Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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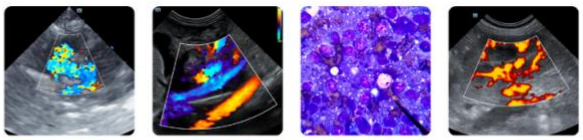

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Ody Lavin

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

14

WEIGHT

5.16kg

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

BluePearl MP ER

REFERRING VET

Dr Esther Schow

INVOICE

22326

DATE

12-1-25

PRESENTING CLINICAL SIGNS

Presented with new azotemia. Hx of presumptive IBD for past 5 years – on corticosteroids. Patient's blood pressure has been normal. Patient's azotemia has resolved with 72 hours of IV fluid diuresis.

Abnormal lab-work values: 11/30: BUN 44. AST 78.
11/29: Crea - 2.7. BUN - 55. AST – 73. POT - 3.0. CHLO – 108

Current Medications: Unasyn, Ondansetron, Cerenia, KCL CRI, DEX SP, FLUIDS
Radiographic Findings - THORAX and ABDOMEN:

Assessment:
Mildly decreased cranial abdominal serosal detail. Differentials include artifact secondary to inadequate radiographic technique VS superimposition of multiple fluid-filled structures or true pathology such as mesenteric inflammation secondary to an acute pancreatitis, gastroenteritis, and/or hepatitis VS mild volume peritoneal effusion.
There is no evidence of a mechanical obstruction or a foreign body.
Medical management of the reported gastrointestinal signs is indicated at this time. If the clinical signs do not respond to supportive care and empiric management OR if the patient's clinical status declines e.g. abdominal distention and pain, protracted vomiting, fever etc., follow-up 3-view abdominal radiographs could be performed to re-assess the GI tract for progressive intestinal dilation. If there is no response to treatment, an abdominal ultrasound to evaluate the internal architecture of the GI tract including the pancreas and rule out an intestinal foreign body not visible on radiographs could also be considered. For further investigation, consider fecal testing (including PCR), CBC, biochemistry, and a GI profile if warranted.

Patient sedated with butorphanol for this study.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (4.09 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.5 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.44 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.43 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.98 cm in width at the level of the hilus) with a normal capsular

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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 curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is moderately distended with ingesta. 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 segmentally dilated with chyme. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas are 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.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

Other

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral nonspecific age-related renal changes with trace right pyelectasia. Given the patient's clinical history, an acute-on-chronic presentation should be considered.

Secondary Findings

- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.
- 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

Ideally, a urine culture and sensitivity would be performed on a pre-antibiotic sample. If not pursued, consider a recheck urinalysis with culture and sensitivity 5-7 days after the last dose of antibiotics. If

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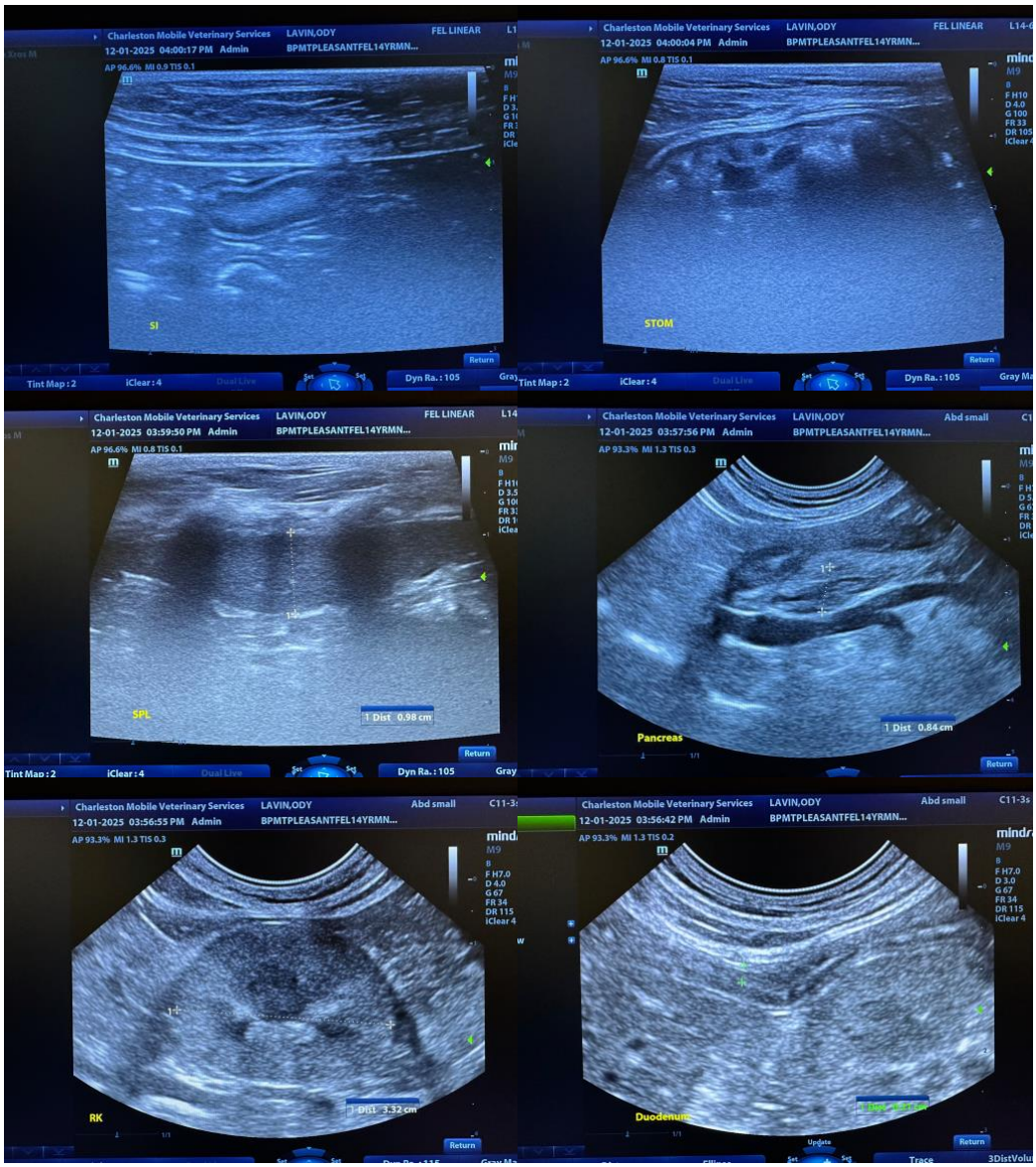
proteinuria is present in the absence of infection, consider a UPC. Once the patient is home and eating normally, consider transitioning to a prescription diet that addresses both the inflammatory bowel disease and renal disease.



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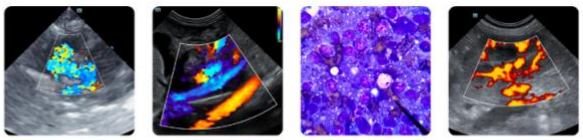

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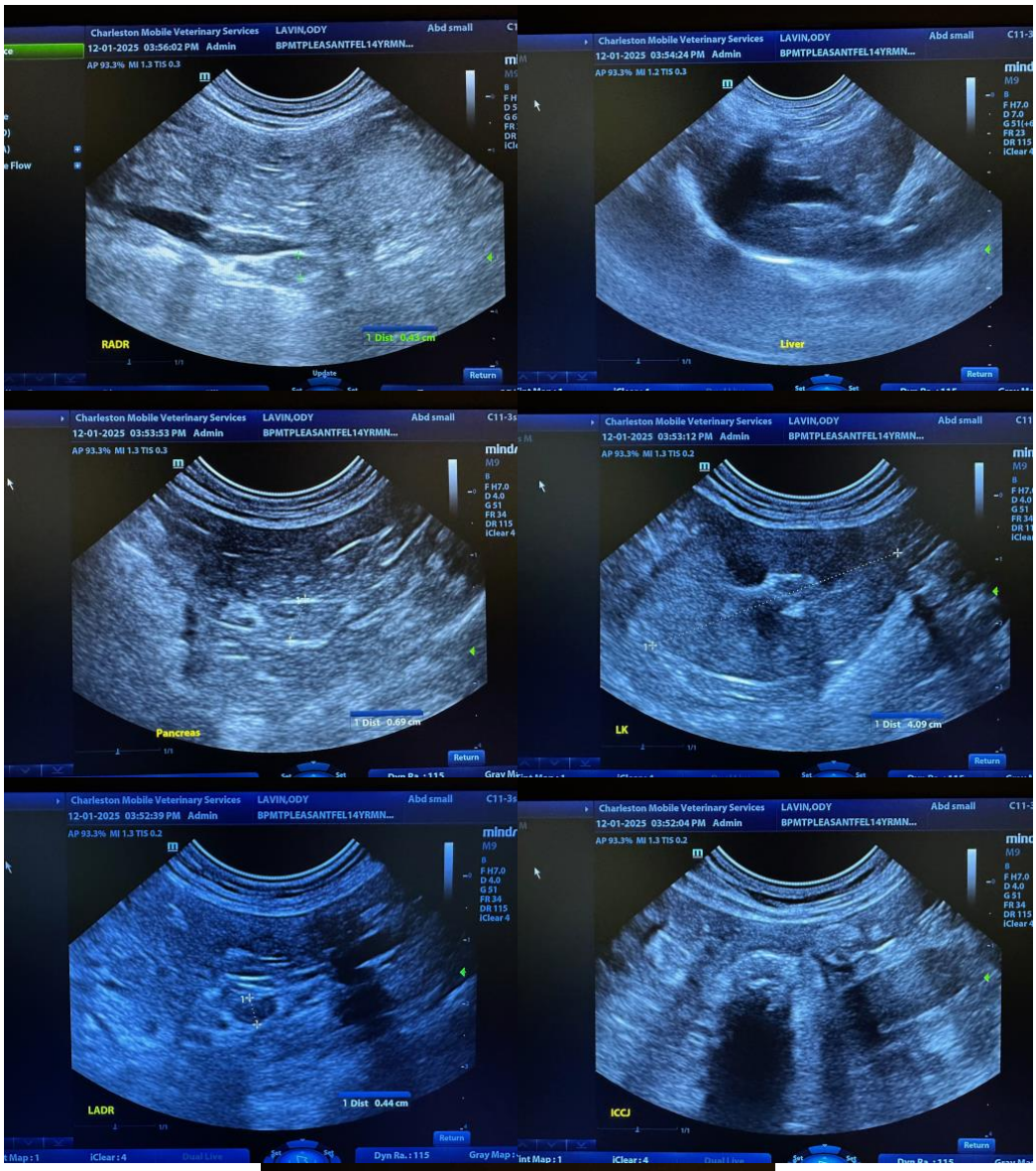

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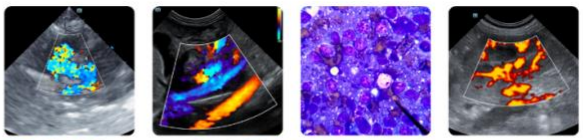

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com