

PATIENT

Chabella Vargas

SPECIES

Canine

BREED

Labrador

SEX

FS

AGE

7 years

WEIGHT

62 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Willakenzie Animal
Clinic

REFERRING VET

Dr. Poquette

INVOICE

13849

DATE

5/11/22

PRESENTING CLINICAL SIGNS

Blood in urine and stool one week ago diarrhea inappentant some vomiting On Proin - sometimes Benadryl (but not currently) - on Trifexis. Also on Metronidazole and Cerenia.

Abnormal PE/Chem/CBC/UA Results: Current Medications Metronidazole, Cerenia, Proin, Trifexis

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 size and 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 symmetry and definition expected for the age of the patient. Multiple variably sized cortical to corticomedullary cysts were present. The largest cyst was present in the lateral right kidney measuring 2.1 cm in diameter. The cysts were thinly walled containing anechoic fluid. Mild bilateral pyelectasia was present. The left kidney measured 6.7 cm in length. The right kidney measured 6.9 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 2.6 cm length x 0.64 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 3.3 cm length x 0.81 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/ 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.



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Gastrointestinal

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The stomach presented intact yet mildly prominent walls. Mild to moderate anechoic fluid was present in the gastric lumen. No evidence of retained ingesta, foreign material, or overt mechanical pyloric outflow obstruction was noted. The pylorus wall width measured 0.55 cm.

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The small intestine presented intact wall layering with subjective propensity for mildly prominent to echogenic segmental submucosa, as well as mildly prominent segmental muscularis layer. No evidence of loss of intestinal wall layering or intestinal masses were noted. No overt evidence of significant intestinal mural hypertrophy. The jejunum wall width measured 0.39 cm. The ileocolic junction was overtly normal.

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The proximal colon exhibited mild distention with nonformed feces. The visualized transverse and descending colon were sonographically unremarkable containing formed to semi-formed feces and luminal gas.

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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.

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Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable urinary bladder and visible proximal urethra
- Bilateral renal cysts and minor pyelectasia
- Mild hypomotile gastritis
- Intact yet mildly prominent to altered small bowel wall layering
- Nonformed feces in mildly dilated proximal colon - possible mild proximal colitis or typhlitis

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Without evidence of lower urinary tract pathology, i.e., cystitis, masses, calculi, etc., potential hematuria may possibly be originating from the kidneys in this patient. The bilateral pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Urine C/S and protein: creatinine ratio on sterile urine sample is recommended.

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The mild small intestinal wall changes may be a normal patient variant or may potentially suggest an underlying inflammatory process, i.e., IBD with concurrent gastritis, nonobstructive gastric stasis, and suspect colitis. Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate, as well as fresh fecal analysis to rule out parasitic ova / Giardia.



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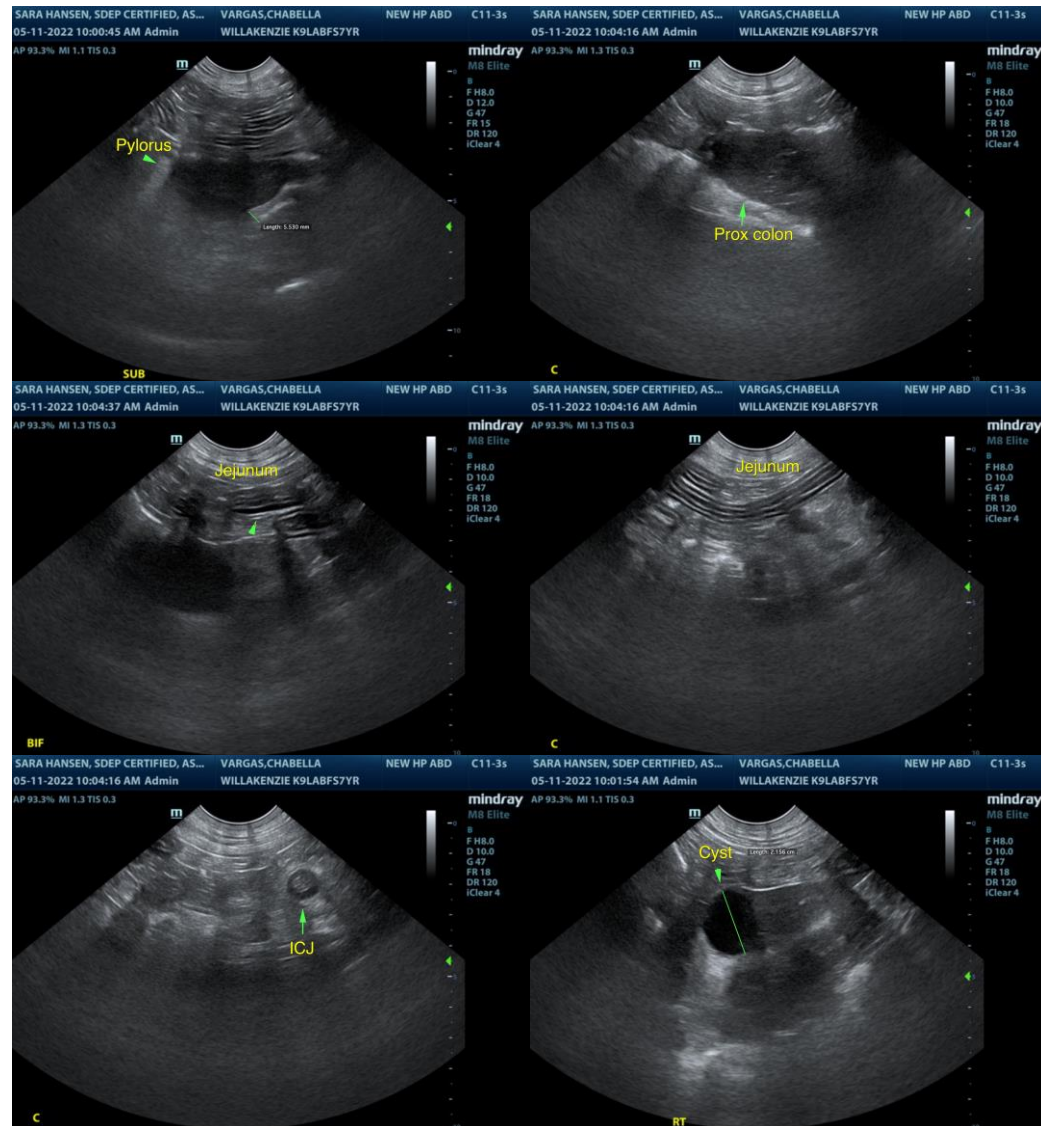
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Although considered less likely, resting cortisol to rule out occult Addison's Disease could be considered.

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 (Proviale or Visbiome), antibiotic trial and as needed gastrointestinal support, i.e., Omeprazole +/- Cerenia if continued vomiting with assessment of clinical response would be reasonable. Intestinal biopsies may be indicated if GI signs continue despite empirical therapy.





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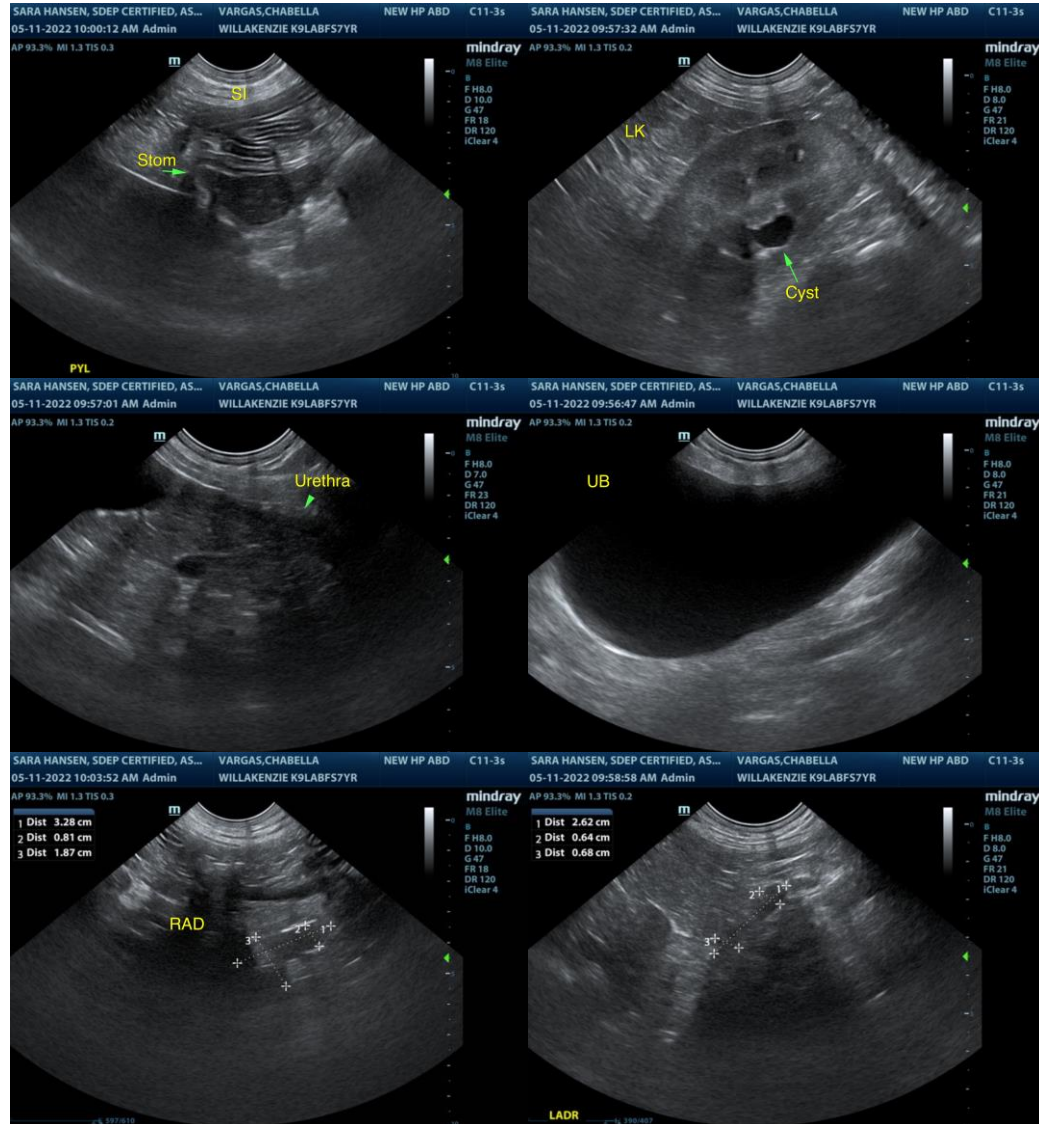
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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