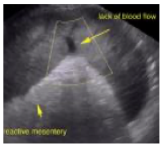
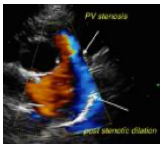
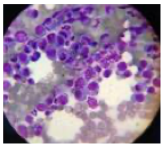
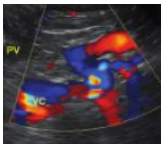
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

SonoPath.com
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PATIENT
Marla Bogart

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
17 years

WEIGHT
8.6 lbs

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

IMAGING PERFORMED BY
Jessica Bailes

HOSPITAL NAME
All Creatures Great & Small VC Corvallis OR

REFERRING VET
Brent Sadahiro

INVOICE
11751

DATE
9.29.22

PRESENTING CLINICAL SIGNS

History: chronic hx of intermittent vomiting and CKD as well as UTI's. More recently owners noticed intermittent pelvic limb pain and anal leakage. Increased water consumption. AGE done 9/12/22; symptoms improved for a few days afterwards but have returned. Progressive weight loss noted. Having intermittent hard stools but no obvious constipation in hx. Had AUS performed 12/20/2017 that showed subtle nodular splenic lesions most consistent w/ lipogranulomas.

Abnormal PE/Chem/CBC/UA Results: Thin BCS w/ generalized cachexia, moist perianal area, otherwise NSF on PE. BW/Urinalysis done 9/29/22: Mild Anemia: 5.8 Moderate Neutrophilia: 23.9K (2500-8500) Monocytosis: 1028 Lymphopenia: 514 Grade 2 CKD BUN 39 Creat 2.3 USG 1.015 Cholesterolaemia 242 Elevated amylase 1445 Elevated PSL 27

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is 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 2 cm, are normal.

The **left kidney** is small in size (2.88 cm in length); with an irregular shape. The cortex is variably thickened. There is moderate loss of corticomedullary distinction. Mild pyelectasia is present (0.24 cm in the transverse plane). There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (2.91 cm in length); with an irregular shape. The cortex is variably thickened. There is moderate loss of corticomedullary distinction. Mild to moderate pyelectasia is present (0.33 cm in the longitudinal plane). A cortical infarct is suspected at the cranial aspect. There is no evidence of hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.34 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is normal size (0.37 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (0.81 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Several small, ill-defined hyperechoic nodules/areas are observed throughout the organ. 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. A 0.88 cm ill-defined hypoechoic nodule/area is observed on the right side, adjacent to the gall bladder. The remaining parenchyma is homogenous. 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. A scant amount of suspended, echogenic debris is observed within the lumen. 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. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas
The left limb is visible with slightly irregular peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat. Several, small hypoechoic nodules are observed. The pancreatic duct is visible but not overtly dilated (0.22 cm in diameter). The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen
There is no evidence of free fluid. A few colic **lymph nodes** are visualized, the largest measuring 0.53 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral degenerative renal changes with a suspected right cortical infarct. The bilateral pyelectasia could be secondary to age-related remodeling, pyelonephritis, PU/PD (if applicable) or some combination thereof. Renal degeneration has progressed since the previous sonogram.

- The pancreatic changes are most consistent with mild chronic pancreatitis with benign nodular hyperplasia.

Secondary Findings

- The hyperechoic splenic nodules are likely benign (i.e., lipogranulomas). This finding was noted on the previous sonogram.

- The hypoechoic hepatic nodule could be consistent with an inflammatory focus, granuloma, emerging tumor, other.

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the azotemia and the sonographic renal changes, consider the following:

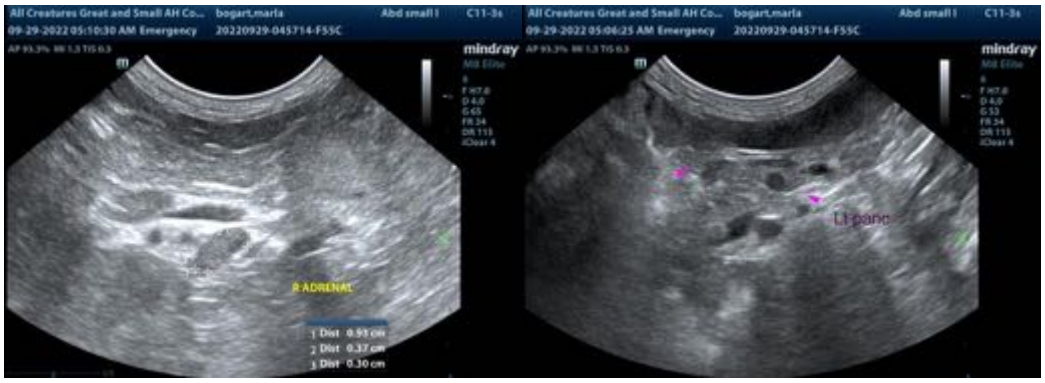
1. Urine culture and sensitivity
2. UPC (if proteinuria is present in the absence of a urinary tract infection)
3. Baseline blood pressure measurement

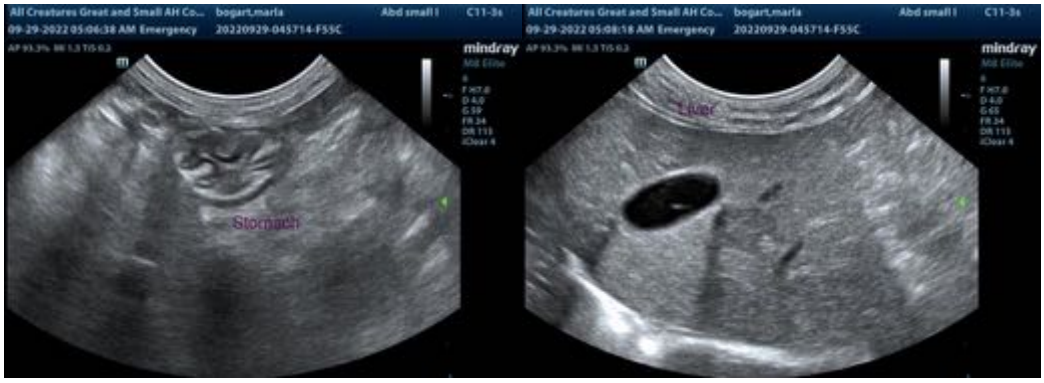
Regarding the weight loss, consider the following:

1. Three-view thoracic radiographs to assess for occult neoplasia in the chest
2. A fecal evaluation for ova and Giardia
3. Malabsorption panel including serum cobalamin and folate, TLI and PLI (send to Texas A&M)

Regarding the pelvic pain, orthopedic and neurologic evaluations should be considered +/- a consultation with a board-certified surgeon or neurologist.

Imaging (i.e., a spinal MRI) may be warranted, depending on examination findings.





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