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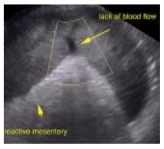

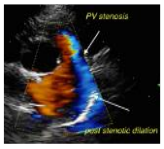

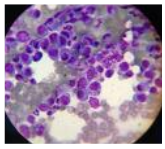
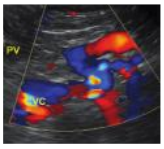

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1-800-838-4268 info@sonopath.com

PATIENT

Alfie Weir

SPECIES

Canine

BREED

Terr X

SEX

M

AGE

4 months

WEIGHT

9.1 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Alastair Westcott

HOSPITAL NAME

Dr. Alastair Westcott, DVM

REFERRING VET

Dr. Alastair Westcott

INVOICE

17166

DATE

6/27/23

PRESENTING CLINICAL SIGNS

Had a history of profound lethargy for the last 4 days. This started with an acute episode of vomiting 4 days ago where some form material was ejected [chew toys and some carpeting material]. There has only been the one episode of vomiting. There has been no diarrhea and he has maintained a good appetite. He has been drinking excessively though and this seems to have increased. Coincident with the vomiting he has developed a RH and right forelimb lameness.

Abnormal PE/Chem/CBC/UA Results: Very lethargic Pyrexic Somewhat bloated and notable abdominal discomfort Very dehydrated with dry/tacky mucous membranes Is ambulatory but favoring the RH and right fore Discomfort on palpation of the medial stifle joint pouch Unusually maintaining a good appetite Significant polydipsia **Bloodwork:** Non-regenrative anemia Marked leukocytosis with left shift Neutrophilia and monocytosis Hypokalemia Mild hyperglobulinemia **Urinalysis:** Isosthenuric Glucosuria Pyuria Prominent and enlarged kidneys on ultrasound

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was mildly distended with normal tone. Normal appearance to the urinary bladder wall was noted. No evidence of inflammatory mural criteria was present. Anechoic urine was present primarily with mild nondependent particulate sediment, which may indicate cellular debris / protein, crystalline debris or mucus. Overtly normal proximal urethral structure was noted to a depth of 2.0 cm.

Focal to intermittent medial iliac lymph nodes, not consistent with inflammatory criteria, were present and considered incidental. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

Both kidneys were enlarged to swollen in size yet maintained symmetrical capsule contour and a 1:3 cortex/medulla ratio. Intact renal architecture was present with subtly indistinct corticomedullary border demarcation. Mild bilateral pyelectasia was present without evidence of left or right ureter dilation. The left kidney measured 8.3 cm in length. The right kidney measured 8.3 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 1.7 cm length x 0.36 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 0.49 cm width at the caudal pole.

Spleen

The spleen was normal in size and contour with subtle generalized splenic parenchyma heterogeneity. No masses or nodules were noted. Normal splenic vascularity was 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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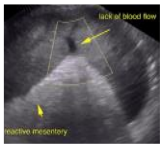

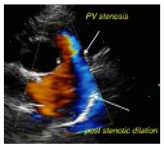

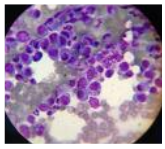
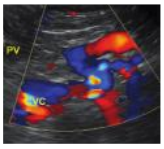

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate, variably echogenic, nonshadowing ingesta without signs of obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Segmental similar appearing nonshadowing ingesta / chyme was present.

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

No overt or visualized omental lymphadenopathy. No evidence of peritoneal or retroperitoneal free fluid.

ULTRASONOGRAPHIC FINDINGS

- Mild urinary bladder sediment
- Bilateral enlarged to swollen kidneys exhibiting intact renal architecture and mild pyelectasia
- Sonographically unremarkable gastrointestinal tract with gastric and segmental intestinal ingesta - gastrointestinal ingesta was sonographically suggestive of food
- Normal splenic size / contour with subtle parenchyma heterogeneity - subjectively benign, suspect hematopoiesis, given non-regenerative anemia
- Sonographically unremarkable liver / gallbladder

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although no reported azotemia, the bilateral kidneys are suggestive of acute nephropathy without overt evidence of dysplastic or neoplastic criteria. Potential considerations may include acute kidney injury, renotoxic insult, pyelonephritis, infectious disease, i.e., leptospirosis, or other.

Correlation with pending urine culture and leptospirosis titers with close monitoring of renal parameters is recommended. Continued empirical broad-spectrum antibiotic protocol, pending urine culture and leptospirosis testing, is warranted. Baseline UPC level could be considered if evidence of proteinuria. Monitoring of appetite with as-needed gastrointestinal support is recommended. Sonographic reassessment of the kidneys is suggested of arising or progressive azotemia and / or progressive clinical signs.

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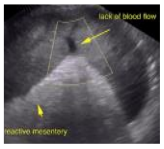

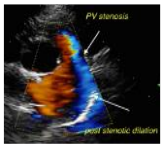

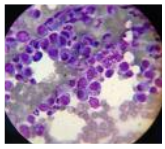
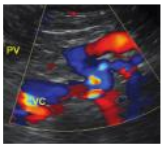

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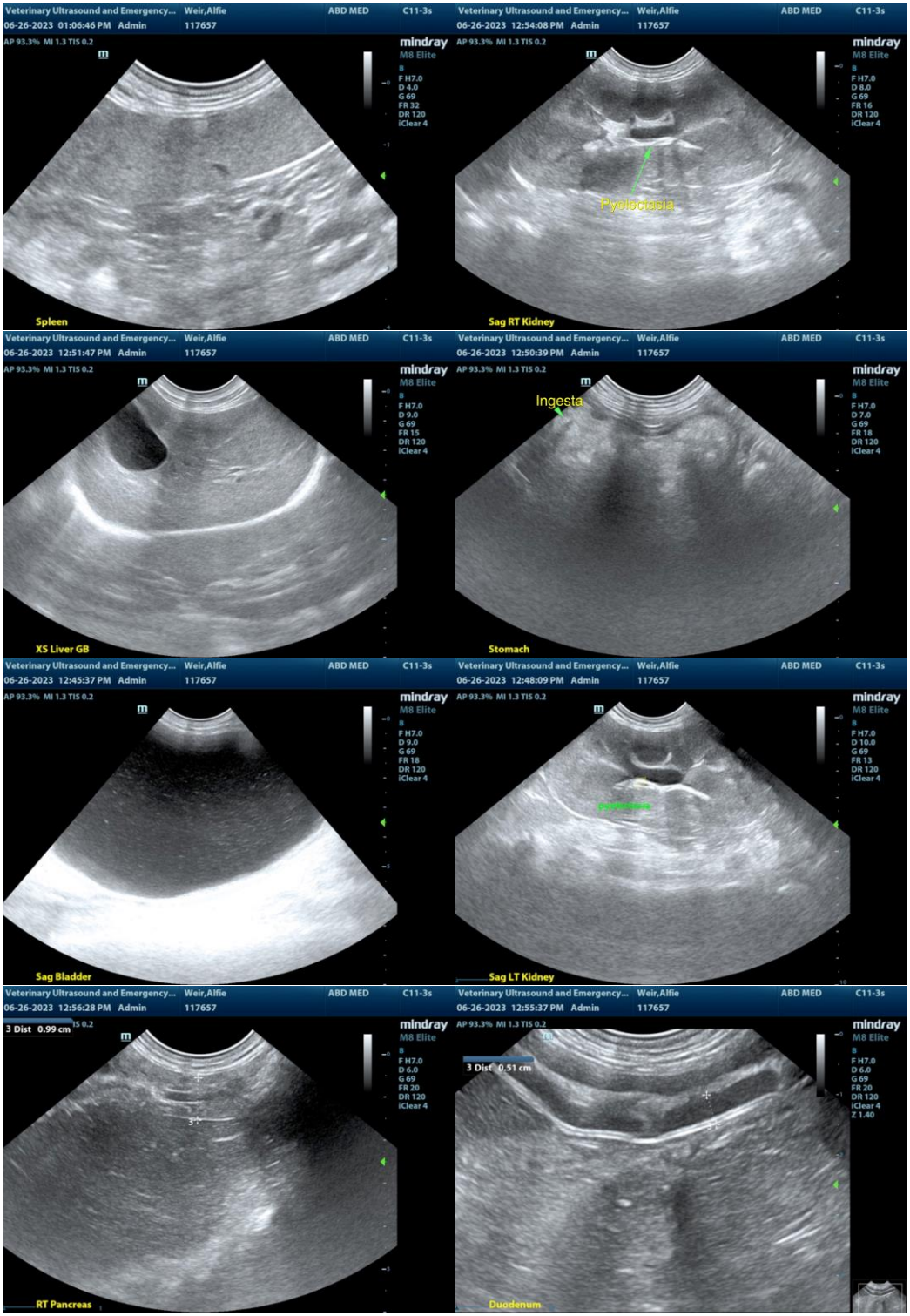

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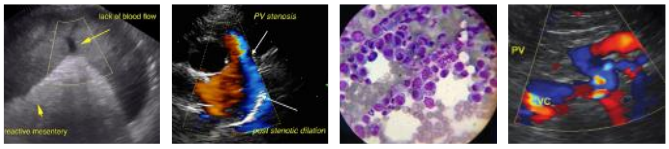

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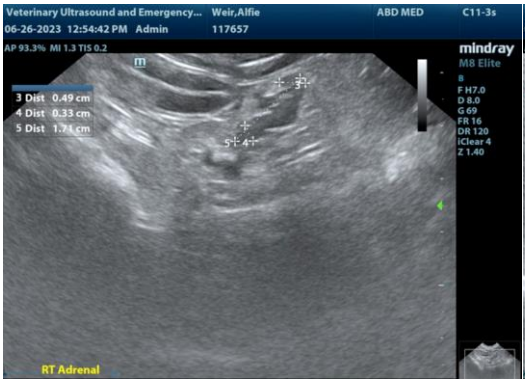

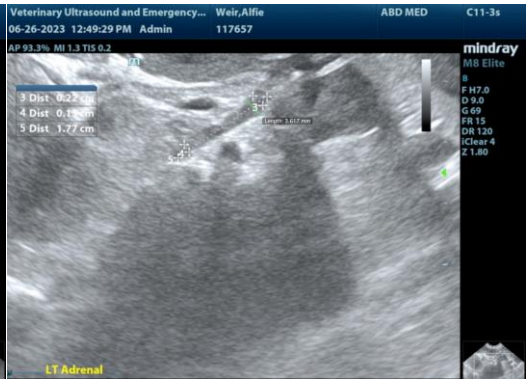

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@sonopath.com