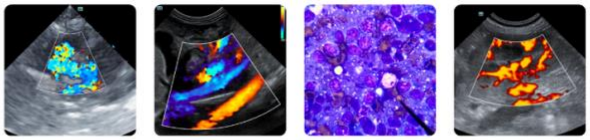


PATIENT

Ripley Ubienski

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

4.58 kg

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Dr. Kuzimski

HOSPITAL NAME

Animal Emergency Hospital Deland

REFERRING VET

Dr. Kuzimski

INVOICE

16417

DATE

06/06/26

PRESENTING CLINICAL SIGNS

Patient presented for continued care given a recent decline in appetite as well as constipation. he has a history of renal disease that owner helps at home with with SQ fluids weekly. he is on vetsulin 5U (owner adjusts dose at home pending BG), epikatin, nausea medication (owner cannot remember which one), and receives solensia monthly

Abnormal PE/Chem/CBC/UA Results: EPOC. creatinine 6.83, BUN > 120, HCT 26%, iCa 1.11, chloride 1.11, potassium 1.8, BE 2.2 fPl Azotemia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended contains a mild amount of suspended echogenic mobile debris. The 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 ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure. The cortices are slightly prominent with hyperechoic renal cortices and a loss of corticomedullary distinction. The cortex to medulla ratio appears appropriate. There is mild to moderate pyelectasis bilaterally with irregular renal capsular contour and mild renal cortical cystic changes. The left kidney measures 4.0 cm. The right kidney measures 3.5 cm.

Adrenal Glands

Both adrenal glands are not readily visualized.

Spleen

The spleen 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. The spleen measures 0.8 cm at the hilus.

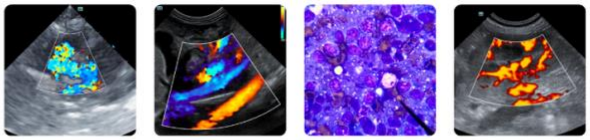
Liver

The liver is normal in size with diffusely mottled parenchyma and mixed hyperechoic nodular changes that do not distort the hepatic capsule.

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. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

Gastrointestinal

The stomach is non-distended with normal wall thickness. Pylorus and pyloroduodenal junction are patent. The small intestine is non-distended with adequate peristaltic activity. The muscularis layer appears slightly prominent and distorts the normal 1:3 muscularis to mucosal ratio. The overall small intestinal wall thickness measures within normal limits. ICJ is patent. Colon contains normal shadowing feces.



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Pancreas

The pancreas is mottled and diffusely hypoechoic with irregular ill-defined cystic changes. The pancreatic duct appears mildly dilated. There is no overt hyperechoic mesenteric or mental fat.

Free Abdomen

There are multiple mesenteric lymph nodes that are prominent with a slightly distorted length-to-width ratio. There is no significant free peritoneal effusion noted.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.
- There is increased renal cortical echogenicity and thickening with a mildly irregular capsular contour. Multifocal cystic cortical changes are noted. This is secondary cystic formation consistent with chronic age-related degeneration and remodeling. There is no evidence of abscessation or suspicion of neoplasia.
- The pyelectasis is concerning for potential ascending pyelonephritis. However, this may also be a geriatric change if the patient has been recently on intravenous fluid therapy.
- The changes to the liver are consistent with the patient's history of endocrine disease. However, concurrent infiltrative neoplastic process cannot be definitively excluded.
- The prominent muscularis layer of the small intestine may represent an early infiltrative disease such as chronic inflammatory bowel disease or other chronic enteropathy. Infiltrative neoplastic process cannot be excluded.
- The cystic and hypoechoic pancreas likely represents chronic remodeling. This may be secondary to a chronic pancreatitis. An acute or chronic pancreatitis cannot be definitively excluded. There is no evidence of biliary obstruction despite the mildly prominent pancreatic duct. This is likely secondary to the pancreatic remodeling.
- The slightly prominent mesenteric lymph nodes display no loss of parenchymal detail or change in echogenicity. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia.

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.

A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

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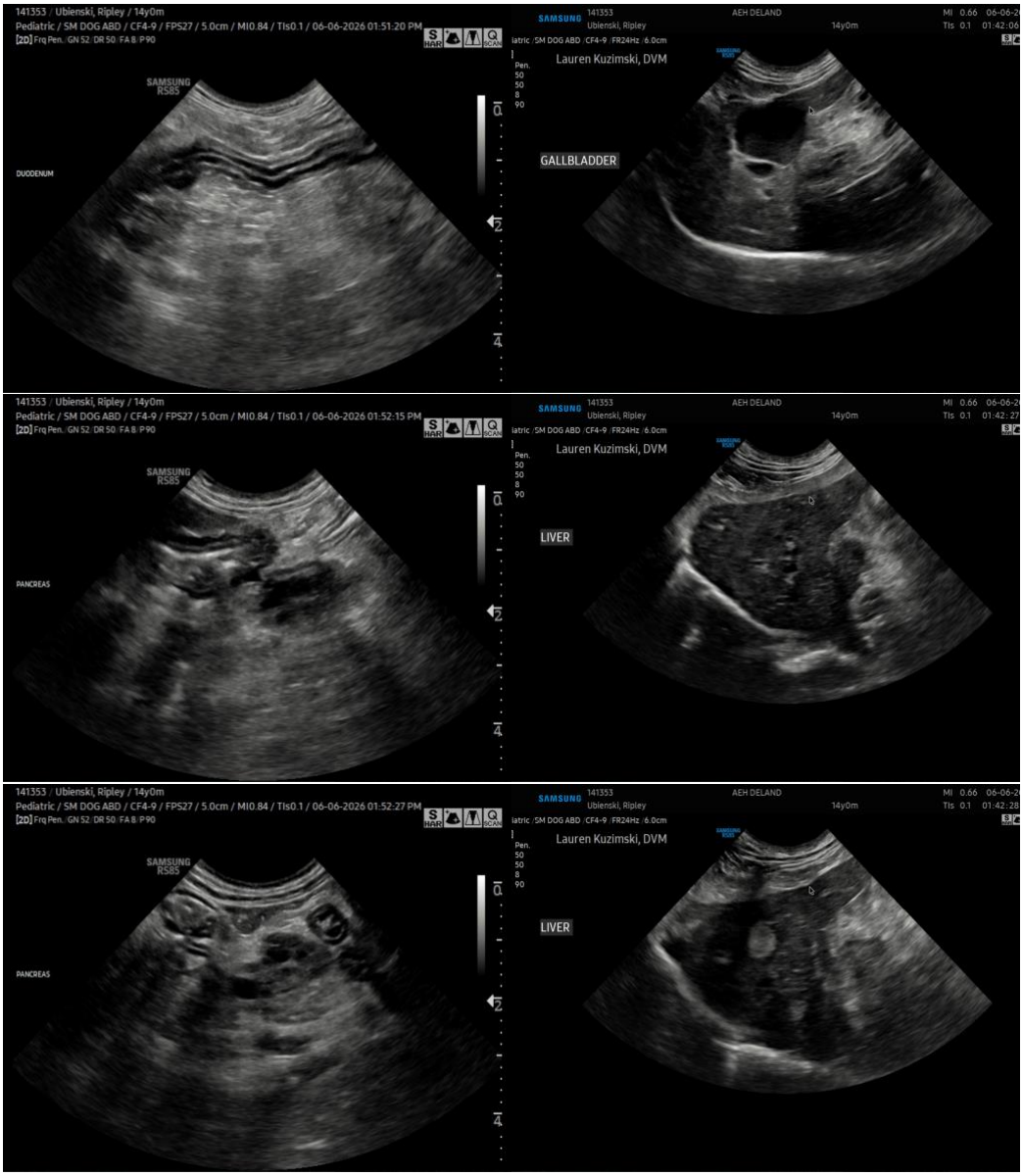
Empiric antibiotic therapy for potential ascending pyelonephritis should be started, pending urine culture. Additionally, fluid diuresis should be instituted given the severity of the azotemia.

Supportive care for potential acute on chronic pancreatitis or chronic enteropathy as a cause of the gastrointestinal signs is also reasonable.



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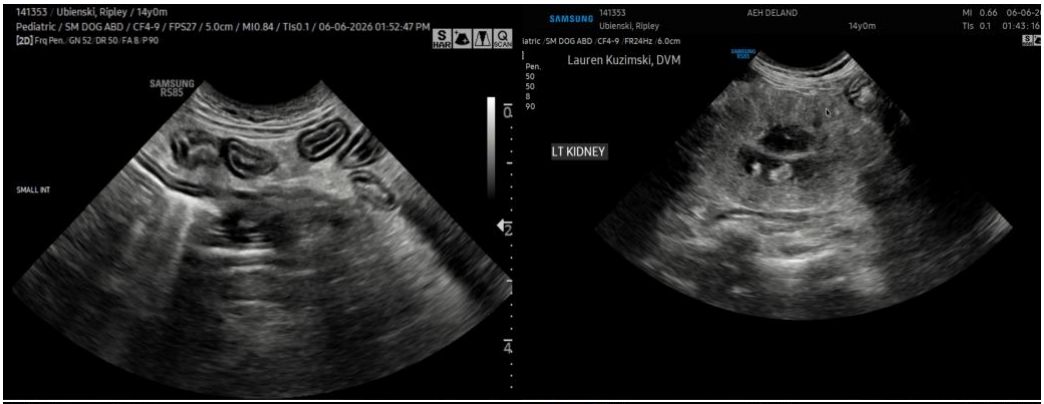

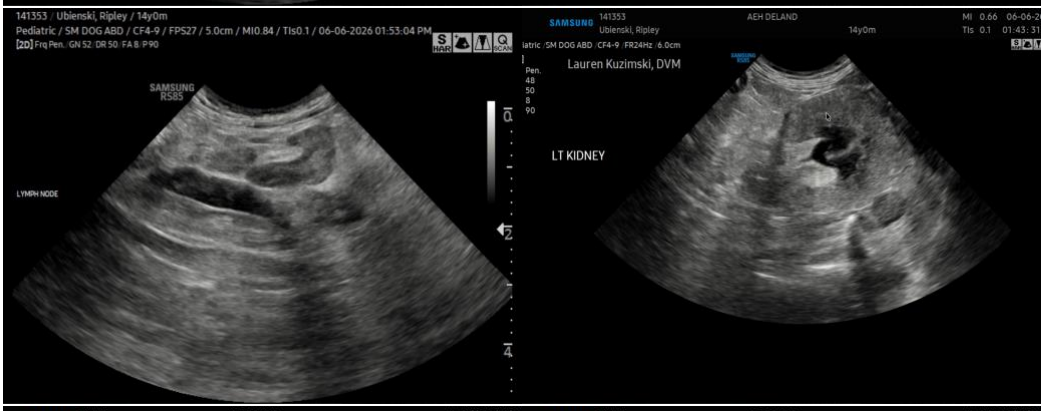

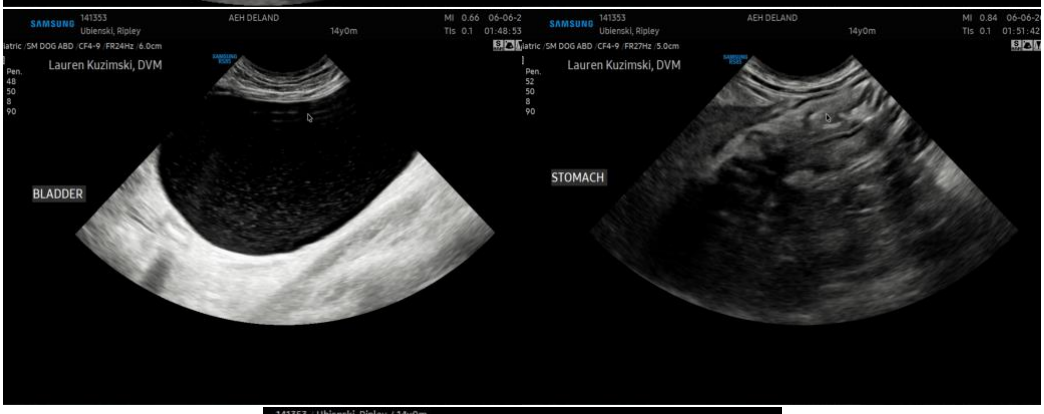

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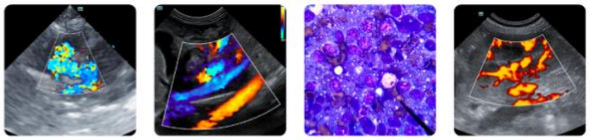

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com