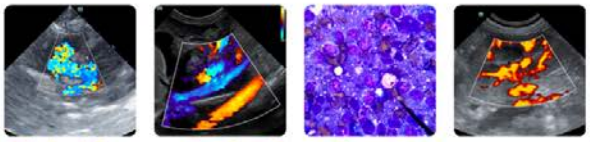


PATIENT

Gideon Sommerville

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

4 Years

WEIGHT

5.25 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

72308

DATE

1/21/26

PRESENTING CLINICAL SIGNS

Transfer from rdvm for DKA. He was not a known diabetic prior to being seen at rdvm. O said for past few days P has been lethargic and not wanting to go outside where he prefers to be, going to lay in unusual spots in the house away from everybody, walking slowly, and P was not eating or drinking today. O has 30 cats so difficult to tell if any v/d, PU/PD, or how long P's appetite has been decreased. O does have another diabetic cat; so she checked P's BG (was in 300 range) and owner gave him 2 units of other cat's vetsulin at 11:19am. Then went to rdvm in afternoon of 1/21; blood work done. admitted at shores for iv fluids w/ K+, cerenia, ondansetron, glucose monitoring, started on Novolin R CRI per protocol, buprenorphine, unasyn.

Concern for DKA.

Abnormal PE/Chem/CBC/UA Results: PE: BCS 4/9, poor body condition for 4-year-old cat rdvm: cbc: rdw 29 H, mono 1.21 H, eos 0.02 L chem: glucose 392 H, creat 0.7 L, K+ 2.6 L, chloride 103 L, TP 9.8 H, globulin 6.8 H, ALT 158 H, t bili 2.3 H, cholesterol 242 H, amylase 398 L Shores: vcheck FPL: greater than 50 H ketones: 7.8 H u/a: rbc <5/hpf, wbc <5 hpf, bacteria none to rare, ketone 2+ (50), glucose 500, pH 5, blood 3+ (250), usg 1.024, leukocytes 3+ (500) epoc 1/21 8 am: bicarb 13.3 L, TCO2 12.7 L, Na 133 L, K+ 2.3 L, chloride 110 L, ica ++ 0.91 L, glucose 509 H

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are large in size (left 5.8 cm, right 5.1 cm) with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. In some views there appears to be a very subtle/trace hypoechoic subcapsular rim or “halo” sign. However, this finding is not consistent in all views.

Adrenal Glands

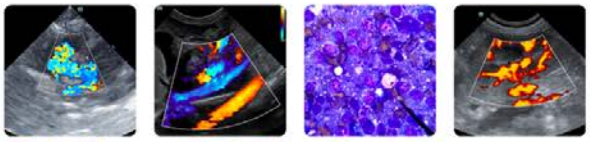
The areas of the adrenal glands are examined without evident adrenal gland pathology, but the glands are difficult to visualize/isolate for measurement.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than



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normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Feline renomegaly – These renal changes can be seen with glomerular or interstitial nephritis, FIP, amyloidosis, acute tubular necrosis or infiltrative neoplasia such as lymphoma. Normal variant due to fat deposition cannot be ruled out but is less common in an enlarged kidney. A subcapsular rim or halo sign could suggest infiltrative neoplasia such as lymphoma. However, as stated above, this change is very subtle and not consistent in all views.

- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.

- Moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Especially given patient's reported hyperglobulinemia, fine needle aspirates of the kidneys +/- liver are recommended if patient's coagulation status is appropriate. A urine culture could be considered if not recently evaluated.

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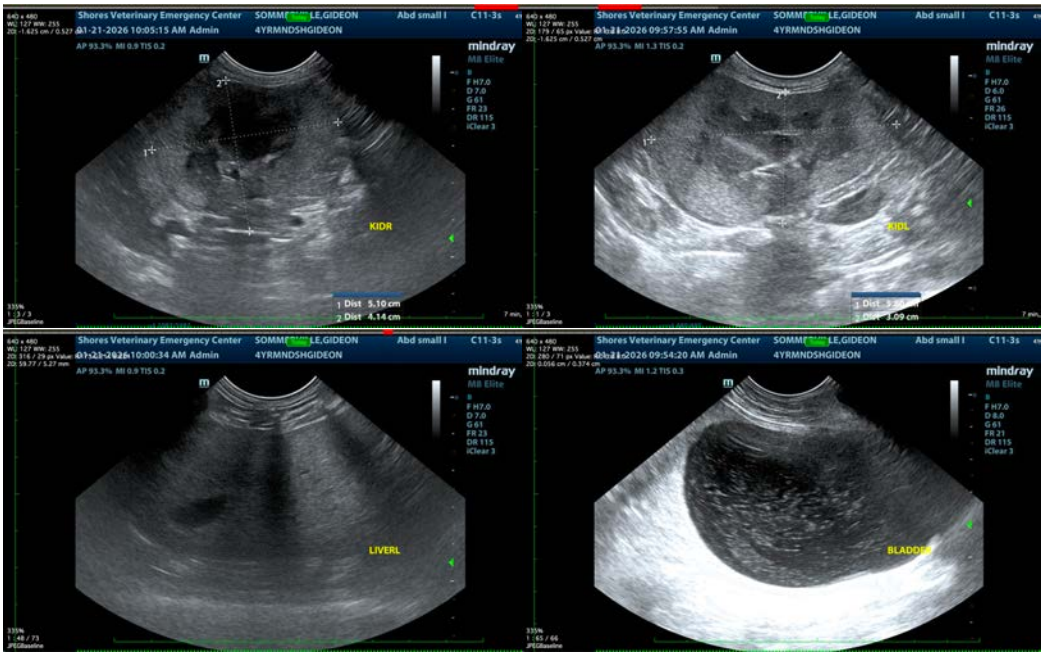
In the meantime, continued supportive/symptomatic medical management of clinical signs and the newly diagnosed diabetes and DKA are recommended.



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.

Beth Johnson, DVM, DACVIM
info@sonopath.com