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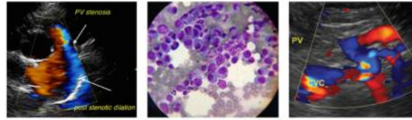

SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Suzie Williams

SPECIES

Canine

BREED

Lhasa Apso X

SEX

Spayed Female

AGE

11 Years

WEIGHT

38 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Haenni

INVOICE

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5/20/20

PRESENTING CLINICAL SIGNS

Blood in urine Hx of UTI with calcium ox crystals. Low urine SpGr Had couple rounds of enrofloxacin and currently on c/d. Crystals have resolved but bloody urine is still significant.
Abnormal PE/Chem/CBC/UA Results: 5/14/22 UA: pH 6.5, +++bld, + protein Bladder Stones on rads

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder exhibited moderate to marked regional to generalized thickening, most prominent in the ventral apical to dorsal apical urinary bladder. Asymmetrical luminal contour. The thickened areas of urinary bladder exhibited mild non-homogeneous mural echotexture along with pinpoint areas of luminally adhered to possible mural mineral. Minimal anechoic urine present in the urinary bladder, which prohibited full evaluation of the urinary bladder walls with some contribution of urinary bladder thickening possibly secondary to lack of luminal urine distention. The urethra was normal in structure and tone to a depth of 2.0 cm. Ventral apical urinary bladder wall measured up to 2.0 cm in width. Dorsal urinary bladder wall measured 0.60-0.70 cm. No evidence of urinary bladder macrocalculi.

No overt pathology including no evidence of medial iliac or sublumbar lymphadenopathy in the area of the iliac trifurcation.

The left kidney exhibited moderate hydronephrosis, exhibited by replacement of medullary parenchyma with anechoic fluid. Suspect concurrent left hydroureter at the level of the urinary bladder. The left kidney measured 5.5 cm.

Normal size and margination were present in the right kidney. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. No overt evidence of hydronephrosis. The possibility of non-visualized emerging concurrent right hydroureter cannot be definitively excluded. The right kidney measured 5.8 cm.

Adrenal Glands

The left adrenal gland was mildly prominent in size with symmetrical contour and homogeneous parenchyma, measuring 2.1 cm x 0.93 cm at the caudal pole.

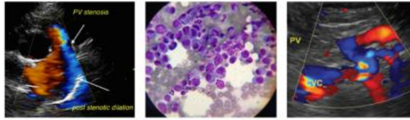
The right adrenal gland was mildly prominent in size with symmetrical contour and homogeneous parenchyma, measuring 2.0 cm x 0.55 cm at the caudal pole.

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

The liver was mildly enlarged. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder



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was non distended in size with mild, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild echogenic, nonshadowing ingesta most consistent with post prandial presentation without signs of ileus, obstruction or foreign material.

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.

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 was evident.

Free Abdomen

No effusion. No omental lymphadenopathy.

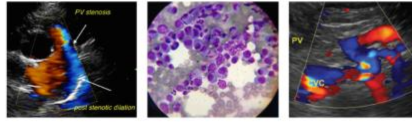
ULTRASONOGRAPHIC FINDINGS

- Regional moderate to severe thickened urinary bladder exhibiting pinpoint luminal to possible mineral.
- Moderate left kidney hydronephrosis with suspect concurrent distal left hydroureter at the level of the urinary bladder.
- Right kidney mild chronic renal changes – no overt evidence of concurrent pyelectasia/hydronephrosis.
- Mild non-specific hepatomegaly.
- Mild gallbladder debris (non-mucocele).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's history of UTI And calcium oxalate crystals, chronic severe cystitis could be present. However, given the urinary bladder presentation, neoplastic criteria (i.e., transitional cell carcinoma or other) is favored. Highly suspect left ureter obstruction at the level of the left ureteral papillae, given suspected distal left hydroureter and concurrent left kidney hydronephrosis. No overt evidence of regional metastasis.

Screening BRAF assay recommended. However, if negative, biopsies of the urinary bladder wall for histopathology +/- tissue culture and sensitivity would be required for definitive diagnosis. Assessment of renal functionality recommended if not recelty done.



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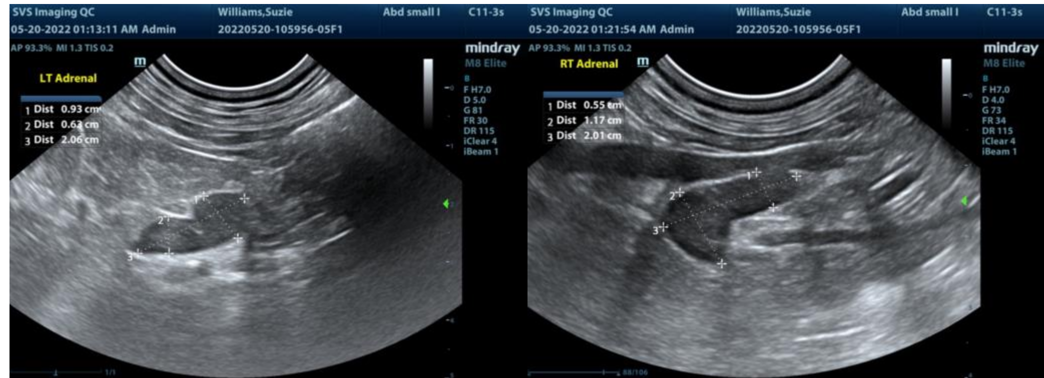

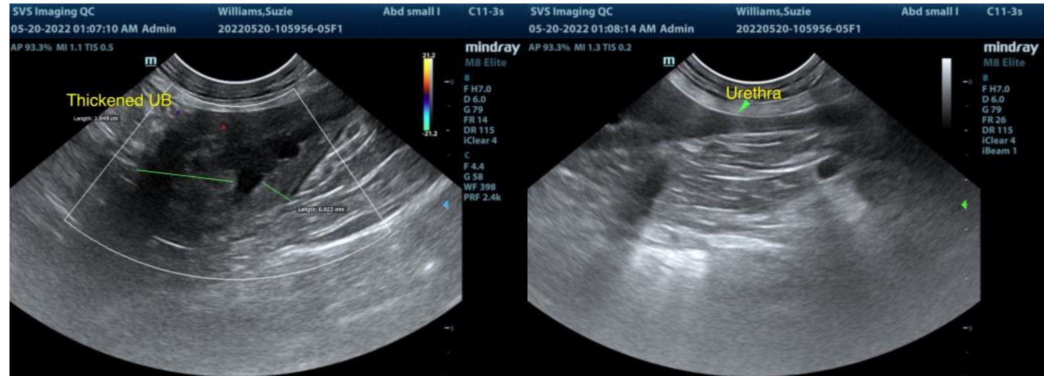

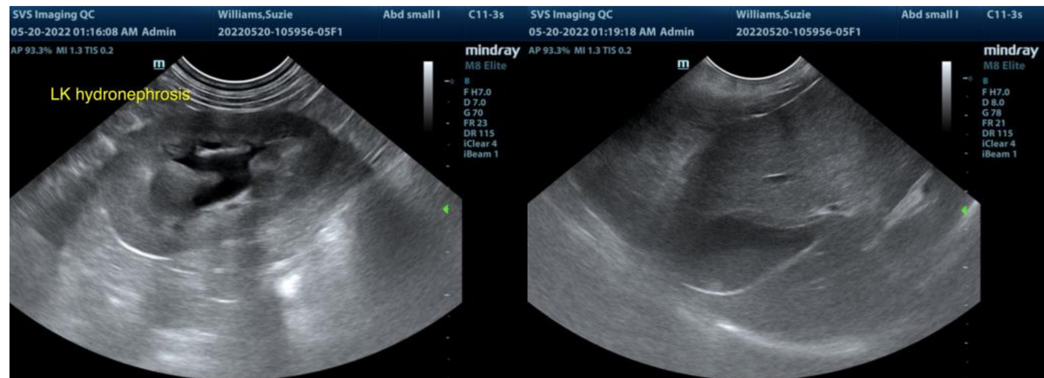

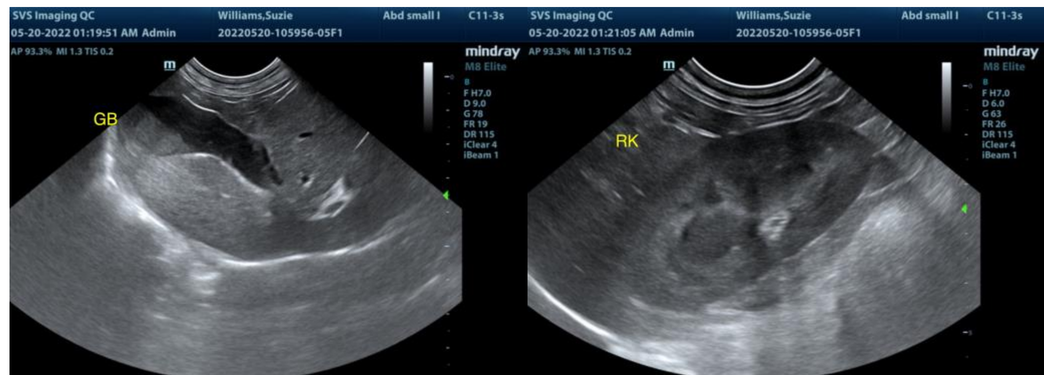

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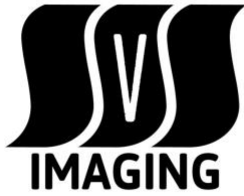

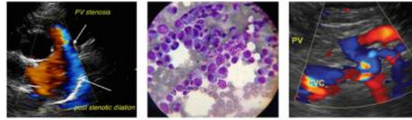

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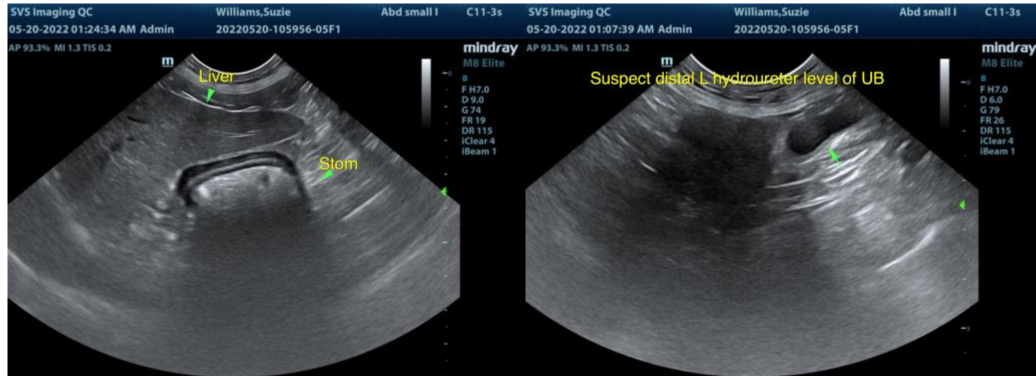

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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