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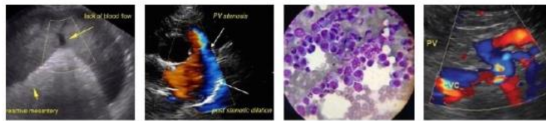


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Tickles Tesseur

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years

WEIGHT

6.5 kg

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Main Street AH

REFERRING VET

Dr. Bronchu

INVOICE

13408

DATE

1/12/22

PRESENTING CLINICAL SIGNS

History: Painful suddenly on Thursday Jan 6th, howling in pain and in and out of litterbox but not voiding urine. Presented to Emerg clinic Friday, urinated large volume of urine on towel at arrival at clinic. Physical exam normal except for painful abdomen and small bladder. Buprenorphine and Gabapentin.

Abnormal PE/Chem/CBC/UA Results: Rads - right lateral showed very large renal silhouette for left kidney, 3 uroliths within the kidney faintly visible on border of kidney.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is severely enlarged (6.73 cm in length); with an irregular shape. A 5.04 cm x 4.80 cm irregularly walled (up to 0.60 cm) well circumscribed fluid filled structure is present at the cranial to mid aspect. The fluid contains a large amount of suspended echogenic debris. The structure causes capsular expansion. The structure causes obliteration of approximately 50% of the normal renal architecture. In the remainder of the kidney, there is mild loss of corticomedullary distinction. A few nephroliths are visualized. Mild to moderate pyelectasia is present (0.42 cm in the longitudinal plane). There is no obvious evidence of hydroureter. Renal vasculature is normal in the caudal aspect.

The right kidney is normal size (4.65 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of the adrenal glands is evaluated. No obvious pathology is seen.

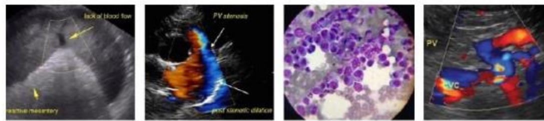
Spleen

The spleen is normal in size with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.



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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal to mildly thickened (up to 0.30 cm) with a normal layering pattern and appropriate mural detail. There is slight disruption in the normal 1:3 muscularis to mucosal ratio and mild thickening of the submucosal layer in most segments. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely visible with minimal deviation of the normal peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

There is no obvious evidence of free fluid. A 0.91 cm gastric lymph node is visualized. Surrounding mesentery is hyperechoic. A few prominent mesenteric lymph nodes are also suspected.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The fluid filled structure in the left kidney is most consistent with an abscess. However, an abscessed tumor or cyst cannot be completely excluded. Left nephrolithiasis is also present along with bilateral age-related renal changes.

Secondary Findings

- Bowel pattern consistent with inflammatory bowel disease. Emerging lymphoma is also possible but considered less likely.

- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

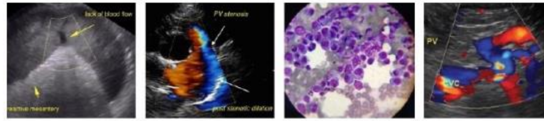
- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Baseline lab work, including a CBC chemistry panel, urinalysis and urine culture and sensitivity is recommended (if not already performed).

- Consider a fine needle aspirate of the fluid filled structure in the left kidney, if clotting status and blood pressure are normal. A 25-gauge needle should be used. The fluid should be submitted for cytology as well as aerobic and anaerobic cultures.

- Alternatively, a left nephrectomy can be considered, if function in the right kidney is



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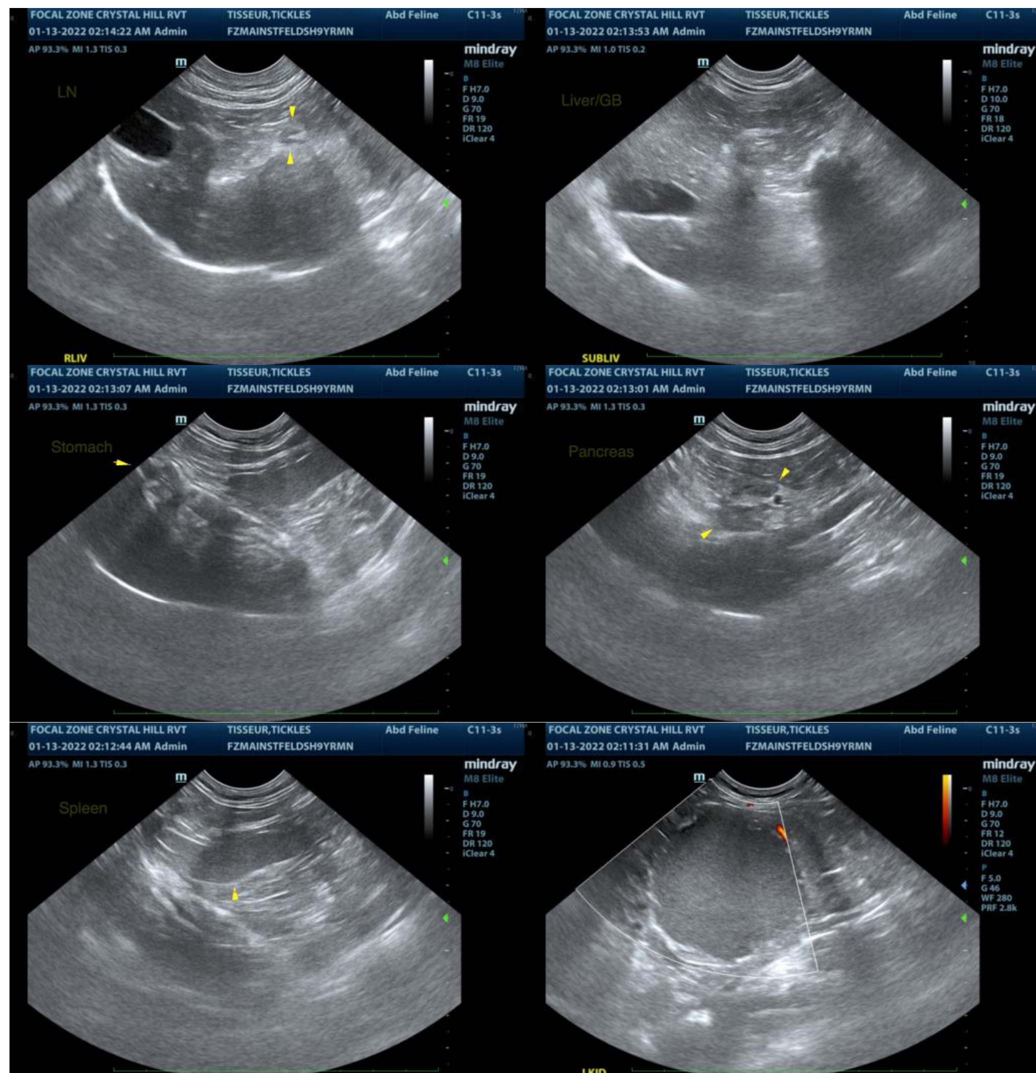
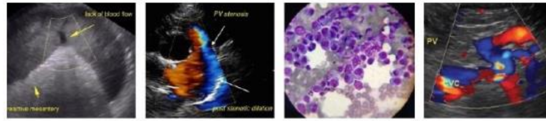
adequate. If surgery is pursued, referral to a board-certified surgeon is recommended, due to the potential for perioperative complications. An abdominal CT scan may be useful in presurgical planning.

- Three-view thoracic radiographs are recommended to assess cardiopulmonary status, particularly if the patient is to undergo anesthesia.

- While awaiting test results, supportive care and broad-spectrum antibiotics therapy (i.e., fluoroquinolone) is recommended.





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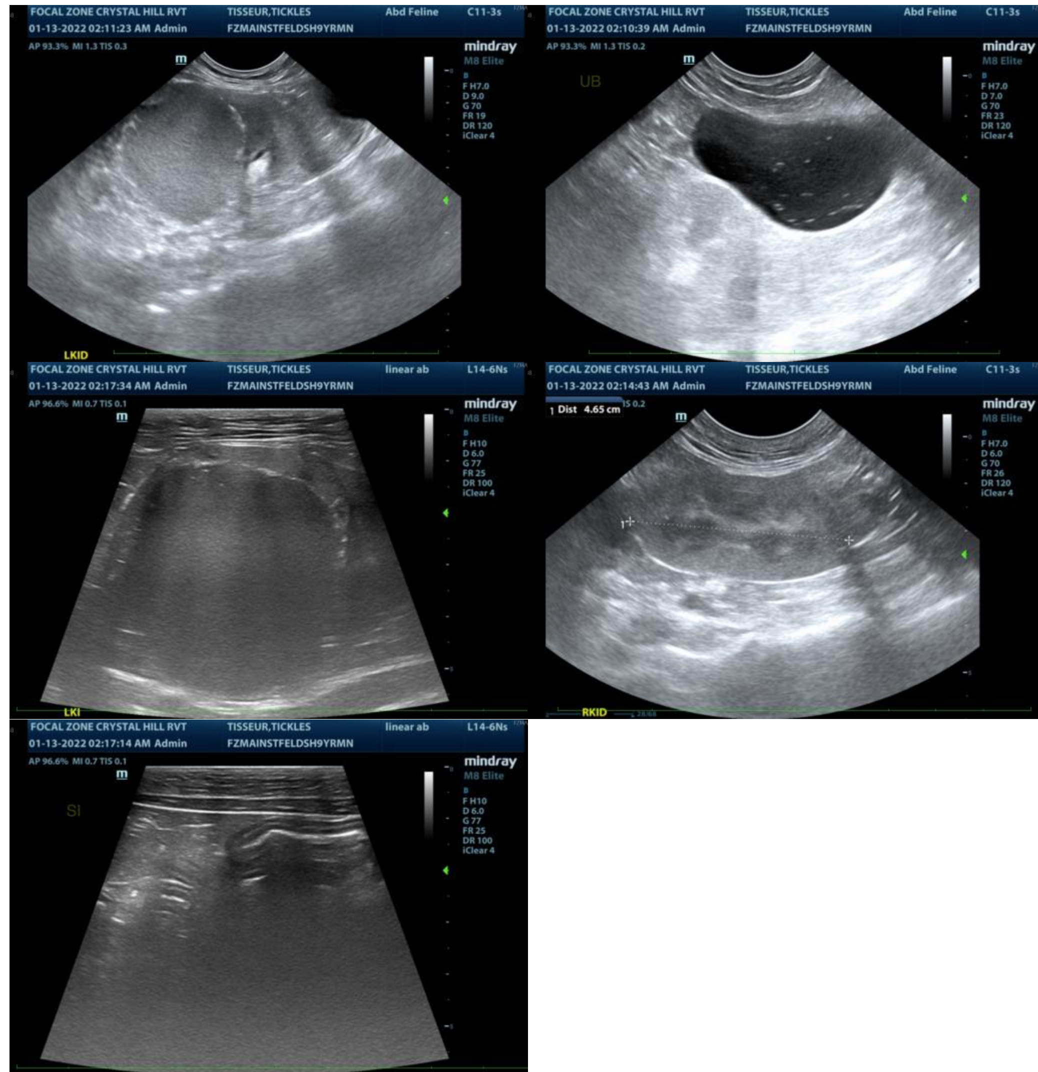

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

andrea_nicastro2@hotmail.com