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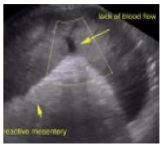
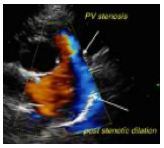
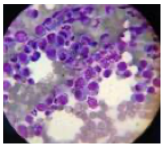
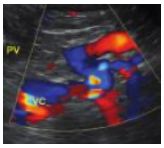
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Chip Hunter

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

5 years

WEIGHT

4.43 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr Belan

HOSPITAL NAME

Glamorgan AC

REFERRING VET

Dr Faulk

INVOICE

13756

DATE

7.19.23

PRESENTING CLINICAL SIGNS

History: Lethargic with high calcium. Hyper Parathyroid testing negative.
Attending concerned about possible Ab mass. Chest x rays taken no abnormalities seen.

Abnormal PE/Chem/CBC/UA Results: Hypercalcemic and PTH test normal. UA 1+ protein

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A few, small cystic calculi are visualized, along with a scant amount of suspended echogenic debris. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.02 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. The cortex is isoechoic relative to the spleen. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few, small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

The right kidney is normal in size (4.24 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. The cortex is isoechoic relative to the spleen. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few, small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.30 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature appear normal.

The right adrenal gland is normal size (0.32 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

The spleen is normal in size (0.94 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 appears 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 portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 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.

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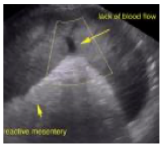
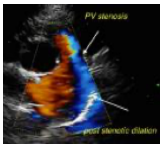
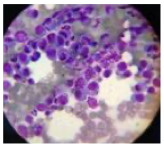
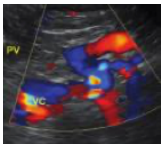

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Pancreas
The pancreas is diffusely visible with minimal deviation from the normal peripheral contours. The parenchyma in the left limb is slightly hypoechoic relative to surrounding omental fat, and subtly mottled in appearance. The parenchyma in the right limb is largely isoechoic relative to surrounding omental fat and mildly heterogenous. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic effusion.

Free Abdomen
There is no obvious evidence of free fluid. A few prominent mesenteric lymph nodes are visualized (the largest measuring 0.68 x 0.26 cm).

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Cystic calculi

Secondary Findings

- Bilateral chronic renal changes with nonobstructive nephrolithiasis
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

*An obvious cause for the patient's clinical signs is not definitively identified in this study. If the parthyroidhormone level is normal in the face of hypercalcemia, this would be considered inappropriate and primary hyperparathyroidism may be present. Other considerations include occult neoplasia, idiopathic hypercalcemia, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Thoracic radiographs are recommended to assess for occult disease in the chest.
- If the PTH is normal in the face of hypercalcemia, consider ultrasound of the thyroid/parathyroid glands to evaluate for a parthyroid nodule.
- If the above diagnostics are normal, a bone marrow aspirate can be considered to assess for neoplasia. However, one would expect CBC abnormalities if neoplasia in the marrow was present.
- A cystotomy with stone removal, analysis and culture is recommended. Alternatively, medical dissolution of the stones can be considered with a prescription renal diet and broad-spectrum antibiotic therapy. If there is no improvement in stone size after 4 weeks of therapy, a cystotomy should be reconsidered. If the stone size is reduced, continue therapy until complete dissolution has been achieved.

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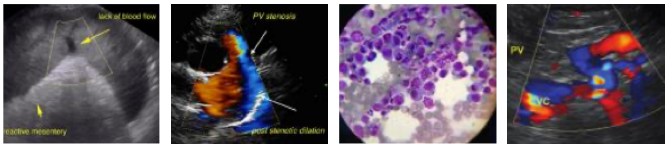

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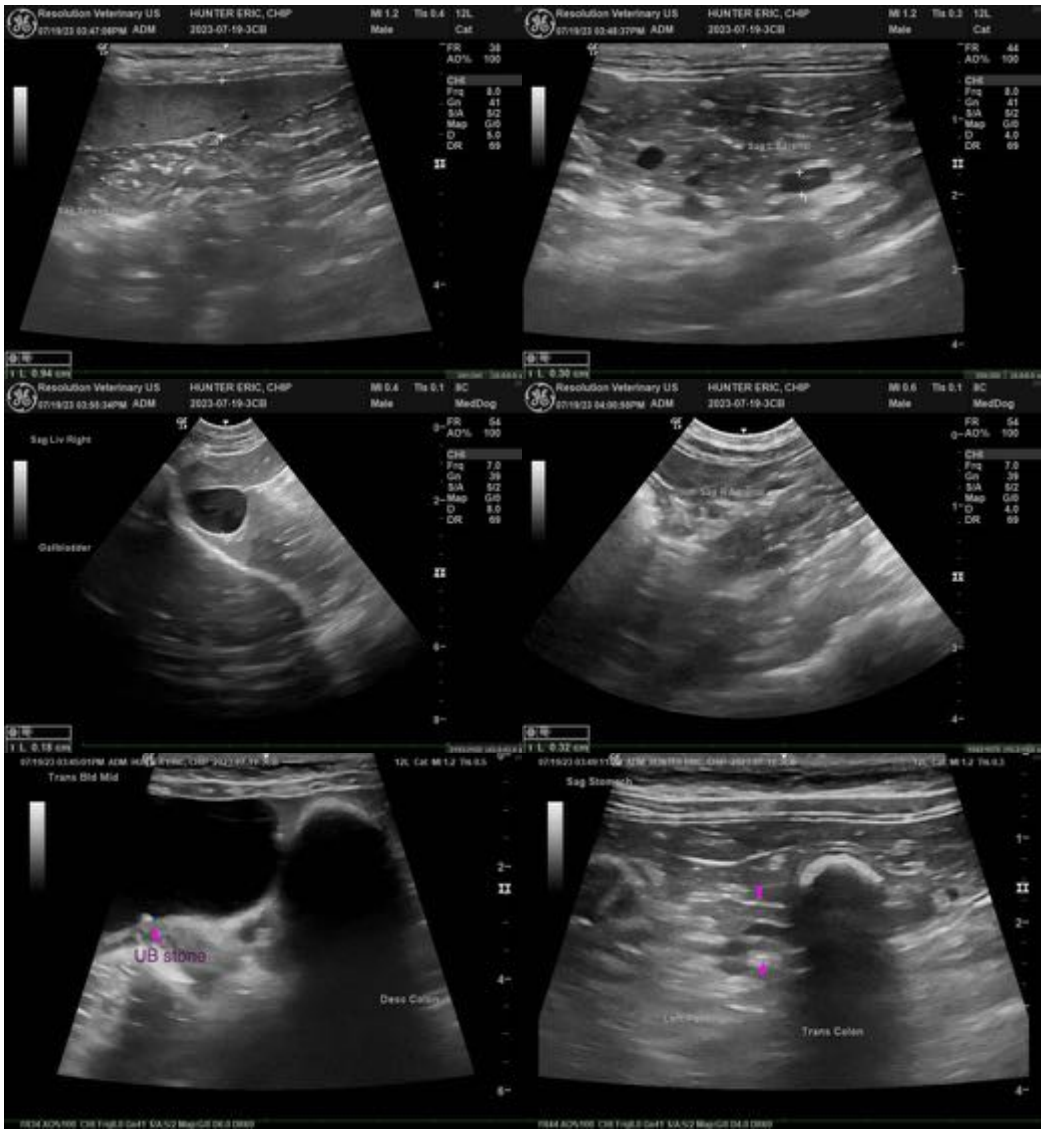

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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