



**PATIENT**

Buddy Van Leeuwen

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

14 years

**WEIGHT**

8.1 lbs

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Dr. Goodman

**HOSPITAL NAME**

Evandale-Blue Ash PH

**REFERRING VET**

Dr. Goodman

**INVOICE**

10875

**DATE**

5/5/22

**PRESENTING CLINICAL SIGNS**

History: Hx of heart disease. Presented 5/2 for respiratory changes and weight loss. Intermittent abdominal component to breathing, more effort to it. Eating and drinking and acting himself otherwise. No coughing, sneezing, vomiting or diarrhea. Performed CBC/Chem/UA/T4 to lab, showed elevated kidney values compared to October 2021. Is down 1lb since November 2021. BP performed today and WNL. Previously on Atenolol and Enalapril but has not been on it in over a year. No current medications.

Abnormal PE/Chem/CBC/UA Results: 10/7/2021: SDMA - 15 BUN - 27 Crea - 1.5 Phos - 3.4  
11/4/2021: SDMA - 11

**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 lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1 cm, are normal.

The left kidney is normal size (3.08 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with poor corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter

The right kidney is normal size (3.79 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with nodule loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

**Adrenal Glands**

The left adrenal gland is normal size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The region of the right adrenal gland is evaluated. No obvious pathology is observed in this region.

**Spleen**

The spleen is mildly enlarged (1.06 cm in width at the level of the hilus) with a slightly swollen medial contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

**Liver**

The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen, with minor changes consistent with age-related remodeling. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

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



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disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

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**Pancreas**

The right limb is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to the surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface in this region is subtly hyperechoic.

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**Free Abdomen**

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A few prominent mesenteric lymph nodes are visualized, the largest measuring 1.99 cm in length.

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**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

**AGE**

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- The pancreatic changes could be consistent with mild low-grade pancreatitis with age-related remodeling +/- fibrosis. This diagnosis could be supported with a positive Murphy's sign and an elevated CPLI.
- Bilateral, nonspecific, chronic, age-related renal changes

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\*An obvious cause for the patient's abdominal breathing is not identified in this study. However, low-grade pancreatitis may be a contributing factor.

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**Secondary Findings**

- Bowel suggestive of inflammatory bowel disease. However, correlation with the patient's clinical history is recommended.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, antigenic stimulation, or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- Mild hepatomegaly. This may be a normal variant for this patient or may represent passive congestion, inflammatory hepatopathy, infiltrative neoplasia (less likely), other hepatopathy.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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- Given the sonographic changes, consider a GI panel including serum cobalamin and folate, TLI and PLI.
- Given the patient's azotemia, consider the following:
  - Urinalysis
  - Urine culture and sensitivity
  - UPC (if proteinuria is present)



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- Thoracic radiographs (three-view) are recommended if not already performed.
- Further recommended should be based on the patient's echocardiogram report.

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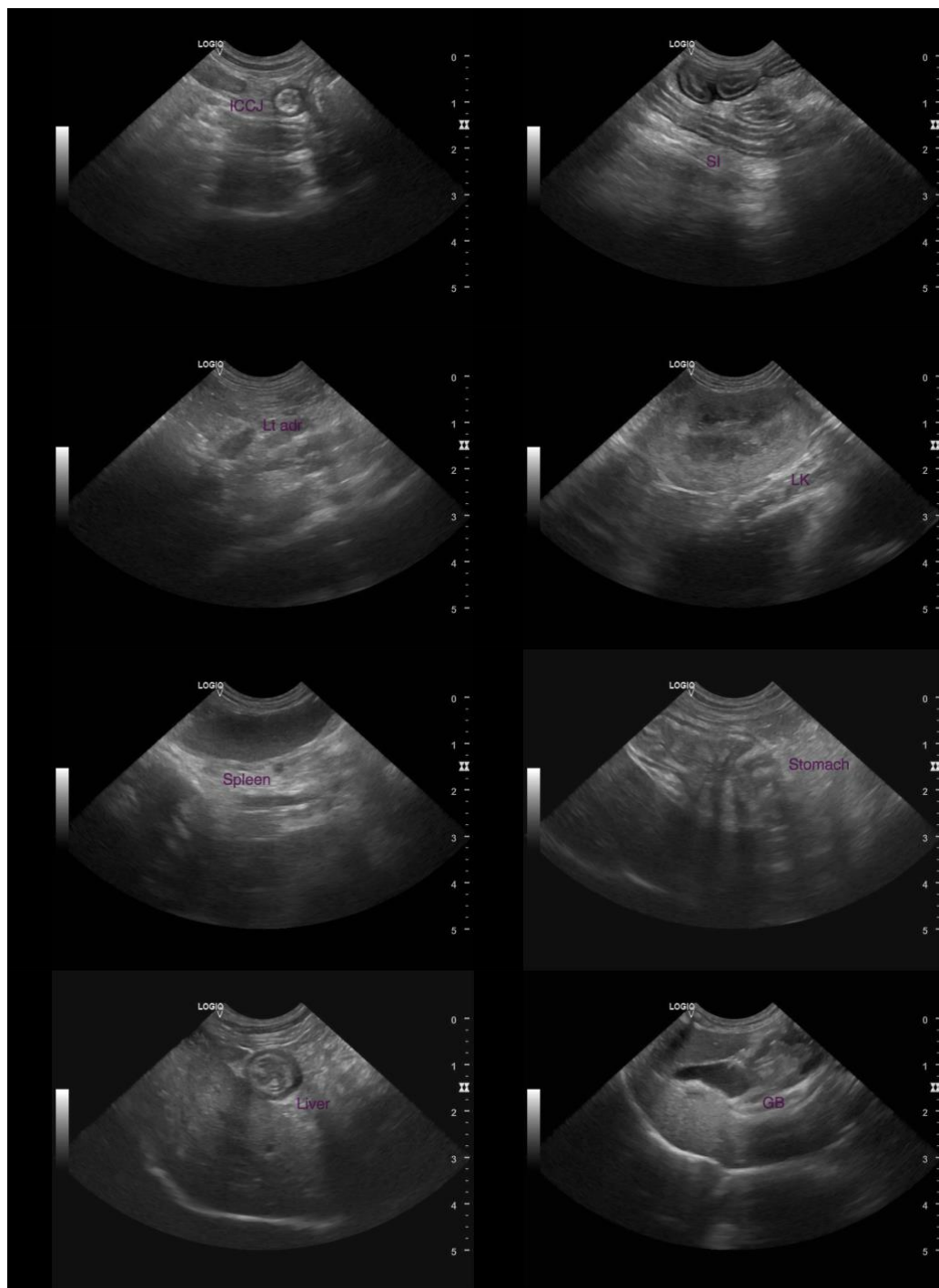
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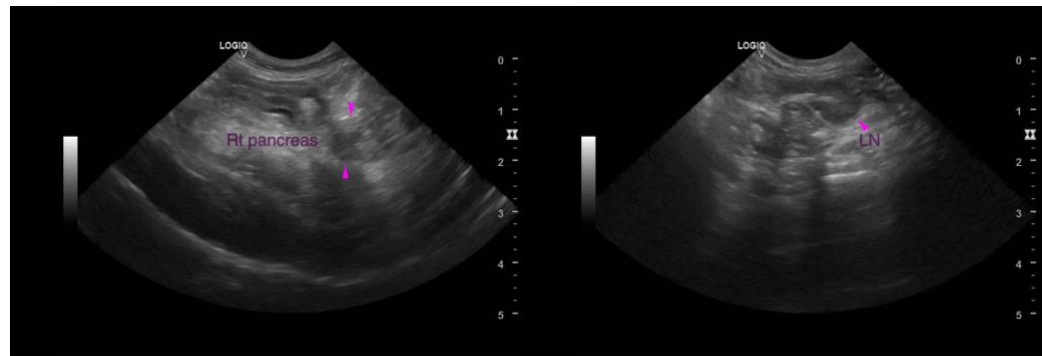
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)**  
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