

**PATIENT PRESENTING CLINICAL SIGNS**

Teddy Foree

Chief Concern / Provisional Diagnosis: Elevated white blood cells that are non-responsive to Clavamox therapy; non-regenerative anemia; senior pet that is ADR / weak. Relevant Medical History and Physical Exam findings: No major physical exam findings indicating underlying condition. Recent Diagnostics: Relevant Laboratory Results / Abnormalities: PCV : 40; TP 9 Globulins 5.5 (2.5-4.5) BUN 41 (7-27) Proteinuria 7.6 Current medications (include full name, dosage and frequency): Herbal Benefit Hips and Knees Protegrity EZ Thyro tabs 0.5mg PO BID Previously was on Benazapril for proteinuria at 2.5mg PO BID however recently stopped b/c was making ill / weak per Sonja

**SPECIES**

Canine

**BREED**

Poodle

**SEX**

Neutered Male

**AGE**

15 years

**WEIGHT**

16

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Loetitia Saint-Jacques, RVT

**HOSPITAL NAME**

MountainView AH

**REFERRING VET**

Dr. Dahlgren

**INVOICE**

12295tw

**DATE**

9/24/21

**Urinary System**

The urinary bladder, trigone, and cystourethral junction exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Nondependent, particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 0.85 cm in diameter.

The area of the aortic trifurcation was free of pathology.

Normal renal size with asymmetrical margination were present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Pinpoint corticomedullary mineralization along with small cortical cysts were present in both kidneys. Mild pyelectasia was noted in the right kidney. The left kidney measured 5.2 cm in length. The right kidney measured 5.1 cm in length.

**Adrenal Glands**

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.8 cm width in the cranial pole and 0.75 cm width in the caudal pole. The right adrenal gland measured 0.54 cm width in the cranial pole and 0.54 cm width in 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. 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/ Gallbladder**

The liver exhibited potential for subjective mild generalized enlargement. 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. Subtle echogenic nodules, suggestive of



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areas of nodular hyperplasia or small lipogranulomas, were present. 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 with moderate, dependent to nondependent inspissated gallbladder debris. No evidence of peripheral gallbladder inflammation was noted.

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***Gastrointestinal***

**BREED**

Poodle

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. Generalized mild jejunal nonspecific mucosal speckling was present.

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Normal visible colon wall layers were present with apparent formed feces in lumen.

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The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

***Free Abdomen***

**WEIGHT**

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No overt lymphadenopathy or peritoneal effusion was present.

**ULTRASONOGRAPHIC FINDINGS**

***Primary Findings***

- Bilateral chronic glomerulonephritis renal pattern with mild right kidney pyelectasia
- Nonspecific jejunal mucosal speckling
- Mild subjective hepatomegaly with intermittent benign nodules
- Moderate nondependent to inspissated gallbladder debris, potential for very early mucocele formation possible

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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Urine culture and sensitivity as well as recheck UPC if not recently done is recommended. If persistent elevated UPC and ACE inhibitor medication is not possible, angiotensin receptor blocker medications along with a restricted protein diet may be considered. Monitoring of systemic blood pressure is recommended.

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The jejunal mucosal speckling is nonspecific and may indicate benign or age-related intestinal mucosal changes. Mucosal speckling has also been associated with nonspecific enteritis if current or previous history of gastrointestinal signs.

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Ursodiol therapy along with monitoring for evidence of cranial abdominal / subxiphoid pain on palpation as well as increasing cholestasis is suggested. CBC / Pathology review and three view chest radiographs if not done to rule out occult thoracic pathology, as well as assessment of cardiopulmonary status, is warranted.



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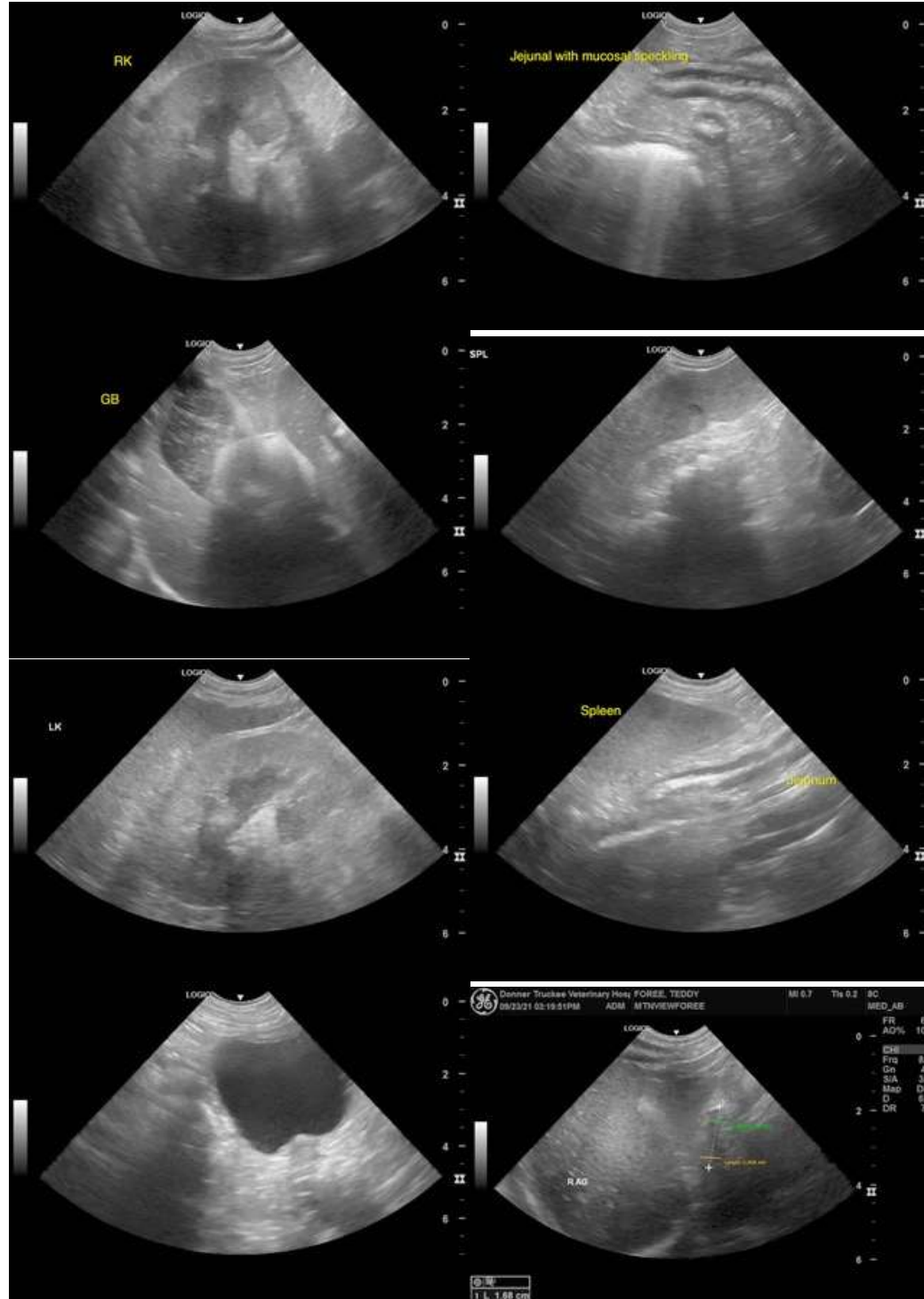
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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