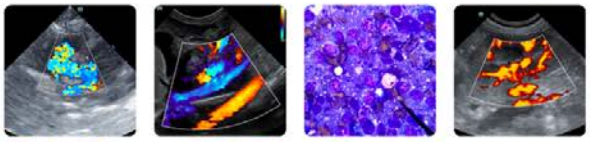

PATIENT

Onyx Douglas

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9

WEIGHT

6.8 kg

INTERPRETED BY

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Dr. Burns

HOSPITAL NAME

Wilvet Salem

REFERRING VET

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PRESENTING CLINICAL SIGNS

Patients' appetite has been declining slowly over past month, then in past week not eating meals and only eating churru treats (but not finishing) - will start flicking her tongue and turn nose away

Patient has history of elevated liver levels that have been monitored at rDVM regularly. No outward symptoms. Most recent BW (done 2 weeks ago) showed liver being WNL and kidney levels elevated.Per O, rDVM recommended hospitalization with supportive care to "flush out kidneys"

U/A reported to be WNL. e: not eating/very little. d: increased thirst. u: WNL. bm: none recently observed - but also another cat in home. v: possibly - ;pile of bile found. d: none

Abnormal PE/Chem/CBC/UA Results: CBC: HCT 28.6 (L), WBC 13.55, neut 6.07, lymph 6.87, PLT 160 Chem10: Creat >13.6 (H), BUN >130 (H), TP 9.3 (H), Globulin 5.7 (H) SDMA: 54 (H) ePOC: Chloride 129 (H), iCa 1.16 (L), BUN >120 (H), Creat >15.0 (H), HCT 30 UA: USG 1.016, pH 5.0, trace protein, glucose 1+, negative for ketones, bili, bld/hemo 2+, WBC <1/hpf, RBC <1/hpf, no bacteria detected, no casts or crystals noted.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. The bladder is moderately distended with anechoic urine and a mild amount of suspended mobile echogenic debris. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are bilaterally enlarged with hyperechoic renal cortices. There is a mildly distorted cortex to medulla ratio in favor of the cortex. The capsules are irregular bilaterally with a mild amount of perinephric effusion and peritonitis present. There is a mild amount of pyelectasis with no significant nephrolithiasis or evidence of ureteral obstruction. Left kidney measures 5.3 cm. Right kidney measures 5.4 cm.

Adrenal Glands

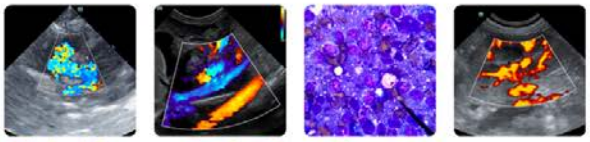
The adrenal glands are not discretely visualized.

Spleen

The spleen measures 0.93 cm at the hilus it is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented.

Liver

The liver is subjectively enlarge with rounded margins. It is diffusely hyperechoic but maintains normal parenchymal architecture. Vasculature is within normal limits with no evidence of congestion. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented.



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Gastrointestinal

The stomach and intestines are free of stasis and peristaltic activity, with no significant dilation noted. There is normal wall thickness and acceptable curvilinear mural detail. The pyloric-duodenal junction and ileocecocolic junction are patent, and the colon contains normal shadowing feces. There is no evidence of shadowing obstructive material or overt infiltrative disease noted. No associated abnormal lymphatic activity is documented.

Pancreas

The pancreas is mildly prominent and hypoechoic with irregular margins.

Free Abdomen

There is diffuse hyperechoic mesentery or omental fat and a scant volume of free peritoneal effusion aside from the previously noted perinephric effusion.

No significant lymphadenopathy documented.

ULTRASONOGRAPHIC FINDINGS

- The bilateral changes to the kidneys may represent an acute glomerulonephritis or infiltrative neoplastic process. Additionally, an ascending pyelonephritis can't be definitively excluded.
- The liver is enlarged and hyperechoic with maintenance of normal architecture. This may represent hepatic lipidosis. However, an infiltrative neoplastic process or chronic hepatopathy can't be definitively excluded, especially given the chronic elevations to liver enzymes.
- The prominent, hypoechoic pancreas with an irregular contour and mixed ill-defined hyper and hypoechoic changes is most consistent with pancreatic remodeling and nodular hyperplasia. This may be secondary to active or acute-on chronic inflammatory disease or pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

Fine needle aspirates of the liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

If clinically feasible or possible, consider abdominocentesis with fluid analysis and cytology to further evaluate the scant to mild free peritoneal effusion. Consider an fPLI to further evaluate the pancreas for evidence of active inflammation or pancreatitis.

Fluid diuresis with supportive care as clinically indicated is recommended to treat the severe azotemia pending additional diagnostics.

Thoracic radiographs should be performed prior to aggressive fluid therapy to ensure no concern for occult cardiac disease.

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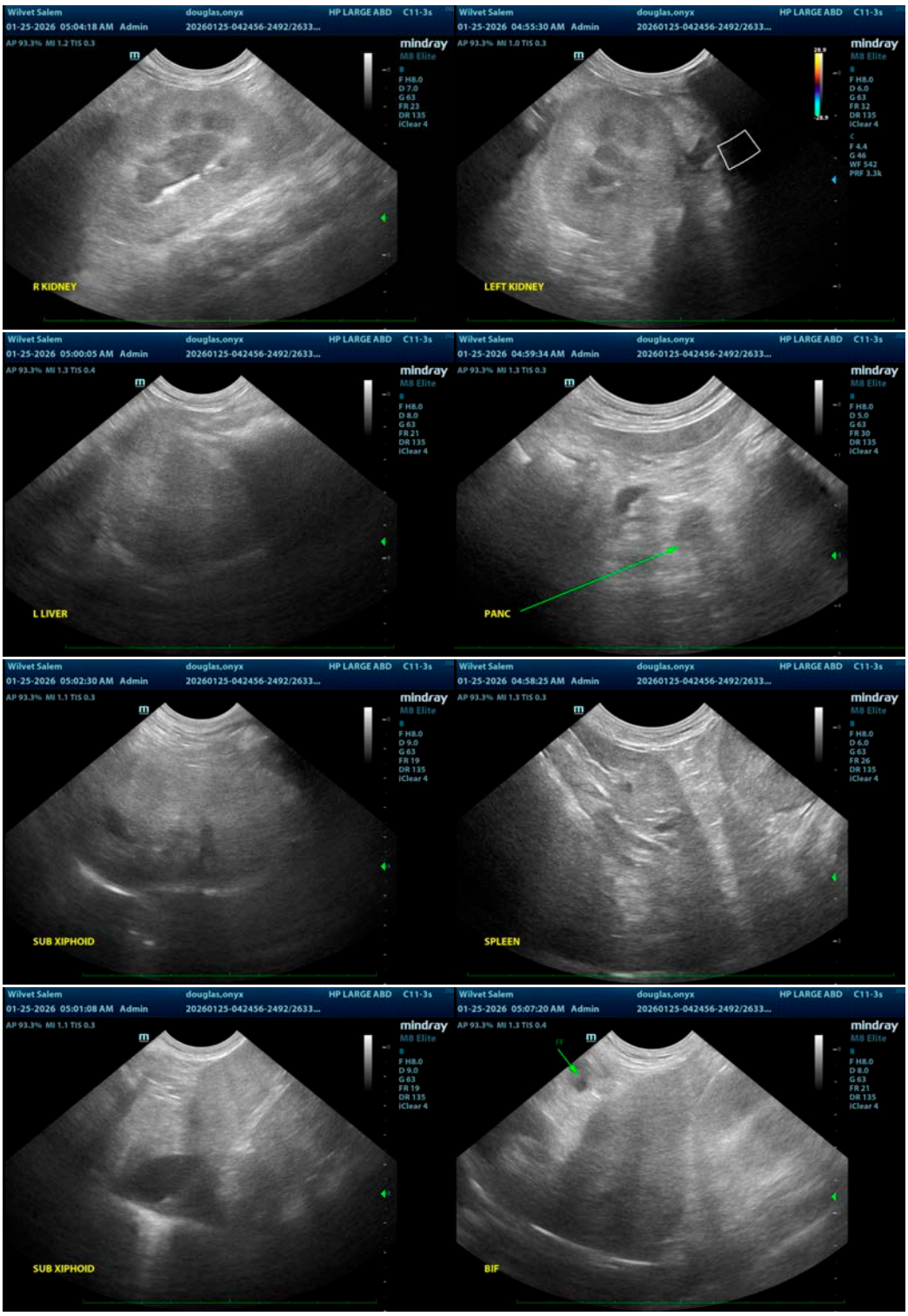

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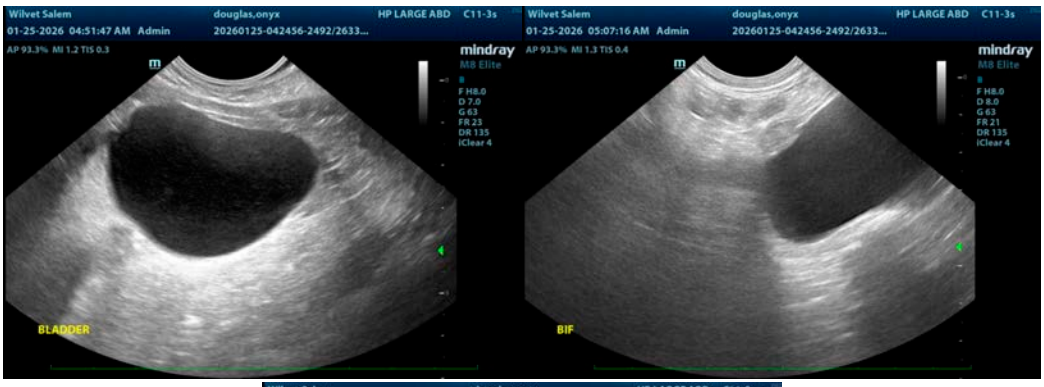

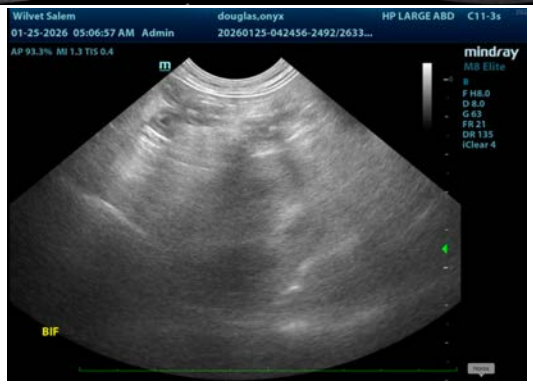

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com