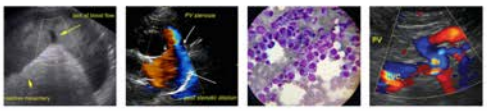


PATIENT

Ginger Grimley

SPECIES

Canine

BREED

Labrador

SEX

Spayed Female

AGE

14 Years

WEIGHT

77.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Anchor Animal Hospital

REFERRING VET

Dr. Katherine Pietsch

INVOICE

25670

DATE

9/16/21

PRESENTING CLINICAL SIGNS

Patient collapsed in hospital when excited last week. Had a similar episode in May when excited. Became pale and tachycardic and then recovered in about 30 minutes. No history of arrhythmic or heart murmur. Has been mildly anemic since May. History of ALP/ALT elevations and IRIS stage 1 renal disease., hypertension, proteinuria and urinary incontinence. Has recurrent UTIs and had mild progression of azotemia suspectd to be se condary to UTI. Looking for cause of anemia, LE elevations, evaluation of kidneys and potential cause of collapse episodes. Taking Enroquin , Enalapril, Amlodipine, Amantadine, Gabapentin, Proin ER, Mirtaza;ine, Galliprant. Radiographs: unremarkable thorax, constipation, chronic renal infarcts, mild arthritis. Sedated for AUS with Butorphanol/Midazolam Abnormal PE/Chem/CBC/UA Results: Culture Staph Pseudintermedius, BUN ;53; Crea 2.2; ALT 182; ALP 1947; HCT 34.3.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder itself exhibited normal thickness and tone. The proximal urethra exhibited subtle subjective decreased tone to a depth of 2.0 cm. 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 were noted.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. Mildly variable corticomedullary echogenicity and mild pyelectasia oted as well as loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 5.8 cm. The right kidney measured 6.1 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.53 cm at the cranial pole and 0.73 cm at the caudal pole. The right adrenal gland measured 0.65 cm at the cranial pole and 0.64 cm at the caudal pole.

Spleen

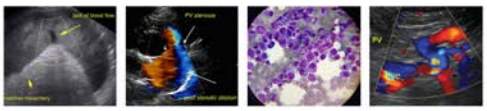
The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. No masses. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age related remodeling with minor potential for inflammatory or neoplastic disease.

Liver

The liver exhibited generalized enlargement with overall mildly increased hepatic parenchyma echogenicity with mild to moderate coarse echotexture. Several subtly expansive non-homogeneous, isoechoic to mildly hypoechoic parenchymal nodular mass lesions were present. Example measured 3.8 cm in diameter. No evidence of capsular escape associated with the nodular mass lesions. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder 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. Mild retained anechoic fluid and echogenic ingesta. Gastric body wall measured 0.50 cm.



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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 ileus, obstruction or foreign material. Duodenum wall measured 0.44 cm. Jejunum wall measured 0.37 cm.

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

A focal area of very scant free fluid noted adjacent to the lateral spleen. No overt lymphadenopathy. The omentum was of uniform echogenicity.

Intermittent, mildly prominent to enlarged mesenteric nodes and medial iliac lymph nodes were present. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). These lymph nodes are likely incidental without neoplastic or inflammatory criteria.

ULTRASONOGRAPHIC FINDINGS

- Mild decreased proximal urethral tone – consistent with incontinence.
- Bilateral moderate chronic renal changes with mild pyelectasia
- Chronic hepatopathy with several non-specific nodular mass lesions – inflammation, hyperplasia, hematopoiesis, granuloma or neoplasia possible.
- Mild gallbladder debris (non-mucocele)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The renal pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Minor potential for chronic pyelonephritis given the recurrent UTIs. Urine C/S and protein: creatinine ratio on sterile urine sample is recommended. Ideally based on urine culture and sensitivity results, a higher dose of antibiotic for shorter frequency (i.e., Clavamox ro Enrofloxacin 20 mg/kg PO SID for 3-5 days may prove more effective at eliminating recurrent infection.

If accessible, ultrasound guided FNA of the hepatic parenchyma as well as nodular lesion warranted for screening cytology. The presence of gastric ingesta is nonspecific and likely indicates post-prandial presentation. Correlation with most recent meal ingestion is recommended. If documented NPO prior to the ultrasound, the presence of gastric ingesta may indicate some degree some of gastric hypomotility or metabolic stasis. The sonographic presentation of the ingesta was most consistent with food, without evidence of foreign material.

No evidence of adrenal tumors as a potential cause of hypertension or collapse. 3-view chest radiographs recommended if not done to assess for the thoracic pathology as well as cardiopulmonary status.

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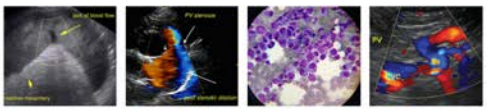

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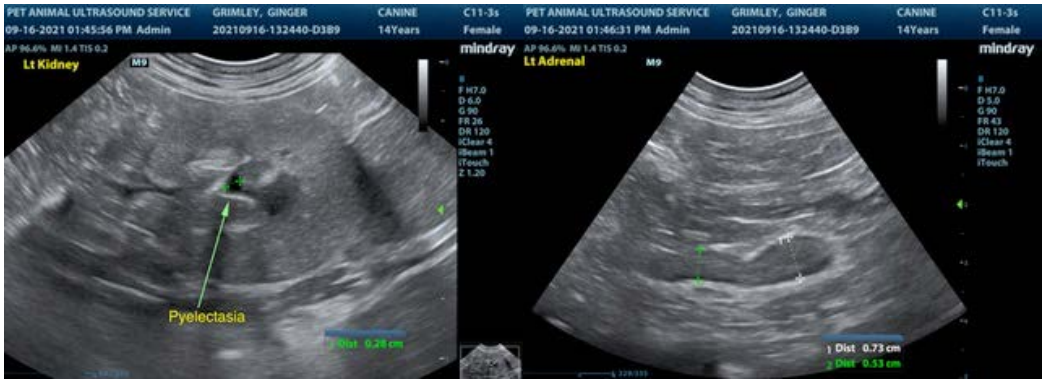

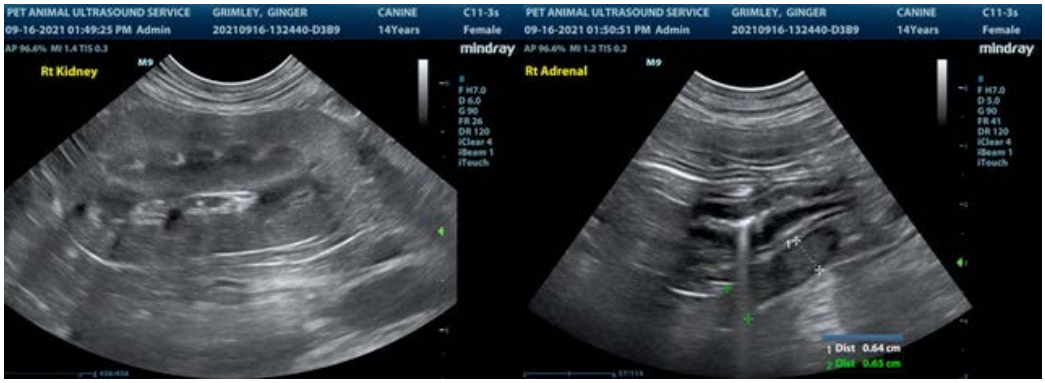

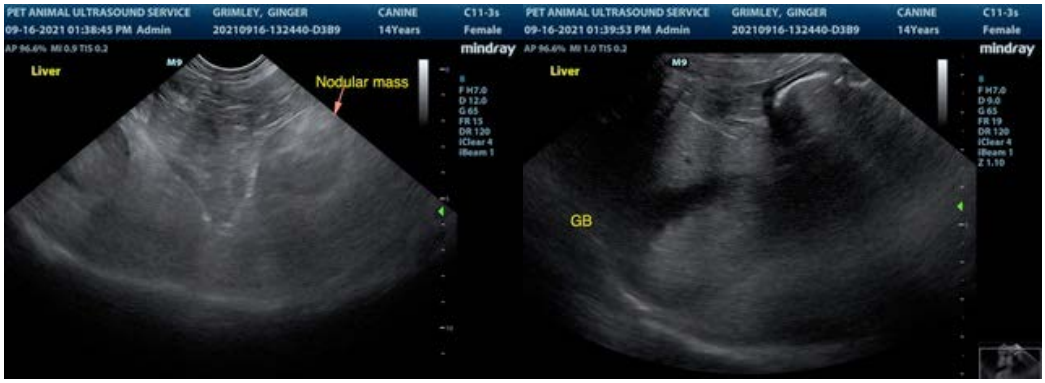

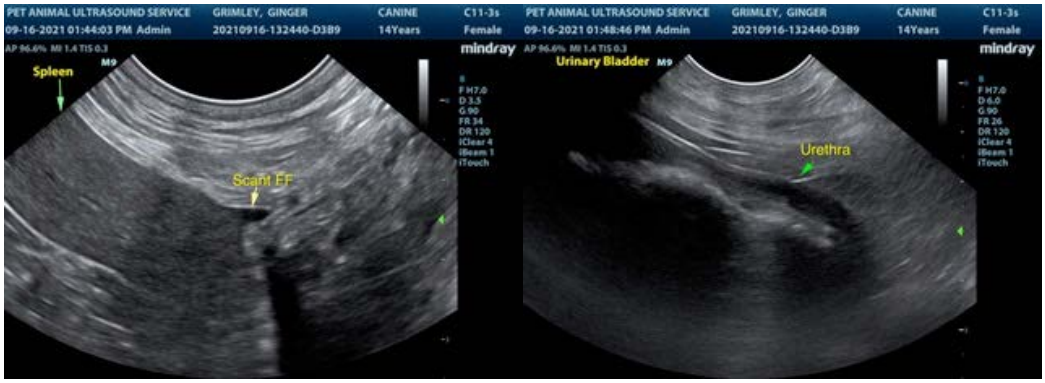

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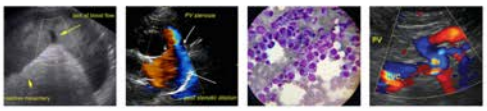

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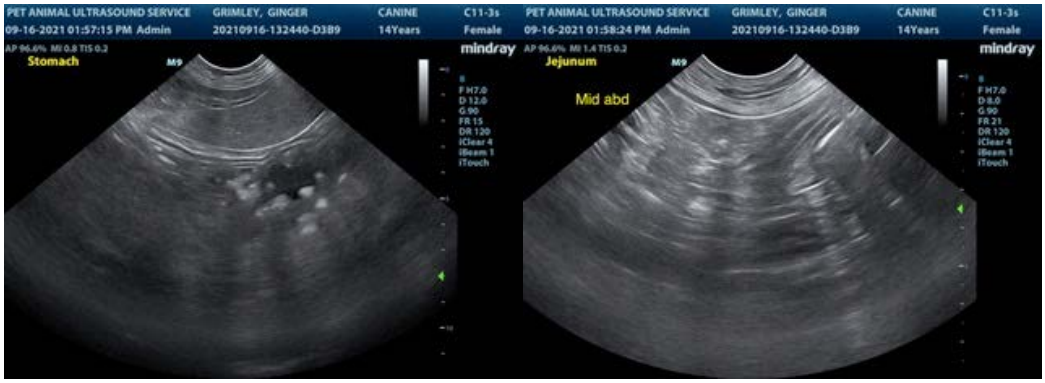

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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