IMAGING PERFORMED BY

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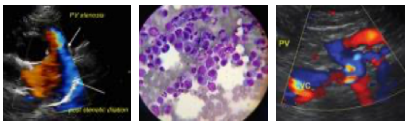

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

10/12/21

PATIENT

Stormy Kammer

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male, neutered

AGE

9/23/2016

WEIGHT

12.1 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Greenbrier VC

REFERRING VET

Dr. Whitfield

INVOICE

12343

PRESENTING CLINICAL SIGNS

History: Three weeks ago, patient presented for decreased appetite, vomiting and polydipsia. Abdominal radiographs were within normal limits. Fpl was negative. CBC/Chem showed dehydration, elevated BUN, Creatinine, and Globulins. P was hospitalized on IV fluids and supportive meds and improved. Since then, P has good energy, is no longer vomiting and is acting normally; however, P is still anorexic and has recently stopped drinking water. Repeat rads wnl. Repeat chemistry showed improved though still elevated creatinine and was otherwise wnl.

Current Medications: Zofran 1 mg BID prn (started on 10/11/2021)
Famotidine SQ injection 10/11/2021. Previously on Elura and Cerenia but discontinued due to poor response.
Lab Results: 9/21/2021: Azotemia and Dehydration -- Creat 3.4 H; BUN 43 H; TP 9.1 H; Glob 5.7 H; RBC and HCT elevated. 10/11/2021: Azotemia (improved) -- Creatinine 2.6 H.
Radiographs: WNL.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: not needed
Stat report not requested

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended. The wall is normal in thickness with a smooth mucosal surface. A small amount of adhered debris/sand is present at the ventroapical aspect. In addition, a small amount of suspended echogenic debris is observed within the lumen. A few tiny cystic calculi (vs aggregations of mineralized debris) are observed near the trigone. The trigone itself and the visible portion of the proximal urethra are normal.

The left kidney is normal size (4.26 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is variably thickened and there is poor corticomedullary distinction. There is no evidence, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.00 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 left adrenal gland is normal in size (0.45 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.47 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.77 cm in width at the level of the hilus) 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.

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 with a normal layering pattern and appropriate mural detail. There is subtle thickening of the submucosal layer in some

segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. The lumen of the descending colon contains shadowing fecal material. No obstructive disease is noted.

Pancreas

The left and right limbs of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. A few prominent lymph nodes are observed adjacent to the ileocecal colic junction, the largest measuring 0.77 cm in length.

ULTRASONOGRAPHIC FINDINGS

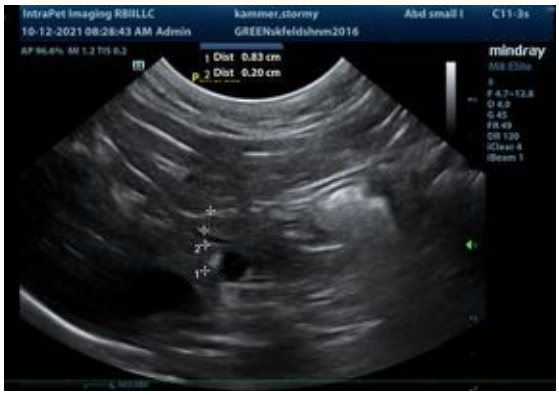
- Bilateral nephropathy, more severe in the left kidney.
- Adhered and suspended urinary bladder debris/sand +/- tiny cystic calculi.
- Bowel pattern consistent with inflammatory bowel disease.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

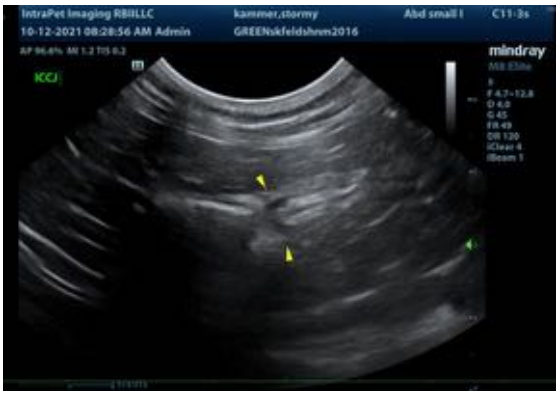
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

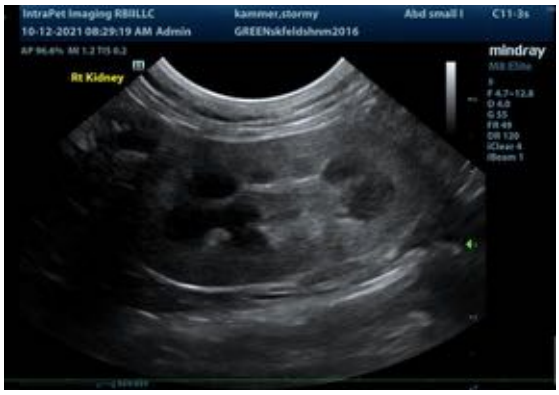
Given the azotemia, a urine culture and sensitivity is recommended to assess for occult pyelonephritis. A baseline blood pressure measurement is also recommended. A UPC should be considered if proteinuria is present.

To further assess for causes of anorexia, consider the following:

1. Three-view thoracic radiographs
2. GI panel including serum cobalamin, folate, TLI and PLI
3. +/- endoscopic or surgical gastrointestinal biopsies.



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kammer,stormy
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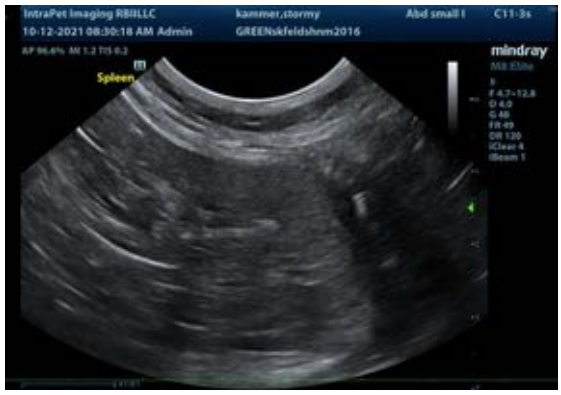
Rt Kidney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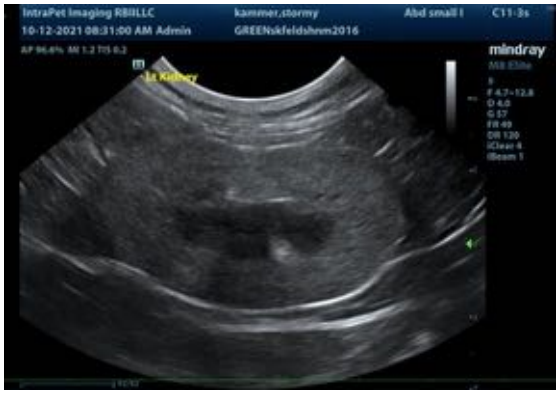
Spleen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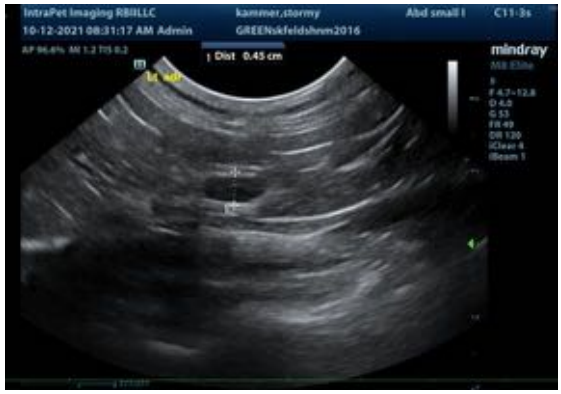
lt Kidney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C11-3s
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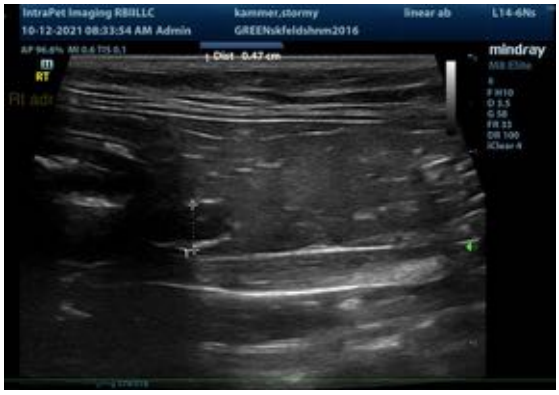
mindray
Dist 0.45 cm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linear ab
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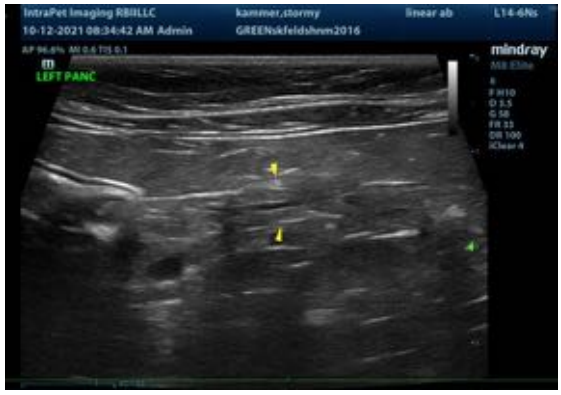
mindray
Dist 0.47 cm
RT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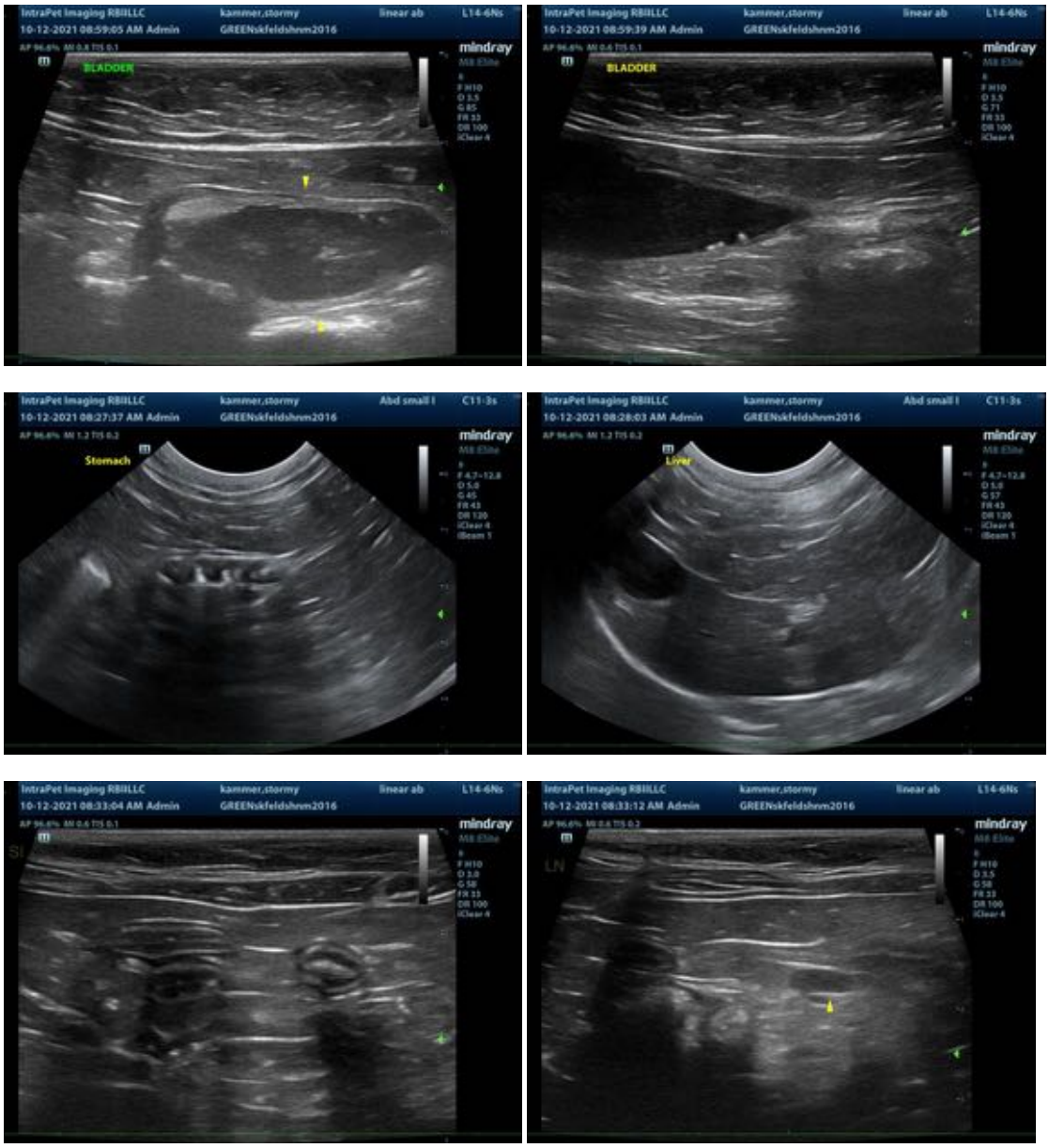
GREENskfeldshnm2016
mindray
LEFT PANC



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*)
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