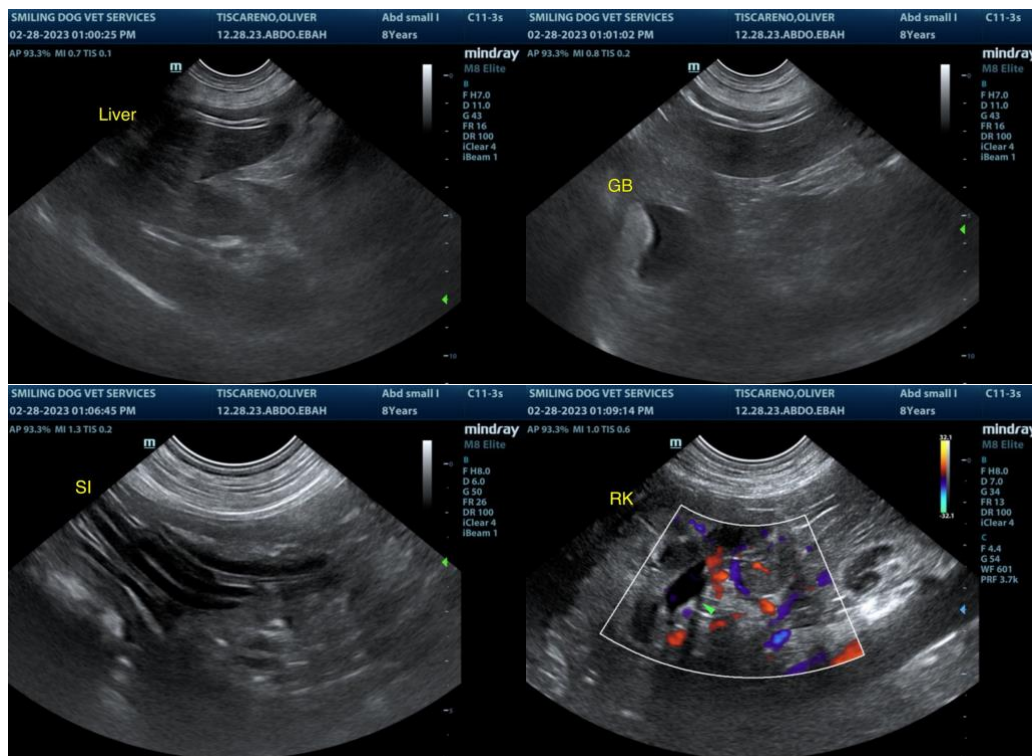
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)**  
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