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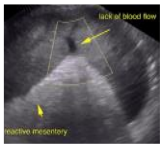
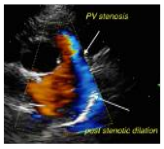
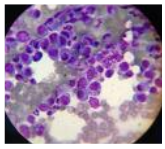
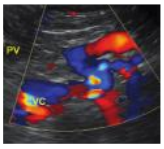

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Coconut Keown

SPECIES

Canine

BREED

American Eskimo

SEX

FS

AGE

12 y, 10m

WEIGHT

16.4

INTERPRETED BY

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

IMAGING PERFORMED BY

Carly Pate

HOSPITAL NAME

VCA McKenzie AH

REFERRING VET

Dr. Fricke

INVOICE

17204

DATE

6/29/23

PRESENTING CLINICAL SIGNS

P presents for elevated BUN and CREA- improved from historical levels, but still elevated. May 2023 labwork showed increased PT/PTT and Azotemia. After discussion it was discussed that C has rodenticide bait stations (Vitamin D3 rat poison or corn gluten rat poison)- treated with Vitamin K and recheck labwork. PT/PTT are now WNL, but Azotemia persists (some improvement is numbers, but still elevated) P has some pickiness about food, doing best on canned food with once a day feeding. Occasional small amount of diarrhea- self resolved. No vomiting. No history of PU/PD Periodontal disease- dental cleaning delayed due to azotemia

Abnormal PE/Chem/CBC/UA Results: 5/22/23 Chemistry profile - Recheck of sample confirms the previous findings - elevated BUN 105, Mild elevation Creatinine 2.1 Clotting time (PT) was reported to be prolonged.; Urinalysis - Usg 1.033 Calcium oxalate crystals 11-20/HPF pH 6.0 MA normal at 0.2 6/27/23 Chemistry profile - Improved BUN, but still elevated - 84, previously 105 Creatinine is higher at 2.4, previously 2.1; CBC - Normal CBC; PT/PTT - Clotting times are now normal. 6/29/23 repeat UA pending

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. Mild adhered luminal mineral in the ventral urinary bladder. The ureteral papillae were normal. Anechoic urine was present in the lumen otherwise. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted. No urinary bladder tumors were present.

No evidence of pathology in the area of the aortic trifurcation.

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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Both kidneys exhibited medullary mineral primarily in the lateral diverticuli. Left kidney exhibited a solitary thinly walled cortical cyst. The left kidney measured 4.0 cm in length. The right kidney measured 3.9 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 0.56 cm width at the caudal pole and 0.56 cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.40 cm width at the caudal pole and 0.65 cm width at the cranial 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.

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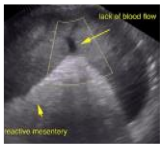

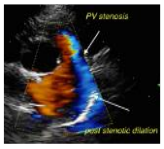

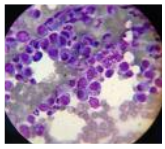
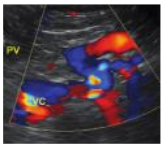

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Liver/ Gallbladder

The liver exhibited potential borderline enlargement. The parenchyma of the liver exhibited overall normal echogenicity with mild to moderate coarse echotexture. Intermittent discreetly hypoechoic intraparenchymal nodule and mild parenchymal remodeling were present. An example of a nodule measured 1.3 cm in diameter. 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 was non-distended in size containing primarily anechoic content with mild to moderate, hyperechoic, nonorganized, gallbladder sediment. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no 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 were evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Mild adhered ventral urinary bladder lumen mineral
- Chronic renal changes with nonobstructive medullary mineral and left kidney cortical cyst
- Mild hepatic parenchymal remodeling with subtle intraparenchymal nodules - subjectively benign
- Gallbladder sediment (non-mucocele)
- Sonographically unremarkable gastrointestinal tract

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patient is suspected to be passing small amounts of mineral from the kidneys into the urinary bladder. Correlation with pending urinalysis, as well as renal staging to include urine C/S and baseline UPC level, if evidence of proteinuria, is suggested.

No evidence of intrabdominal neoplastic criteria. CKD therapy with as-needed gastrointestinal support, monitoring of renal parameters, and urinalysis going forward is suggested.

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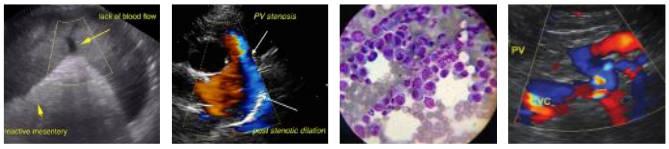

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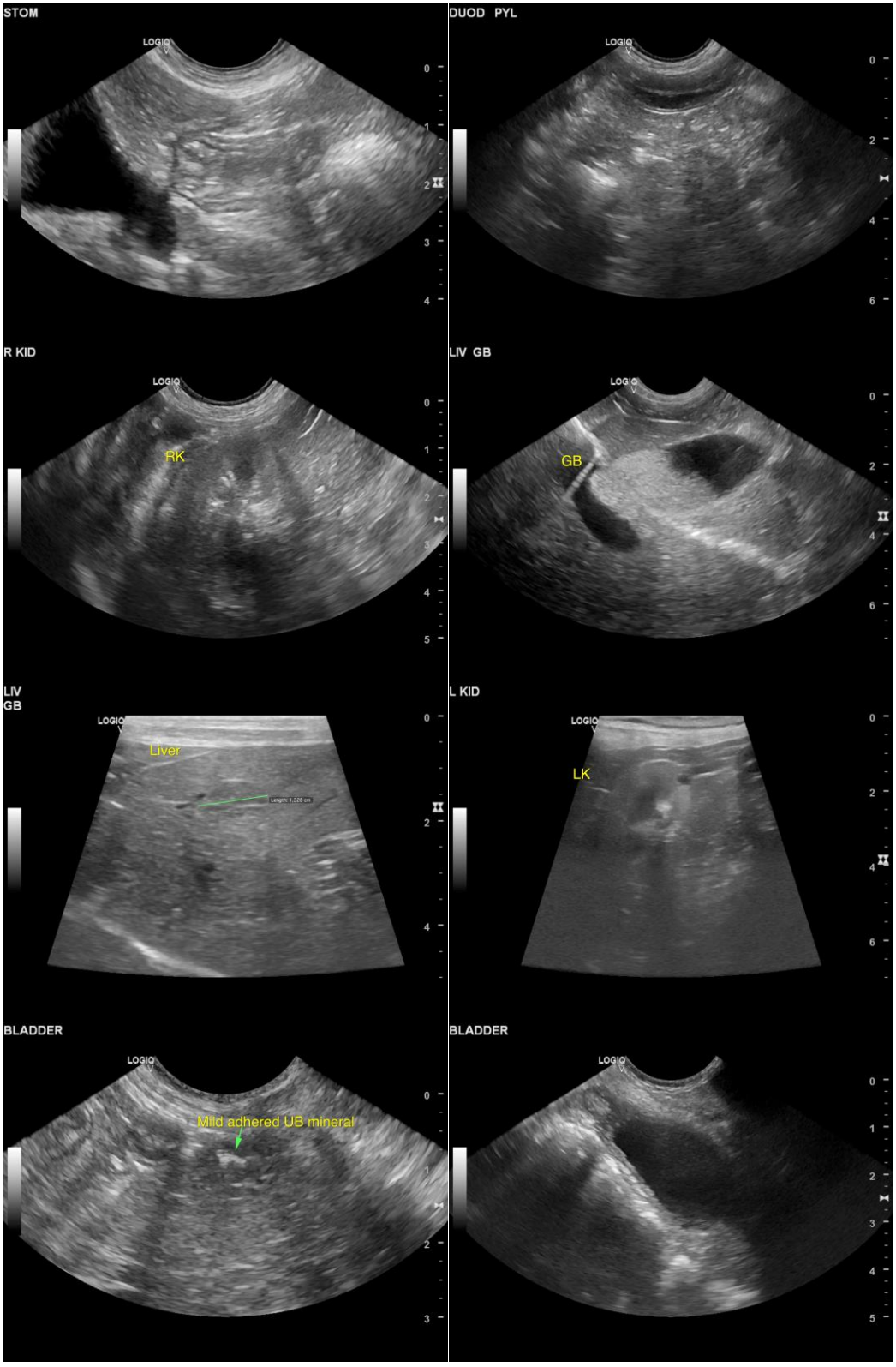

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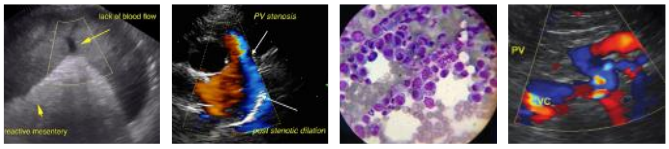

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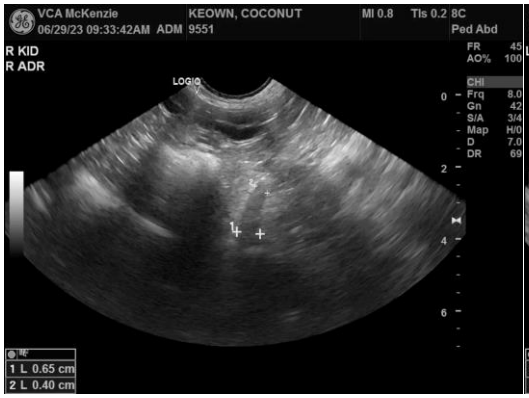

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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